

SHERIFFDOM OF NORTH STRATHCLYDE AT PAISLEY

Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Determination by Sheriff Ruth Anderson QC Sheriff of North Strathclyde following an Inquiry held at Paisley into the circumstances of the death of Declan Hugh Hainey born 17th April 2008

Note: Other than in Section 6(1) (a) and (b) of my formal determination, I shall refer to Declan Hugh Hainey simply as Declan and I shall refer to his mother Kimberley Mary Hainey as Kim Hainey.

The Sheriff, having resumed consideration of the cause DETERMINES that in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

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

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

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

(ii) Declan's death might have been avoided

a. if there had been comprehensive communication of reports, assessment forms and minutes of the various meetings which took place both pre and post birth to the other agencies involved in the case after it was closed to the Social Work team at Royal Alexandria Hospital. In particular Health Visitors and Family Matters should have been

provided with all the information available on Kim Hainey and Declan. Had they been so, then the Health Visitors would have categorized the case as one requiring 'intensive' as opposed to 'additional' support, and would have called for more intensive social work involvement. Family Matters in turn would have referred the case to the Area Team of the Social Work Department prior to Declan's first birthday with a view to Child Protection measures being taken and /or a referral to the Reporter being made.

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

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

(d) Having determined that on a balance of probabilities neglect was a contributory factor (see (b) above) the following defects in the system contributed to Declan's death

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

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

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

(e) The following four factors are relevant and recommendations have been made in respect of these.

1. Staffing levels in Social Work and Health Services
2. Action to be taken when a Notification of Concern in relation to an unseen child is received by a social work department
3. The distribution of medical information to those working in cases where there are children of substance misusing parents or carers.
4. Mandatory training of general practitioners in the guidance and protocols relating to child protection.

The Background

This Fatal Accident Inquiry has attracted considerable public interest, not least because it follows upon the trial and conviction of Kim Hainey on a charge of the murder of her son. The trial took place in late 2011 and on 15th December 2011 the jury, by a majority, convicted her of the murder of her son Declan. It might be helpful if I were to set out here the terms of the charge in respect of which the guilty verdict was returned:

‘Between 1st September 2008 and 30th March 2010, both dates inclusive, the precise dates being to the prosecutor unknown, at 45 Bruce Road, Paisley and elsewhere, having sole custody, charge and care of Declan Hainey, your son, both 17th April 2008 then residing with you at said 45 Bruce Road, you KIMBERLEY MARY HAINEY did, on various occasions wilfully ill-treat and neglect said Declan Hainey, fail to provide him with adequate nourishment and fluids, leave him alone and unattended within said 45 Bruce road for excessive periods of time and fail to seek to provide medical aid and care for him, and did thereby, and by other means to the prosecutor unknown, cause unnecessary suffering and injury to the health of said Declan Hainey whereby he died and you did murder him.’

Kim Hainey appealed her conviction for murder and on 17 April 2013 the Court of Criminal Appeal quashed that conviction. No motion was made by the Crown for a retrial. The Crown thereafter petitioned for a Fatal Accident Inquiry which commenced on 12 May 2014. I am not aware of any precedent for an Inquiry taking place in such circumstances.

The Statutory Framework

Section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 ('the 1976 Act') sets out the purpose of an Inquiry such as this in the following terms:

"at the conclusion of the evidence, and in submissions thereon, as soon as possible thereafter, the Sheriff shall make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction

- (a) Where and when the death, and any accident resulting from the death, took place
- (b) The cause, or causes, of such death, and any accidents resulting in the death
- (c) The reasonable precautions, if any, whereby the death, and any accident resulting in the death, might have been avoided
- (d) The defects, if any, in any system of working which contributed to the death, or any accident resulting in the death
- (e) Any other facts which are relevant to the circumstances of the death.

The Purpose and the Parameters of a Discretionary Inquiry

Where in relation to any death, there is a public interest in inquiring into the circumstances surrounding the death and those do not, as a matter of law, require the holding of a mandatory Inquiry, the Lord Advocate, in the public interest, may apply to the court for the holding of such a discretionary inquiry. The Inquiry into the death of Declan is a discretionary one.

It is well settled that it is not the purpose of a fatal accident inquiry to determine any question of civil or criminal fault or liability. In *Black –v- Scott Lithgow Limited* 1990 SLT 612 Lord President Hope stated at page 615 G-H:

"There is no power in this section [6] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident.....It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to settling out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required."

Assistance in identifying the purpose of such an Inquiry as this may be found in the words of Sheriff Brian Kearney in his Determination after the Inquiry into the death of Mildred Allen (14th November 1985) in which he states:

“The essential purposes are the enlightenment of those legitimately interested in a death, i.e. the relations and dependants of the deceased, as to the cause of death (and of any accident resultant of the death). And the enlightenment of the public at large, including the relations, as to whether any reasonable steps could or should have been taken, whereby the death might have been avoided, so that lessons may be learned.....”

Sheriff Charles Stoddart in his determination following the Inquiry into the death of Christine June Foster (25th February 2002) said the following:

“An Inquiry under the 1976 Act is an exercise in fact finding and not fault finding, and so it would be quire wrong for me, in the context of these proceedings to ascribe directly to any one named individual or body blame for the death. Section 6 of the Act does not permit me to do that, but it does entitle me to set out in my determination the reasonable precautions whereby her death, and the accident which result in it, might have been avoided”As Sheriff Principal Mowat expressed in his Determination, following upon the Lockerbie disaster: ‘ in terms of Section 6(2) of the Act, a sheriff’s determination may not be founded upon in any other judicial proceedings arising out of the death, and by this method, Parliament has indicated that the finding of fault is not intended as the purpose of the Inquiry.”

Section 6 of the 1976 Act

I shall turn now from the general purpose of an Inquiry to the determinations which are available under the various subsections.

Section 6(1)(a) Date of Death

On all of the available evidence it was not possible to identify with precision the actual date on which Declan died. The evidence which I accepted did however point to a latitude of some weeks during the months of July and August 2009. I gave consideration to narrowing the latitude which I have taken. However, I relied on evidence from a variety of sources and no one could pinpoint dates with any precision. I therefore came to the view that the latitude which I have taken was the appropriate one. The Crown and other parties in their submissions were in broad agreement with my determination under this subsection. I had intimated my preliminary thinking on this matter on the first morning of submissions and no party who was represented at the Inquiry submitted that I should determine a latitude that was materially different.

Section 6(1)(b) Cause of Death

On this, there was dispute and only the Crown submitted that I should determine that neglect of her son by Kim Hainey contributed to his death. All others submitted that as the cause of death at post-mortem was unascertained it was not open to me to go further than this, and to do so was simply to speculate. I did not agree with the latter submission. On the whole evidence before me, I am satisfied that Kim Hainey's prolonged neglect of her young son **at least** contributed to his death. I set out below my Findings in Fact in relation to that neglect and I discuss it further in my Note.

Determination under Section 6(1)(c)

'the reasonable precautions, if any, whereby the death, and any accident resulting in the death, might have been avoided'

What is a 'reasonable precaution'? Carmichael on Sudden Deaths and Fatal Accident Inquiries (3rd ed) at paragraph 5-75, p174 states: "what is envisaged is not a 'probability' but a real or lively possibility that the death might have been avoided by the reasonable precaution'.

What constitutes a 'lively possibility' has been considered in other determinations and I make reference to four.

1. In the Inquiry into the death of James McAlpine (October 1985) Sheriff Kearney gave some guidance where the deceased, a 7 year old boy, died during what was presented to his parents as a straightforward medical procedure:

".....in relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one."

2. In his Determination arising out of the death of John Kelly Sheriff W. Holligan states:

"It is not the function of an inquiry to make findings of any fault or to apportion blame.....Causation does have a role. In particular the provision of section 6(1)(c) and (d) seem to me to proceed on the basis there will be, in most cases, a process or event which falls to be examined in order to see what led to an accident. Having established such process or event, it is then possible to see what steps might have been taken to avoid the outcome or what defects there were. In my opinion, the provisions of Section 6(1)(c) and (d) fall to be applied objectively and with the benefit of hindsight. Section 6(1)(e) gives some support to this interpretation. There might be circumstances that might be relevant to the death but might not have been established to have a causal link".

3. Sheriff Ruxton in her determination in 2014 into the death of Kathryn Beattie observed;

“Thus the term ‘might’ should be applied in a sense that incorporates the notion of something qualitatively more than a remote possibility: a possibility with some substance and potential rather than a fanciful or notional possibility.”

4.Finally in the Rose Park Inquiry Determination (20th April 2011) Sheriff Principal Lockhart made the following comment:

“The question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference’.

In the light of all of the evidence led in the course of the Inquiry, including the evidence of the various changes in policy and procedure which have occurred since the death of Declan in respect of the agencies for whom Renfrewshire Council and Greater Glasgow and Clyde NHS Board were at the material time responsible, and with the guidance afforded from what has been said in other inquiries, I have come to the view that the precautions which I have identified in terms of Section 6(1)(c) are reasonable precautions which had they been taken either individually or cumulatively might have avoided the death of Declan in the summer of 2009

Determination under Section 6(1)(d)

Under this subsection I have identified two systems which could readily have been put in place prior to 2008-2009. The fact that these systems did not exist at the material time contributed to Declan’s death in that no overview was being taken of the situation and no one was in overall charge of the case. This meant that no one in a position of responsibility for Declan’s protection from the early months of 2009 had a proper appreciation of how the situation was deteriorating and the risks that such deterioration meant for the safety of Declan.

Determination under Section 6(1)(e)

In considering the scope of Section 6(1)(e) in the Inquiry into the death of John Kelly, Sheriff W Holligan had this to say:

“The provisions of section 6(1)(e) are still wider and, in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation,”

Under this section I have identified four factors which I consider of relevance and on which I have made recommendations.

The Inquiry

Evidence in this Inquiry began on 12 May and was heard over some 36 days between then and 22 July 2014. Written submission from all parties were lodged by the morning of 18 August 2014 and were supported by fairly brief oral submission on 18 and 19 August 2014. I have set out the Findings in Fact more or less chronologically to allow the story of Declan's short life to unfold as far as the evidence will allow. I recognise that my Findings are fairly lengthy, but I consider it important that the detail of the evidence on which my determination proceeded should be set out. I have expanded on some matters in my Note. I have collected my Findings under headings covering various short periods of time, starting with broad Findings in relation to his mother's life prior to her pregnancy and then make more detailed Findings in relation to identifiable periods e.g. from 17 April 2008 (the date of Declan's birth) until 30 September 2008 (the approximate time of the move to 45 Bruce Road). There is some necessary overlap, when things were happening across the selected periods of time, and also some occasional but unavoidable repetition.

Findings in Fact

a. The period up to the conception of Declan

1. Kim Hainey was born on 22 May 1974. Her mother is Elizabeth Rodden (nee Hainey) and her father is James Breslin. Her parents did not live together at any time, and her father, who moved to England soon after her birth, had little contact with his daughter other than a few visits when she was a baby, and a time in her mid to late teens when she visited him and his second family in Oxfordshire. James Breslin never saw Declan and at no time during Declan's life did Kim Hainey visit him in England. She was brought up by her mother and her maternal aunt, Ann McNeillage ('Aunt Ann'), and they lived in the same house when she was young. Her Aunt Anne played a large role in her life. From her early teens at least she showed an independent streak and found employment both in England and then in Scotland. Elizabeth Rodden married her husband John Rodden in 1998.
2. At some time Kim Hainey worked in Glasgow with Direct Line Insurance. She bought a small flat with a mortgage and led an independent life. In 1999 her maternal uncle Hugh Hainey died after being diagnosed with cancer the previous year. She was very upset by the death, she became depressed and around that time started drinking

heavily and from 2005 started to abuse drugs including heroin. As a result she lost her employment, and as a consequence her flat. Between 2001 and 2007 she had three separate admissions to Dykebar Psychiatric Hospital in Barrhead ('Dykebar'). She was depressed, and overdosed on at least one occasion. There was no formal diagnosis of mental illness. Her excessive consumption of alcohol and her drug use contributed to her instability.

3. From around 2000 Kim Hainey was not in regular employment and lived a chaotic life. She had contact with her mother and family on occasions and would then disappear for long periods, of up to a year. Throughout that time she continued to abuse drugs. She had no permanent home nor any real stability in her life. Her mother often did not know her whereabouts. She led a chaotic life.
4. She was an in patient in Dykebar from 18 December 2006 until 3 January 2007, and again from 10 February until approximately 18 February 2007.
5. While an inpatient in Dykebar in January/February 2007 Kim Hainey met David Gibson, who was also a patient in Ward 2, and formed a relationship with him. She was discharged from the hospital on approximately 18 February when she return drunk after being out on a pass and was aggressive to staff. David Gibson was also discharged that day. He was married with children, but his contact to his children was supervised at that time. He and Kim Hainey lived together for some months thereafter, as a result of which Declan was conceived sometime in the summer of 2007. By the end of 2007 their brief relationship had come to an end. David Gibson never saw his son, nor did he ever request to see him.
6. On two occasions between March and May 2007 Dr Brandon, Kim Hainey's general practitioner at the Love Street Surgery, Paisley, signed her off as unfit for work for 8 weeks because of her 'low mood'.
7. In the summer of 2007 she advised her mother that she was pregnant and Mrs Rodden immediately started buying items in preparation for the birth.

b. The period from conception to the birth of Declan on 17 April 2008

8. In the summer of 2007 Kim Hainey and David Gibson were involved in an incident in Millport on the Isle of Cumbrae when both had been drinking, as a result of which David Gibson was charged though no conviction followed.
9. On 6 September 2007 Kim Hainey consulted Dr Brandon at the Love Street Surgery regarding her pregnancy. Arrangements were made for her to have a scan, on 7 September 2007, 14 September 2007 and 10 October 2007. She failed to attend any of these appointments.

10. By December 2007, Kim Hainey and David Gibson had separated, and efforts were made by Irene Carswell, one of the Health Visitors attached to Love Street Surgery, to locate her as there had been no contact with any health professional since her consultation with Dr Brandon on 6 September. Around December 2007 she moved in to her mother and stepfather's house at 38 Friendship Way Renfrew on the condition that she did not take drugs.
11. On 19 December Kim Hainey attended an appointment at the Love Street Surgery. She was seen by Dr McKeown. She refused to be examined. A urine sample showed positive for pregnancy. On 28 December 2007 she failed to attend an arranged appointment with her General Practitioner
12. Sometime towards the end of 2007 Mr. & Mrs. Rodden went to Portugal on holiday, leaving Kim Hainey to look after their home. When they returned around the beginning of January 2008 they found her in the house with a man who was not known to them. They found evidence of drug abuse and as a result she was put out of the house. There was no contact between mother and daughter till 17 April 2008, the day Declan was born.

2008

13. On 14 January Mrs Rodden attended at Love Street Surgery to inform the practice of her concerns about her daughter's pregnancy, her heroin consumption and the fact that her whereabouts were unknown.
14. On 21 January Kim Hainey presented herself at Accident and Emergency at Royal Alexandra Hospital, Paisley ('RAH') with a chest infection, and stomach cramps. Examination confirmed that she was some 28 weeks pregnant. She was malnourished, unkempt, had a temperature and her personal hygiene was poor. She was suffering from withdrawal symptoms. She had recently obtained a prescription for antibiotics from her general practitioner which she had not presented to the pharmacy. She was kept in hospital and was discharged on 29 January 2008.
15. SNIPS (Special Needs in Pregnancy) is a unit attached to the RAH dealing specifically with expectant mothers who have addiction problems. In 2007/2008, SNIPS was run by two experienced midwives, Flora Dick and Rose Dougan. On 22 January Flora Dick sent a Notification of Concerns about a Child form to the Social Work Department at RAH. New Expectations form part of the Social Work Department at RAH. At that time it comprised one Drug Worker (Hazel Martin) and a Family Support Worker (Linda Horsburgh). The service provided 'an intensive support package' to pregnant women who were misusing drugs, or had a history of doing so. It was the practice to meet clients in their own homes. Hazel Martin, a very experienced practitioner in the field, joined New Expectations in November 2007 and Kim Hainey was her first client. Hazel

Martin visited her in hospital on 22 January 2008. Kim Hainey refused to engage with her. She was reluctant to give any information about where she had been living and with whom, but self-reported smoking 5 x £10 bags of heroin per day, which she claimed had reduced to between 2 and 3 bags per day over the previous two weeks. She refused to consider embarking on a methadone programme.

16. On 23 January Hazel Martin took her to the Family Matters Clinic in Espedair Street Paisley. Family Matters is a multi-disciplinary project which provides early intervention for families where a parent or parents have a background of addiction (both drugs and alcohol) and where there is a child under the age of three years. It is a child-centred service. The doctors at Renfrewshire Drugs Service (RDS) supervise methadone programmes and issue prescriptions. Kim Hainey was placed on a methadone prescription of 30 mls and quickly stabilised at that level, despite the level of her self-reported consumption. On 23 January Hazel Martin tried unsuccessfully to contact Mrs Rodden by telephone. She did not leave a message on the answering service. She did not try at any other time to contact Mrs Rodden.
17. On 29 January Kim Hainey was discharged from RAH and moved into temporary furnished homeless accommodation at 24 Waverley Drive Paisley arranged for her by Hazel Martin. Throughout February and March she did nothing to ensure she obtained permanent accommodation for herself and her unborn child. She did not cooperate with the Housing Department. She made no preparations for the birth of her child.
18. On 30 January she arrived at RDS clinic smelling of alcohol. Dr Barnes, one of the prescribing doctors at the service, advised her of the risks of consuming alcohol while on a methadone programme. She would not accept the risks and refused to say from where she had obtained the money for the alcohol. Hazel Martin was present at that consultation.
19. On 5 February, and two subsequent dates that month, she failed to attend the afternoon group meeting at New Expectations which she had been advised to do. These group meetings were set up to assist pregnant women with basic information about childbirth, and the early months of child-care. Kim Hainey had no experience of either.
20. On 12 February Kim Hainey attended the RDS clinic. She was seen by Dr Barnes. By that date, the medical records from Dykebar were available to RDS. No discussion of their contents took place in 2008. Hazel Martin was therefore throughout 2008 ignorant of the detail of Kim Hainey's mental health history and her in patient stays.
21. On 14 February Kim Hainey cancelled a pre-arranged meeting with Hazel Martin which had been set up to discuss the Initial Assessment Meeting ('IAM') scheduled to take place on 15 February 2008. At this time, Hazel Martin had various concerns about the situation. These included Kim Hainey's alcohol consumption, her general lack of cooperation, her conspicuous failure to make any preparations whatsoever for the birth of her unborn child, her failure to cooperate with the Housing Department regarding future accommodation, and her lack of contact with her mother from whom she had

assured Hazel Martin she would receive material support. At this late stage in her pregnancy, she had established a pattern of failing to attend appointments, or cancelling them at short notice. These failures and cancellations were a prevalent feature of her contact with all agencies.

22. On 15 February the IAM took place at the behest of the social work department attached to RAH. The allocated Social Worker was Hugh Madden. His senior was Helen Morley. She took the Minutes. Hugh Madden had only recently returned to work after long-term sick leave and Helen Morley had joined the team within the previous few weeks and although a qualified social worker for many years, had no recent experience in child care/child protection cases. In 2008 Renfrewshire Child Protection Committee had promulgated an inter-agency protocol to be applied in Child Protection and Inter-agency Working with Children Affected by Drug or Alcohol Misuse. This was contained in a document called Getting Our Priorities Right (GOPR). In the introduction to the protocols it is stated:

'The Protocols are designed to ensure that the well-being and protection of children affected by drug and alcohol misuse is the subject of coherent and cohesive services across agency and professional boundaries. They reflect the basic aim of all working on integrated assessment for children and of 'Getting Our Priorities Right' and Hidden Harm, that all concerned should work together and communicate with each other.'

23. As was the practice in 2008, the general practitioners were not invited to the meeting. No Health Visitor was invited. Despite the fact that the undated and unsigned Minutes of this meeting record that Flora Dick (SNIPS) was in attendance, no one from SNIPS was at the meeting. A variety of child protection concerns were raised and Hugh Madden was instructed to prepare an assessment in terms of the GOPR protocol and to make arrangements to obtain Kim Hainey's medical records. A pre-birth meeting was scheduled for 17 March. Had Hugh Madden or Helen Morley requested the medical records from RDS, these would have been provided.
24. On 21 February Kim Hainey cancelled a planned Home Visit by Hugh Madden and Linda Horsburgh, despite being warned by Hazel Martin that she was running the risk of losing care of her unborn child. She advised Hazel Martin that she did not care and was going out.
25. In the first half of March Hugh Madden continued to work on the assessment. On 12 March he met Mrs. Rodden and her sister Ann at the Roddens' home in Friendship Way. It was made clear to him that the family would support the baby but not Kim Hainey. He was advised that she could be abusive and aggressive and when under the influence of alcohol could be very violent and nasty. Mrs Rodden advised Hugh Madden that because of all the trouble she had caused in the past, her daughter would not be permitted to stay at Friendship Way.
26. The pre-birth meeting took place on 17 March. It was the responsibility of Hugh Madden to invite the Health Visitors. He did not do so. The meeting should have been

chaired by Helen Morley. At the last minute, she was unable to do so and Bernadette McGrinder, the other senior social worker at RAH chaired the meeting. The pre- birth report prepared by Hugh Madden did not contain an introduction, a debate of the issues, a risk assessment or a contingency plan. He had not obtained Kim Hainey's medical records. What the report did contain was not sufficiently detailed to enable a proper professional assessment of any risks to the baby which might exist. No fewer than eight significant concerns were identified in relation to Kim Hainey's ability to care for the unborn child. These were a. history of drug use/potential for relapse b. history of domestic violence – within the family home and also in relation to David Gibson c. lack of preparation for the arrival of the baby d. no permanent housing and failure to engage in the process of identifying suitable accommodation e. her failure to contact her mother on whom she was allegedly depending for support, and who had made it clear there would be no support for her, only for the baby f. mental health issues which had not been properly investigated and g. self-neglect when well into her pregnancy. Despite these many concerns, the meeting concluded that there were 'no significant child protection concerns at the moment'. That was a wholly unrealistic assessment of the situation.

27. The meeting categorised her attendance at 2 out of 6 group work meetings at New Expectations, as a positive factor. It also categorised the existence of 'good indirect family support' as a positive factor, despite the fact there had been no family contact since the beginning of January 2008 when Kim Hainey had been put out of the Roddens' house. The meeting was well aware of a history of fragility in family relationships, the conditional nature of the support being offered, and of Kim Hainey's recent and past issues with alcohol. Her methadone programme was at a very early stage and the fact that she had stabilised on a prescription of 30 mls per day after reporting a habit of 5 x £10 bags per day (described by Hazel Martin as a 'heavy addiction') should have caused questions to be asked.
28. By at least the date of the pre-birth meeting both Hugh Madden and Hazel Martin were aware that Kim Hainey told lies, that she was not engaging with the assessment process, and had given both vague and misleading information. Hugh Madden was unable to obtain a clear picture of her ability to be a good parent. He had significant child protection concerns, but did not ensure that these were minuted. Hazel Martin also had child protection concerns but did not articulate these in such a way that they were minuted.
29. During March and April Kim Hainey attended the ante-natal clinic on four occasions, missing one appointment on 1 April.

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

30. On 17 April Kim Hainey gave birth to Declan. There were no complications at the birth and Declan was a healthy child. On that day, Mrs Rodden and her daughter were reconciled and arrangements made that the new mother and baby would spend the first two or three weeks of Declan's life at the Roddens' home.

31. On 21 April a post-birth meeting took place. The role of SNIPS ended that day. Hazel Martin did not attend the meeting. Neither of the two Health Visitors attached to the Love Street Surgery was able to attend. Margaret Armstrong, the Health Visitor from Foxbar Clinic who did attend had been provided with no papers, and had to read Hugh Madden's report while the meeting was on going. The focus of the meeting was on the positives, and despite the fact that a full picture was not available, including the medical records, the decision of the meeting was that there were no child protection concerns. In terms of the GOPR protocol a Discharge Care Plan should have been made. The protocol states:

'All women and babies should have a care plan at the point of discharge from hospital – this should be the case regardless of decisions made around formal child protection measures.'

No Discharge Care Plan was made. The meeting agreed that a further inter agency review was to be held within 3 months of April 2008. No such review took place.

32. From their discharge on 21 April until the end of June Kim Hainey and Declan lived at 38 Friendship Way, supported emotionally, financially and materially by Mr and Mrs Rodden and her Aunt Anne. Declan was healthy and thriving, and there was a clear bond between mother and son. Irene Carswell the Health Visitor visited and found all well. On 3 June she routinely tested Kim Hainey on the Edinburgh Post Natal Depression Scale (EPNDS). She scored 5, which required no further action. The test should have been repeated by Irene Carswell in 3 months' time. This was not done.

34. In the Spring, Kim Hainey obtained the tenancy of an upper flat at 45 Bruce Road in Paisley. Between receipt of the keys and her eventual move in September 2008, the flat was repaired, redecorated, carpeted and furnished by the Roddens. Mrs Rodden took on an extra cleaning job on a Sunday to help meet the expense. The Roddens also postponed work in their own home to work on the flat.

35. On 27 June Mr & Mrs Rodden looked after Declan while Kim Hainey went out for the evening. She returned late in the evening, under the influence of alcohol and acting very aggressively. Declan was sleeping in the living room. She tried to pick him up to leave the house. She was shouting and bawling. She assaulted her mother and her step-father. As a result the police were called and she was arrested and taken from the house. She returned the following day when she had sobered up. Mrs Rodden contacted the police and played down the whole incident. As a result no further action was taken.

36. On 30 June Hugh Madden visited Friendship Way to investigate the incident. When he reported to Helen Morley, she said that she would need to speak to Kim Hainey and also to

see Declan, to ascertain if there were grounds for Child Protection procedures. She did neither of these things. Further, neither Hugh Madden nor Helen Morley spoke to Irene Carswell about this incident, and when on 3 August 2008 Irene Carswell visited Friendship Way, she obtained only Kim Hainey's version of events which did not include either her drinking or the fact that she had been taken into custody. Irene Carswell did not speak to the social workers about the incident and incomplete information was given to Hazel Martin. The three agencies failed to communicate effectively with one another on what was a serious incident.

37. Hazel Martin was not at work between the beginning of July until September as a result of a road traffic accident and annual leave. She was not involved in the decision to close the case. When Hugh Madden returned from three weeks annual leave towards the end of July he was advised by Helen Morley that she had decided to close the case. On 6 August Hugh Madden and Linda Horsburgh visited Kim Hainey and Declan at Friendship Way. On that day, the case was closed to social work at the RAH. No consideration was given to postponing the decision until after the move into 45 Bruce Road. No consideration was given to providing additional supports such as regular evening welfare checks at 45 Bruce Road.

38. In the summer of 2008 and prior to the move to 45 Bruce Road, Hazel Martin met Kim Hainey in the street on several occasions. Sometimes Declan was present and sometimes he was not. She saw nothing to concern her. She assessed Kim Hainey as a loving mother to Declan.

39. Towards the end of September 2008 Kim Hainey and Declan moved into the flat at 45 Bruce Road.

d. From the end of September 2008 until Christmas 2008

40. During the month of October Mrs Rodden saw her daughter and grandson regularly. On 31 October Kim Hainey had a small family party at 45 Bruce Road to celebrate Hallowe'en. From that date until 30 March 2010, no family member entered the flat.

41. Between the end of September and Christmas 2008 Kim Hainey and Declan spent many weekends with a friend Natalie Gillespie, her partner and their baby daughter Maia at their home a short distance from Bruce Road. Kim Hainey lied to her mother about these weekends, telling her that she was spending them in Beith babysitting for a friend who had a job in a pub, and obtaining £20 for doing so. It was during this period that she started to withdraw contact between her family and Declan, and also withdraw her cooperation with New Expectations and Hazel Martin, as well as the Health Visitors.

42. After the move to Bruce Road, Hazel Martin had difficulty in contacting Kim Hainey by phone, and no access was obtained to 45 Bruce Road on an arranged visit in November 2008.

There were two arranged visits to 45 Bruce Road in November 2008 by Irene Carswell when no access was obtained.

43. On 21 November Hazel Martin and Linda Horsburgh visited Kim Hainey and Declan at 45 Bruce Road. They saw nothing to cause them concern. The decision was taken that day to close the case to New Expectations, and to transfer the case to Family Matters. The transfer took place on 19 January 2009.
44. On an unknown date in December Kim Hainey left Declan alone sleeping in his cot at 45 Bruce Road sometime after midnight to visit Tesco to buy milk.
45. During December Hazel Martin continued to experience difficulties in making contact with her and when Irene Carswell attended at Bruce Road for an arranged visit there was no reply. The Health Visitor had not seen Declan since the beginning of September.
46. On 11 December Declan was seen at the surgery by Dr Brandon. This was the only time in his life that Declan was seen by a general practitioner. It is very unusual for a child, especially a first child, to be seen by a general practitioner on only one occasion within the first fifteen months of life.
47. On 18 December 2008 Kim Hainey attended the RDS clinic without Declan. She told Hazel Martin that she had 'the odd glass of wine'.
48. On the nights of 24 and 25 December 2008, Kim Hainey and Declan stayed with the Roddens. They did not stay overnight with the Roddens again, nor did Mr & Mrs Rodden or Aunt Ann look after Declan again,

e. From 1 January 2009 till Declan's first birthday on 17 April 2009

2009

49. In January the Roddens booked a villa in Portugal and flights for them and for Kim Hainey and Declan for October 2009. Mrs Rodden gave her daughter money to obtain a passport for Declan. No application was made by Kim Hainey for a passport for her son.

50. On 19 January the case was transferred by Hazel Martin to Jill Stevenson the drugs worker from Family Matters. The meeting at which the transfer took place was unplanned and no papers were brought by Hazel Martin. No minutes or notes were taken of this meeting. It was the responsibility of Hazel Martin to transfer all papers including the Single Shared Assessment form which had been completed by her in February 2008 and signed by Kim Hainey in December 2008. She did not do so. The only document Family Matters ever received in relation to the case was 'the referral form' in which it was incorrectly stated that Kim Hainey had been stable on a methadone prescription throughout her pregnancy. Hazel Martin accepted that the contents of the form painted a rosier picture of the situation than was the reality. It was the responsibility of Jill Stevenson to ensure that Family Matters received all documents in connection with the case. She did not do so, despite reminders

from her supervisor Gillian Turner. Family Matters lacked basic information such as the level of Kim Hailey's methadone prescription, her claimed level of prior addiction, as well as the history of the pregnancy and her history of failed appointments and reluctance to cooperate.

51. On 28 January Kim Hailey failed to attend the clinic for her first meeting with Jill Stevenson.

52. On 10 February Jill Stevenson had the first supervision meeting with Gillian Turner her senior at Family Matters in which the case was discussed. Gillian Turner was told that Kim Hailey had failed to attend the clinic on 28 January. Gillian Turner categorised the case as 'low priority' despite the lack of information, and her failure to read the Swift Notes which are the computerised records of all involvement with clients which can be accessed by any worker. She should have read the notes prior to categorising the case. She never at any time read the Swift Notes. Supervision of a case should have taken place every six weeks. There should have been at least 3 further such meetings before the decision to close the case was taken in August 2009. Only one further supervision meeting took place, on 12th May. The quality of the notes of the meeting in February was poor, and any decisions which may have been made were not recorded as such.

53. On 19 February Jill Stevenson attended 45 Bruce Road for a planned home visit. She did not gain access. She phoned the Roddens house and obtained an abrupt and unhelpful response from Mr Rodden. On 24 February Kim Hailey cancelled an appointment with Jill Stevenson.

54. From about the beginning of February Kim Hailey stopped taking Declan with her to Lloyds pharmacy where she obtained her daily methadone prescription. She started to arrive late in the afternoon, outwith the stated times when a prescription should be collected. Her appearance had deteriorated. She often appeared with a puffy face, and bloodshot eyes. From March onwards she frequently smelled of stale alcohol and gave the impression that she had been drinking excessively the previous evening.

55. On 25 February Kim Hailey attended the RDS clinic. Hazel Martin saw her. She did not look well and was unkempt. Jill Stevenson met Kim Hailey for the first time. Declan was not present and Kim Hailey was tearful and depressed. She was smelling of alcohol and claimed to have had a glass of wine with her Aunt Ann the day before. Jill Stevenson came to the view that she was lying.

56. On 27 February Kim Hailey cancelled an appointment with Jill Stevenson and in the course of the telephone call was tearful. She claimed she was looking after a neighbour's child as well as Declan. Jill Stevenson carried out the EPNDS over the telephone in which the score was 23, suggestive of professional assistance being required. The test should have been done in person by Kim Hailey and not over the phone when she was allegedly responsible for the care of two young children. Jill Stevenson had no training in supervising such a test. The score is not one which can be relied upon.

57. On 6 March Irene Carswell visited 45 Bruce Road. This was the only time she was in the flat. Kim Hainey was anxious and 'feeling depressed' and finding it difficult to live on her own with Declan. Irene Carswell did not consider undertaking the EPNDS. Declan was not keen to support himself in a sitting position for any length of time, although he was 11 months old. He had sores on his scrotum and the rash had spread to his tummy. He also had what might have been 'nappy rash' on his buttocks. Irene Carswell arranged for a prescription. This was the first time the Health Visitor had seen Declan since September 2008. She did not see him again. She did not raise the lack of contact with Declan at the fortnightly meetings which the doctors at the Love Street Surgery had with the health visitors.

58. On 6 March Jill Stevenson went with Kim Hainey to a consultation with the General Practitioner Dr Patel to discuss Kim Hainey's low mood. Kim Hainey said that she did not wish to be referred to psychiatric services and that her low mood was linked to her menstrual cycle. Declan was not present, nor was he discussed.

59. On 10 March Kim Hainey attended a service called Crisis Counselling to which she had been referred by Jill Stevenson. She had a meeting with a trainee counsellor. She failed to attend the second meeting arranged for 17 March and on 24 March Crisis Counselling closed the file. At a later date, Kim Hainey told Jill Stevenson that she was attending Crisis Counselling but seeing another counsellor. That was a lie.

60. On 25 March Kim Hainey attending the RDS clinic smelling of stale alcohol. She gave two different stories, telling Hazel Martin that she had been drinking wine with her mother the day before, and telling Dr. Haigh (the RDS doctor) that she had been out with a friend for a pizza and had a few glasses of wine. Jill Stevenson was concerned and advised Irene Carswell of her concerns. At that time a blood test taken from Kim Hainey disclosed that the Gamma GT level in relation to her liver function was raised, suggestive of regular heavy drinking. Irene Carswell should have recategorised the case to 'intensive'. She failed to do so. Had she done so, contact with Declan would have increased, possibly to once a week, there would have been a case discussion with the three agencies i.e. the doctors, the health visitors and Family Matters and an Unscheduled Attendance Form would have been completed and recorded on the Child Health Surveillance system.

61. On 26 March Dr Haigh (RDS) told Jill Stevenson that she had seen in Kim Hainey's medical records details of her contact with Dykebar Psychiatric Hospital. This was the first time the contents of these records had been discussed with any worker responsible for the case. On 27 March Dr Haigh wrote to the Love Street Surgery in the following terms: *We are naturally concerned about Kim's alcohol consumption and will endeavour to establish whether she is alcohol dependent or not at this stage. Her key worker will liaise with her health visitor and ascertain her suitability to care for her child.* Dr Patel was aware of the contents of the letter by the beginning of April. He did not discuss them with Irene Carswell.

62. On 26 March Elizabeth Cochrane (senior social worker at Family Matters) was told by Jill Stevenson about her concerns and she instructed an unplanned visit to 45 Bruce Road either on 27 March or the following week. By this time, Family Matters were aware of Kim

Hainey's mental health history. They were also aware of the evidence which pointed to regular excessive drinking, their own assessment of Kim Hainey as a liar, and her ability to keep Declan away from the various agencies. However, no instruction was given to arrange a multi-disciplinary meeting or to carry out an investigation under Child Protection Procedures.

63. On 30 March Jill Stevenson made an unplanned visit to 45 Bruce Road but did not obtain access. She was aware that Irene Carswell was leaving her post. She telephoned Dr Patel and emphasised that the case should be passed quickly to another health visitor. Dr Patel did not discuss the case with Irene Carswell at any time.

64. On 31 March Irene Carswell left her post. She was not replaced until the beginning of August when Linda Flannigan took up the position. She did not discuss any of her cases with her line manager Elaine Byrne nor did she discuss any individual case with Ruth Walsh (the other Health Visitor at Love Street clinic) who was going to be holding all cases until Irene Carswell had been replaced. She continued to work for 5 hours on some Fridays. She retained the Hainey case. Had she re-categorised to 'intensive' as she should have done, the case would have been passed on to another Health Visitor. Neither Irene Carswell nor any other health visitor saw Declan after 6th March.

64. On 3 April Kim Hainey cancelled an arranged home visit with Jill Stevenson with the excuse that she was looking after a neighbour's child. Jill Stevenson thought she was lying. On 8 April she cancelled another appointment. She told Jill Stevenson that she was staying at Friendship Way. It did not occur to Jill Stevenson to suggest she would visit her and Declan there. On 15 April she cancelled the third appointment made in April. Jill Stevenson's concerns were heightened. She discussed them with Gillian Turner and was instructed to keep trying to get into 45 Bruce Road. No other instruction was given. The options of a multi-disciplinary meeting or a Child Protection investigation were neither discussed nor instructed. On 16 April Jill Stevenson made a request for a health visitor to visit 45 Bruce Road. No visit took place. Kim Hainey later cancelled an appointment arranged with Jill Stevenson for 20 April. That was the fourth cancelled appointment in a three week period.

65. On 17 April Kim Hainey's family went out for a meal to celebrate Declan's first birthday. That was the last time Declan was seen by any member of the family. A photograph taken of Declan on his birthday is the last known photograph of him. Throughout the rest of 2009 Kim Hainey continued to visit her mother, often two or three times each week, telling her lies as to why Declan was not with her. Mrs Rodden continued to provide food, and items of clothing for Declan, as well as money to help her daughter and grandson. Invitations to Sunday lunch were regularly extended, and food prepared especially for Declan but Kim Hainey repeatedly failed to turn up. Aunt Ann continued to send money for 'the wee fellow' via her sister, and to buy food for her niece and great nephew.

f. The period from 17 April 2009 until 17 August 2009

66. In the second half of April Jill Stevenson spoke on the phone to Dr Patel and to Ruth Walsh expressing her concerns about the situation. She also contacted the pharmacy who had not seen Declan for some time. (see Finding in Fact 54).

67. On 21 April Jill Stevenson made an unplanned visit to 45 Bruce Road but did not gain access. She then phoned Mrs Rodden who confirmed that Kimberley and Declan had been staying at Friendship Way for two weeks around Easter. That was not true. Mrs Rodden said that she was worried about Declan but Jill Stevenson did not ask her to expand on that. Mrs Rodden told Jill Stevenson that her daughter told 'so many lies', and she expressed concerns about the level of her daughter's alcohol consumption. Later that day, Jill Stevenson spoke to Kim Hainey on the phone and when she was told that Jill Stevenson had made an unplanned visit to Bruce Road earlier, she shouted down the phone and would not listen to Jill Stevenson.

68. On 21 April Anne Shearer the dispenser at Lloyd's pharmacy in response to Jill Stevenson's telephone call asked Kim Hainey why she did not bring Declan with her any more, and was given various explanations, such as the weather being too cold, or Declan being at his nursery, or that he was being looked after by a neighbour. Declan did not at any time attend a nursery, nor with one exception in July 2009 (see Finding in Fact 83) was he ever in 2009 looked after by a neighbour.

69. On 22 April after the case had been with Family Matters for 3 months, Jill Stevenson and Linda McCulloch gained access to 45 Bruce Road and met Declan for the first and last time. Both workers thought there were some odd aspects to the visit e.g. Declan showed no upset when the two workers went into the house when on their arrival Kim Hainey was taking out rubbish (which Jill Stevenson thought might have contained empty bottles), he did not look to his mother for reassurance when she came back into the flat, she did not lift him at any time during the visit which lasted in excess of an hour, and he seemed pale and quiet. He did respond to Linda McCulloch at one point. During the visit Kim Hainey became very angry and aggressive in front of her son. He did not react in any way. Declan remained in a travel cot watching a children's DVD and drinking from his bottle throughout the visit. Jill Stevenson told Gillian Turner of her concerns and a further home visit instructed by Gillian Turner was arranged for Friday 1 May 2009. That visit was cancelled by Family Matters. On 22 April Jill Stevenson telephoned Ruth Walsh and communicated her concerns about the lack of interaction between mother and child. She was told that Irene Carswell would visit Bruce Road on 24 April. That visit did not take place. A rearranged visit for 1 May by the Health Visitor did not take place. Neither Family Matters nor a Health Visitor gained access to 45 Bruce Road after 22 April.

70. On 22 and 23 April Kim Hainey attended the pharmacy with Declan. He was never seen at the pharmacy again. On all subsequent daily visits by Kim Hainey to the pharmacy prior to Declan's death, Declan was left alone at 45 Bruce Road.

71. On 12 May Gillian Turner and Jill Stevenson had a second supervision meeting about the case. An action plan was produced, which focussed on Kim Hainey. Declan was not mentioned in the plan which contained three substantive actions i.e. 1. To continue to support Kim Hainey, 2. To liaise with Health Visitors, General Practitioner and Crisis Counselling, and 3. To assess her alcohol use. There followed three phone calls, on 27 May, and on 23 and 24 June between Jill Stevenson and Kim Hainey and a planned visit on 29 May at which Jill Stevenson did not gain access. She made two further unplanned visits to 45 Bruce Road on 21 July and on 6 August. On neither occasion did she gain access.

72. On 12 May Jill Stevenson went on annual leave. She returned to work on 27 May. By that date Gillian Turner had left Family Matters. From the end of May Elizabeth Cochrane, the other senior social worker at Family Matters was the supervisor for the case. When Gillian Turner left Family Matters her case load doubled. She had no time to supervise all the cases. Declan's case was not supervised. From the end of May until 13th August, the day on which the case she closed the case, she had no involvement with the case and Jill Stevenson did not at any time seek to discuss the case and her concerns with her.

73. On 15 May Kim Hainey did not attend the appointment for Declan's immunisation. Irene Carswell spoke to her on the phone and was told that she was unwell. She did not attend the appointment rearranged for 22 May. A third appointment was made for 28 May, which was not attended. Irene Carswell did not check if Declan had attended for immunisation on 28 May 2009. Family Matters were not advised of Kim Hainey's failures to attend.

74. In an evening in mid-May Kimberley Hainey visited the home of Stacey McCance. She told Nicole Paterson that she had left Declan in 45 Bruce Road on his own. When Nicole Patterson mentioned phoning the Social Work Department, Kimberley Hainey said it was a joke and that her mother was babysitting at the flat. That was a lie. Declan was alone and unattended in the flat.

75. On 29 May Kim Hainey spent from around 7 pm till late in the evening at the home of Stacey McCance. Declan was at 45 Bruce Road alone and unattended. Lisa Milton, a neighbour, who was present suggested she should go and check on him, but she did not do so.

76. On 30 May Kim Hainey was seen smelling of alcohol and without Declan in a neighbour's back garden. Lisa Milton accused her of never having Declan with her. On 31 May Kim Hainey left Declan alone and unattended at 45 Bruce Road until the early hours of 1 June, while she was socialising at the home of Stacey McCance.

77. In May and June Declan was heard crying in 45 Bruce Road for periods of between 4 and 5 hours on a daily basis and mostly in the evenings. Kim Hainey turned up the volume on her television to mask the sound of her son's crying. The crying continued through the summer but had stopped entirely by the autumn of 2009. During that time Kim Hainey spent time in neighbours' homes on many evenings drinking and without Declan. She also spent time at the home of Robert Milton with whom she had a short-lived sexual relationship, and would on occasion stay overnight with him, sometimes not leaving till

lunch-time the following day. Kim Hainey told him that Declan was being looked after by members of her family. On one occasion she pretended to have a telephone conversation with her mother in the course of which she 'told' her mother not to give Declan 'any more chocolate'. On the occasions when she was out of the house, she left Declan alone and unattended.

78. On an occasion during May/June Catherine Rowand saw that Declan had a rash which had the appearance of bed sores. On two occasions in May/ June Catherine Rowand drove Kim Hainey and Declan to Love Street Surgery when Kim Hainey pretended to her that she was seeing the doctor about Declan's nappy rash/sores. Declan was not seen by any doctor at Love Street Surgery after 11 December 2008.

79. On 4 June Kim Hainey left Declan alone and unattended at 45 Bruce Road from the early evening until around noon on 5 June 2009. She spent part of that time in the house of a neighbour, thereafter in Johnstone either at a public house or in the home of an acquaintance, and finally at the house of Robert Milton. She pretended to Catherine Rowan that her mother was looking after Declan and pretended to phone her mother to ask that Declan be kept a little later the next day because she was going out that evening. Around the end of June she spent two consecutive nights at the home of Robert Milton, leaving Declan on his own for up to 48 hours.

80. During the month of June, Kim Hainey told her neighbour Catherine Rowand that Declan was at her mother's, or her aunt Ann's, or at a playgroup to explain his absences. He was at none of these places. She was leaving him at 45 Bruce Road alone.

81. On 19 June Ruth Walsh inherited *inter alia* Declan's case, but at no time did she look at the file. Health Visitors were so understaffed that they were struggling to provide even base-line cover.

82. Sometime at the beginning of July Kim Hainey left Declan with Stacey McCance at her home for about an hour. When she returned, Stacey McCance thought she was possibly drunk and certainly under the influence of something. This was the last time that Declan was seen alive by anyone other than his mother.

83. During the months of June to August Kim Hainey frequently obtained a lift from Catherine Rowand on Thursday evenings and was dropped off at a house in the Lochfield Estate in Paisley. She lied to Catherine Rowand, telling her that Declan was with her mother or her Aunt Ann. On some of those occasions Declan was still alive and she had left him alone at 45 Bruce Road.

84. On 13 July Kim and Declan did not attend the first birthday party of Nicole Gillespie's daughter to which they had been invited.

85. On 3 August Linda Flannigan replaced Irene Carswell as a full-time Health Visitor with the Love Street Surgery. During August, Ruth Walsh was seconded to the clinic at Renfrew, and Linda Flannigan became responsible for 300 cases, over a 37.5 hour week.

86. On 13 August at a meeting between Jill Stevenson and Elizabeth Cochrane, Elizabeth Cochrane took the decision to close the case. This was the first discussion of the case which had taken place since Gillian Turner left Family Matters. No documents or case papers were brought to the meeting and the decision was taken by Elizabeth Cochrane on the basis of what Jill Stevenson told her. Despite her concerns and the instruction that at least one further visit should have taken place in May, Jill Stevenson had not seen Kim Hainey nor Declan since 22 April. There was no discussion with other service users. At that time Family Matters did not have a protocol on case closure. The closing summary put on the Swift System by Jill Stevenson was inadequate, and Elizabeth Cochrane did not put a manager's note on the system, as she should have done. The manager's note should have stated why there were no child protection concerns.

f. The period from 17 August 2009 until 30 March 2010.

87. On 17 August a telephone conversation took place between Jill Stevenson and Linda Flannigan, during which Linda Flannigan was asked to give 'extra monitoring' to the case. Linda Flannigan suggested that if 'extra monitoring' were required, then the case should be referred to the Area Social Work Team. She was advised by Jill Stevenson that Family Matters was part of Social Work services and that there were no concerns about Declan.

88. On 17 August Linda Flannigan made an unplanned visit to 45 Bruce Road. She did not obtain access and left a card arranging a visit for 19 August. On 19 August she attended at 45 Bruce Road but did not gain access. On either 19 or 20 August Kim Hainey telephoned Linda Flannigan and told her that she had no worries about Declan and that he was now walking and had a good appetite.

89. Sometime in August Kim Hainey told Catherine Rowand that she was moving back to Friendship Way, prior to the holiday to Portugal. She told her that the reason Declan had been crying such a lot was that he was teething and she had been advised to leave him crying in his room. Prior to the end of August, Catherine Rowand and her family returned from a week's holiday. They did not hear Declan crying after their return.

90. Towards the end of the summer Kim Hainey and her aunt Ann had an argument in the course of which Kim Hainey said that her mother would not get Declan and that no one would get Declan.

91. In September Kim Hainey told her mother that she would not be going to Portugal and refused to allow the Roddens to take Declan on his own, explaining that she could not do without him. The two flights were cancelled and the Roddens went to Portugal on their own the following month.

92. By August/September the money which Kim Hainey was given by the family which had amounted to between £20 and £30 twice per month had increased to between £60 and £80 twice or three times per month, in addition to the items that the family continued to buy for Declan. Her visits to Friendship Way continued on a regular basis until just before Christmas,

with the exception of a two week period when she told her mother that she had visited her father in Oxfordshire. Kim Hainey told her mother that Declan was attending a nursery.

93. In October Kim Hainey told the family that the social work department had advised her that her flat was not warm enough for Declan and aunt Anne's husband delivered a calor gas heater to the flat. Kim Hainey was waiting at the door and he was not invited in.

94. Sometime towards the end of October/beginning of November Linda Flannigan who was anxious to see Declan sent a letter to Kim Hainey at Friendship Way, as she thought she was living there. On 5 November an irate Kim Hainey phoned the health visitor complaining about her having written to her at her mother's address. An appointment was arranged for 16 November at Bruce Road. Kim Hainey cancelled that appointment by phone on 13 November.

95. On 6 November Kim Hainey visited the pharmacy and asked that Sudocream (a remedy for nappy rash) be dispensed for Declan. That was done.

96. In December Natalie Gillespie met Kim Hainey in Paisley. She was told that Declan was in a nursery full time and that Kim Hainey was working in her uncle's garage which she identified. On 14 December Natalie Gillespie visited the garage. No one there knew Kim Hainey. She was not working there. The garage was not owned by her uncle.

97. In December Kim Hainey contact her aunt Ann by phone and asked for her Christmas money early because Declan had parties to attend. She visited and was given £60 for herself and £50 for Declan. She told her aunt that she and Declan were going to her father's in Oxfordshire on Boxing Day.

98. On 17 December Linda Flannigan called at 45 Bruce Road for a visit arranged by letter. She did not gain access.

99. On 23 December Kim Hainey telephoned Linda Flannigan. She sounded most apologetic about the missed visits but was very excited about Declan enjoying the Christmas activities. She advised that she was spending the festive period in England at her father's. Linda Flannigan was not concerned.

100. On 24 December Kim Hainey and Declan did not arrive at Friendship Way where Mrs Rodden was expecting them. On 25 December Mrs Rodden tried without success to contact her daughter by phone on numerous occasions. Mrs Rodden did not see her daughter again until February 2010.

2010

101. One evening at the beginning of January Kim Hainey visited Catherine Rowand after 2200. She seemed upset and said that she had just found out that her uncle had died. She asked to borrow alcohol as the off-licence was shut. She was given a half bottle of vodka and a couple of cans. No uncle of Kim Hainey had died.

102. On 19 January Kim Hainey was phoned by Linda Egan on instructions from Linda Flannigan to arrange an appointment. Linda Egan was told that she was in Banbury at her fathers and that all was well with Declan.

103. On an unknown date in February Kim Hainey turned up at Friendship Way. Her Aunt Ann was there. She spoke about her trip down south with Declan over Christmas and how the family had all had a great time with Declan. Aunt Ann noted that when her niece was shown all the presents which had been bought for Declan's Christmas, she selected only the more expensive items to take away. Mrs Rodden gave her daughter a belated Christmas present of £100.

104. Sometime in February Kim Hainey turned up at Robert Milton's house. She had been drinking and was upset. She told him that she had an aunt who was dying. That was a lie.

105. On 2 March Linda Flannigan attended at 45 Bruce Road for an arranged home visit. No access was gained, and on 3 March Linda Flannigan phoned Mrs Rodden and found out that Kim Hainey had no contact with her father. Kim Hainey left a telephone message for Linda Flannigan advising her that she still lived at 45 Bruce Road, and that afternoon Linda Flannigan went to the flat. She did not gain access but left a message advising that Social Work would be informed. She contacted Kim Hainey by phone on her mother's landline and was told that Declan was with Stacey McCance. A home visit was arranged for 10 March.

106. On 5 March (a Friday) Linda Flannigan raised her concerns at the Health Visitors meeting with the General Practitioners and was told she should contact Social Work. She called at 45 Bruce Road on her way home, did not gain access and saw that a note she had left two days earlier was still in the letter box.

107. On 8 March Linda Flannigan reported the matter to Social Work. She sent a 'Notification of Concern about an unseen child' form to the social work Department which included the telephone number for Mrs Rodden. A planned home visit on 9 March was cancelled due to no social worker being available. Linda Flannigan went on leave on 10 March. She sent

108. On 16 and 17 March two home visits were made by a social worker and a social work assistant, but no access was gained. On 17 March the social work assistant attempted on several occasions to contact Mrs Rodden by phone. There was no reply. She did not leave any message.

109. On 24 March Social Work attended at 45 Bruce Road. There was no reply.

110. On 30 March Social Work finally made contact with Mrs Rodden and advised her that consideration was being given to reporting Kim Hainey and Declan as missing persons. Social Work understood that the Roddens would go to Bruce Road that evening and asked that they report to Social Work the next morning.

111. On the evening of 30 March Mr & Mrs Rodden and Anne McNeillage went to 45 Bruce Road. Declan's body was found by Mr Rodden. The flat was in a squalid condition and there was no power. The Crime Scene Manager and the pathologist Dr Julie McAdam attended. Declan was left in the flat overnight with a police guard outside the property.

112. On 31 March Dr John Manlove attended and later Declan's body was removed to Yorkhill Hospital, Glasgow where on 1st April a post mortem was carried out by Dr Claire Evans and Dr Julie McAdam. The cause of Declan's death was unascertained.

113. On 1 April James Breslin who had been alerted to the situation contacted Kim Hainey by telephone. She told him that Declan was at the nursery and put the phone down on him.

114. Each year in Scotland 5 boys aged between 1 and 2 years die. Of those 5, 20% that is 1 child will die due to unexplained causes.

115. There is a risk of dehydration if a child is left without fluids for lengthy periods of time. The younger the child, the higher the risk. The smaller the child, the higher the risk. When a child is left without food for periods in excess of 8 hours, the result is hunger. When those periods are longer and reoccur, the result is that the child becomes malnourished.

116. The adverse repercussions of being left without food and fluid are cumulative. If a child is regularly neglected in this way, then at the start of each period of being left there is a degree of increasing fragility. Although it is not possible to be definitive in relation to time, when a young child is left alone without food or fluids the blood sugar will drop. This can cause convulsions and can result in brain damage and unconsciousness. Convulsions are directly linked to the regurgitation and inhalation of vomit. Low blood sugar affects breathing control, and breathing can stop as a result.

117. Dehydration places the body systems under strain, as a result of which the body starts to shut down. Kidneys fail, and both the heart rate and the breathing rate are subject to increased rapidity. When a child is left unattended for periods of up to 48 hours there is a real risk of death.

118. The neglect of a child is a complicated scenario. When a child is regularly and for long periods of time left unattended, that does not happen in isolation. The child will lie in cold, wet and soiled nappies. As a result nappy rash will develop and will not heal. The child may be at risk of both hypoglycaemia and hypothermia. The child may cry for long periods of time. The various aspects of neglect build into a package which becomes life-threatening to the child.

g. Post March 2010

119. In 2010 Renfrewshire Child Protection Committee commissioned an independent Significant Case Review into the circumstances of Declan's death. The Review was completed in October 2010. It made 16 recommendations. These are set out in the Note which follows.

120. The Care Inspectorate is the body which has statutory responsibility for inspection of child protection services. In 2012 Renfrewshire Child Protection Committee invited the Care Inspectorate to review the progress made in response to the recommendations of the Significant Case Review. The conclusion of the report produced by the Care Inspectorate is set out in full in the Note which follows.

121. A child may now be placed on the Child Protection Register pre-birth. That was not possible in 2008.

122. Present practice is that an unborn child with a mother who is misusing substances or has a history of so doing will automatically be the subject of a comprehensive child protection assessment, known as CP1, to be completed prior to the pre-birth meeting. The release of medical records forms part of this assessment process.

123. General Practitioners, Health Visitors, and Homemakers are now invited to the meetings which form the CP1 assessment process. General Practitioners are invited to complete a pro forma report if they choose not to attend meetings.

Personae

Evidence at the Inquiry was led on behalf of the Crown for the public interest by Stuart Cassidy Deputy Head of Scottish Fatalities Investigation Unit.

In the early days of the Inquiry some parties who had been represented collectively chose to obtain separate or alternative representation. I do not consider it necessary to detail those changes. They are of no moment in this Determination. Parties were represented at the Inquiry as follows:

1. James Wolfe QC, Irvine for Renfrewshire Council
2. Alistair Duncan QC, Campbell for Greater Glasgow and Clyde NHS Board
3. L. Donald, Solicitor Advocate, for Dr Brandon and Dr Patel
4. C.H.S. MacNeill QC for Bernadette McGrinder
5. Malcolm McGregor, Advocate, for Helen Morley
6. Miss McGraw, solicitor, for Irene Carswell, Ruth Walsh, Margaret Foster, and Linda Flannigan
7. Gordon Lamont, Advocate, for Hugh Madden, Hazel Martin, Linda Horsburgh and Lyndsay Jones
8. Ruth Charteris, Advocate. for Jill Stevenson
9. Claire Mitchell, Advocate. Linda McCulloch
10. Michael Stuart, Advocate, for Gillian Turner
11. Kate Bennet, Advocate, for Elizabeth Cochrane
12. Edward Targowski QC, Reilly, for Kimberley Mary Hainey

During the course of the Inquiry I heard from the following witnesses.

1. Elizabeth Rodden, mother of Kim Hainey and grandmother of Declan
2. John Rodden, husband of Elizabeth Rodden
3. Anne McNeillage, sister of Elizabeth Rodden
4. Catherine Rowand, neighbour at Bruce Road
5. Stacey McCance, neighbour at Bruce Road
6. Natalie Gillespie, friend of Kim Hainey
7. Margaret Milton, neighbour at Bruce Road
8. Nicole Patterson, resident in Bruce Road and related to the Milton family
9. Lisa Milton, neighbour at Bruce Road
10. Nicole McKibben, neighbour at Bruce Road
11. Robert Milton, friend of Kim Hainey
12. Dillon Pooley, Police Sergeant
13. Claire Cunning , Renfrewshire District Council
14. Flora Dick, midwife, SNIPS
15. Bernadette McGrinder, Senior Social Worker at RAH
16. Dr John Manlove Forensic Entomologist
17. Rose Dougan, midwife, SNIPS
18. Hugh Madden, Social Worker at RAH
19. Helen Morley, Senior Social Worker at RAH
20. Dr Claire Evans, Consultant Paediatric and Perinatal Pathologist, Southern General Hospital
21. Hazel Martin, Drug Worker with New Expectations
22. Jill Stevenson, Drug Worker with Family Matters
23. Linda McCulloch, Addictions Worker with Family Matters
24. Gillian Turner, Senior Social Worker, Family Matters
25. Elizabeth Cochrane, Senior Social Worker, Family Matters

26. Anne Shearer, Dispenser at Lloyds Pharmacy
27. Julie Dynes, Senior Social Worker, Paisley Area Team
28. Linda Horsburgh (formerly Ferguson) Family Support Worker, Social Work, RAH
29. Margaret Armstrong, Health Visitor at Foxbar Clinic
30. Irene Carswell, Health Visitor, Love Street Clinic
31. Ruth Walsh, Health Visitor, Love Street Clinic
32. Linda Flannigan, Health Visitor, Love Street Clinic
33. Daniel Brandon, General Practitioner, Love Street Surgery
34. Parag Patel, General Practitioner, Love Street Surgery
35. Sylvie Sneider, Crisis Counselling
36. Lyndsay Jones, Social Work Assistant
37. Elaine Byrne Team Leader for Children's Services
38. Jack Beattie Consultant Paediatrician Yorkhill Hospital
39. Rosalind Barnes, General Practitioner, with RDS (evidence in part only)
40. Charles McMahon, Consultant Psychiatrist, RDS
41. Andrew Dunn, Detective Sergeant (retired) Crime Scene Manager at locus 45 Bruce Road
42. James Breslin, Kimberley Hainey's biological father, whose evidence was by Affidavit

In addition Joint Minutes of Agreement were lodged which included the recommendations of the Significant Case Review (the body of which I chose not to read) as well as Professor Sebire's Report from which Finding in Fact 114 is drawn.

NOTE

Declan's life was a short one but during it he came into contact with a number of family members, neighbours at 45 Bruce Road, the flat in which he lived with his mother from the end of September 2008 until his death in the summer of 2009, and a variety of workers from health and social work agencies of one kind or another. Three family members, Mr & Mrs Rodden and Ann McNeillage had considerable contact in his early months. There was evidence that Ann McNeillage's husband was also in contact from time to time, but no evidence was led from him. The Inquiry heard from 8 neighbours and friends who saw both mother and son at various times over the period from September 2008 until the summer of 2009, from 9 employees of

Renfrewshire Council's Social Work Department, 5 of whom had direct contact with Kim Hainey and her son, and 4 of whom were line managers for those with direct contact, 2 general practitioners at the Love Street Surgery where Kim Hainey and Declan were patients, 1 doctor from Renfrewshire Drugs Service who had no direct contact with them, and 4 health visitors who each at certain times 'held' Declan's case, but only one of whom had direct contact with mother and son. Of the two 'prescribing' doctors at RDS, the Inquiry heard from Dr Barnes and only in part.

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

PRELIMINARY MATTERS

The prosecution of Kim Hainey for the murder of her son, her conviction, and the subsequent quashing of that conviction which form the background to this Inquiry is referred to above. In the course of submissions four matters were raised which merit comment at the start of this Note.

1. It was submitted on behalf of Kim Hainey and others that I was not entitled to make any determination in respect of Section 6(1)(b) – the cause of death – which went beyond that which was the conclusion of the post-mortem examination i.e. that the cause of death is unascertained. In making a determination as to the cause of death I must of course be guided by the terms of the post-mortem report. My determination reflects that. The state of decomposition of Declan's body and the insect infestation which had taken place as a result of his body lying as it did for many months resulted in the absence of most of his vital organs, and the long time that he had lain unattended after death meant that radiological examination was extremely limited. Pathological and radiological findings therefore were very much restricted. It was submitted that I could not on an evidential basis go further than determine the cause of death as unascertained. In my view that does not mean that I must set aside all of the evidence before the Inquiry which pointed to Kim Hainey's prolonged neglect of her child, from at least the beginning of February 2009. Nor does it mean that I should not take into account the way in which his mother treated his body after death nor her determined efforts over many months to deceive others into believing that Declan was still alive. Further I had the benefit of the evidence of the consultant paediatrician Dr Beattie and also the statistics provided by Professor Sebire. I have not sought to amend the cause of death. I have reflected in my Determination under 6(1)(b) what I am satisfied is the proper inference to be drawn from all the evidence before me. I would have been failing in my duty had I not done so.
2. It was further submitted on behalf of Kim Hainey with reference to Article 6(2) of the European Convention on Human Rights that I was precluded from making any finding that her neglect of her son contributed to his death because as it was submitted 'she

remains with the prospect of live criminal proceedings.’ The Crown had not granted her immunity as at the date of the Inquiry and the Crown have in certain circumstances the power to seek to re-indict her (for a crime or crimes not specified by senior counsel) under the provisions of the Double Jeopardy 9Scotland0 Act 2011. Article 6(2) of the convention reads as follows: ‘Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.’ These proceedings are however not criminal proceedings and Kim Hainey presently faces no criminal charge in relation to the death of her son. I heard no evidence that she would do so in the future. A Fatal Accident Inquiry is simply that – an Inquiry – and no finding or determination by a presiding sheriff may be founded on in any subsequent proceedings, whether criminal or civil. The test to be applied in any determination fall far short of the standard of proof required in criminal proceedings. I am satisfied that Article 6(2) does not preclude me from drawing any proper inference from the evidence in the Inquiry which may bear on any culpability on the part of Kim Hainey in relation to the death of her son.

3. It was also submitted that I was disadvantaged in my task by not having heard the oral evidence of Kim Hainey. A transcript of the evidence she gave in her trial for murder formed part of the productions in the Inquiry. I chose not to read that transcript and advised parties of my decision. No party attempted to persuade me to do otherwise. Any evidence contained in the transcript was evidence given in response to questions by her defence counsel and by the Advocate Depute. Those questions were asked in a particular context and for a particular purpose. I did not consider that the contents of her evidence in the context in which it was given would have provided me with any additional assistance in reaching my determination. I did not at any stage in the evidence nor in the preparation of my Determination consider myself at a disadvantage because I did not hear evidence from Kim Hainey. I had before me wide-ranging and detailed evidence which enabled me to obtain a very full picture of Declan’s short life.
4. It was submitted on behalf of Kim Hainey that she had been a loving and caring mother up till the point when she suffered a severe breakdown on the sudden and unexpected death of her child and as part of that breakdown she denied Declan’s death to the outside world. I accept that, despite her complete disregard for the well-being of her unborn child for many months into her pregnancy, and her stated lack of interest to Hazel Martin as to whether the baby was taken into care or not, when Declan was born she bonded well with him. For the first few months of her life, she was a loving and caring mother, supported by her own mother and other members of her family. However, sometime after October 2008 she began to restrict contact between her family and Declan, and after 17th April 2009, she did not allow her family to see him again. By March 2009 at the latest, Kim Hainey was drinking heavily and regularly and was finding it difficult, as a single mother, to look after Declan. However, she chose to withdraw from family support, other than to continue obtaining money and items of food and clothing for Declan. She did not accept the professional help that was available to her, and made it very difficult for Health Visitors and Family Matters to maintain contact with her, and more particularly with Declan. The prolonged course of neglect is detailed elsewhere, as is her repeated lying, both before and after her son’s

death. As well as the numerous and lengthy occasions on which she left him alone at 45 Bruce road, there was other evidence from which it can be inferred that she was failing to care for her son. They were rarely seen together. She had a short-lived relationship with a man who never saw Declan and to whom she lied about her son's whereabouts. Declan had sores on his scrotum and a rash on his tummy at the beginning of March. Three months later, he had sores on his buttocks which Catherine Rowand described as having the appearance of bed-sores. Only one prescription was obtained for those sores. That was on 6th March 2009. She did however pretend to Catherine Rowand that she was taking Declan to the general practitioner about the condition. There was no evidence that she ever took her son to a facility such as 'Rhyme Time', offered by the social work department. He did not attend playgroup or nursery, as she pretended he did. At the visit by Family Matters on 22nd April which lasted more than an hour, there was no physical contact between mother and son, in marked contrast to the interaction which Hazel Martin had witnessed in the autumn of 2008. By the time of the October holiday to Portugal, Declan was dead. However, she had not applied for a passport for her son in the early part of 2009, despite having been given the money to do so by her mother.

I am satisfied that Declan died where he was found. There was no evidence to say whether his mother found him there dead or dying. There is however evidence that she did nothing to obtain assistance for her son. She did not call the emergency services, or her family. She continued in the weeks and months following Declan's death to 'go about her business'. On the many occasions when she visited Friendship Way, she was bright and chatty. She was well-turned out and Mrs Rodden saw nothing to suggest that her daughter was ill, either mentally or physically, or indeed worried or upset about anything. She was able through her telephone contact with Linda Flannigan, a very experienced health visitor, that all was well and that Declan was thriving..

She was also able – both before and after Declan's death – to recognise when she had to take some action to divert potential suspicions as to the situation. The following are some examples : (1) on 22nd April 2009, having cancelled no fewer than 4 arranged appointments with Jill Stevenson, she allowed access on that date to 45 Bruce Road; (2) by April 2009 she had not taken Declan to the pharmacy for several months. When this was queried by Anne Shearer, she took Declan to the pharmacy on two consecutive days – 22nd and 23rd April – and then never thereafter; (3) when Catherine Rowand saw the sores on Declan's body in around June 2009, Kim Hainey pretended to her on 2 occasions that she was going to the doctor to obtain a prescription; (4) on 5th November 2009 she found out that Linda Flannigan had sent a letter to her at Friendship Way because she thought she had moved there. On 6th November Kim Hainey went to the pharmacy and obtained a cream for Declan's 'nappy rash'. None of this suggested to me that Kim Hainey was having a lengthy and severe breakdown of some unspecified nature. There was a history of lying and manipulation and after her son's death that pattern of behaviour continued. By her deceit she was able to deceive others, and to an

extent control the situation, with the result that Declan's body was not discovered until 30th March 2010. I reject the submission that she was at all times a loving mother who suffered a severe breakdown on the death of her son.

Section 6 (1)(a) DATE OF DEATH

While there can on the evidence be no precision as to the date of death, all of the evidence points to Declan dying sometime in the period 1 July to 31 August 2009.

1. The last sighting of Declan was by Stacey McCance at the beginning of July 2009
2. The last 'use by' date on the many milk bottles lying discarded in the living room of 45 Bruce Road was 24 August 2009
3. I found Dr John Manlove the forensic entomologist an impressive and careful witness. His Report (production 7) which he expanded on in his evidence was of considerable assistance. He placed Declan's death as no later than November 2009, but could not preclude a date as early as or possibly earlier than September 2009. It should be noted that in the preparation of his report he was given no information as to when Declan had last been seen.
4. In September 2009 Kim Hainey announced that she and Declan would not be going to Portugal in October as planned.
5. Towards the end of the summer 2009 in the course of an argument Kim Hainey told her aunt Ann that her mother would not get Declan and that 'no one would get Declan'.
6. After Catherine Rowand returned from holiday towards the end of August 2009 she did not hear Declan crying in 45 Bruce Road again.

There was one piece of evidence from Ann McNeillage suggesting that Declan was still alive in November 2009, when she said she had heard him in the background of a telephone call she had with her niece. I had no hesitation in rejecting that evidence. Whatever or whomever she heard in November 2009 it was not her great-nephew.

Section 6(1)(b) CAUSE OF DEATH AND EVIDENCE OF NEGLECT

The pathological findings at post-mortem have resulted in the conclusion that the cause of death is 'unascertained'. Declan's body had lain for at least 7 months in his cot at 45 Bruce road and had been subjected to various cycles of insect infestation. The state of decomposition and the degree of mummification restricted both pathological and

radiological examination. From a medical perspective, it was impossible to conclude that Declan's death had been caused by homicide, neglect, accident or some natural cause.

The Inquiry had the benefit of the report (production 9) of Professor Sebire, Professor of Paediatric and Developmental Pathology and Consultant Pathologist, and from the oral evidence of Dr Jack Beattie, Consultant Paediatrician at Yorkhill (lately retired). The Inquiry also had the evidence of the quality of Kim Hainey's care of her son from at least February 2009 until his death, as well as the evidence of her behaviour after the summer of 2009, the state of the flat at 45 Bruce road at the end of March 2010 and the circumstances in which Declan's body was found.

My determination that neglect was at least a contributory factor is based on the following evidence:

1. On no occasion subsequent to 25^h December 2008 did Declan stay overnight at Friendship Way Renfrew. On no occasion in 2009 did any person baby sit Declan in the flat at 45 Bruce Road. From at least as early as February 2009 until the day of his death, Kim Hainey repeatedly left Declan alone and unattended in the flat at 45 Bruce Road. On occasions she left him for a few hours in the evening when she visited neighbours to drink alcohol. She left him alone in the house when she got a lift from Catherine Rowand on Thursday evenings. On the evening of 4 June 2009 until approximately 12 noon on 5 June 2009 she left him unattended at 45 Bruce Road. On other occasions between June 2009 and August 2009 she left him unattended when she spent evenings drinking in the house of Robert Milton, and thereafter spent the night with him. On at least one undated occasion, she left him unattended for around 48 hours. She left him alone during the day when she attended the RDS clinic, and when she made her daily weekday visit to the pharmacy for her methadone prescription. Although each day cannot be identified by date, there is abundant evidence that Declan was left alone on many occasions.
2. Although it has not been possible to ascertain the precise date on which he died, I am satisfied on the evidence before me that Declan was left alone in 45 Bruce Road on many occasions from the time when he was last seen at the beginning of July 2009 until the day of his death. He spent many hours over many evenings crying and uncomfortable.
3. Kim Hainey drank excessively over a period of time, from at least February 2009 when she had sole responsibility for her son.
4. She failed to attend to his needs. She allowed what might have started as a nappy rash to deteriorate into sores in the area of his scrotum, and for a rash to cover his buttocks and his tummy.
5. When his body was found on 30 March 2010, Declan was lying on an uncovered plastic mattress in his cot, covered in a yellow towel. He had no nappy on, one leg was out of his baby-gro and there was a soiled nappy and a baby bottle with curdled milk lying near

his head on the bare mattress. The cellophane wrapper from a cigarette packet was lying between his legs (Kim Hainey was a smoker).

6. Although it is not possible to ascribe the squalor of the accommodation in its entirety to a time before the death of Declan, there is evidence that it had commenced prior to his death. There was a baby bath full of soiled nappies, and a soiled nappy lying in a corner of the hall. In the flat, there was a collection of plastic milk containers with use by dates ranging from 29 June 2009 to 28 August 2009. There was no evidence of Declan drinking formula. Photographs of the nursery show it to be in a state of utter disarray, with items of clothing as well as toys strewn over the floor to such an extent that the carpet cannot be seen.
7. Her behaviour after Declan's death is demonstrative of her lack of care for her son. She failed to call for any emergency assistance or for help from her family. She hid his death from her family and the authorities. She left his body in his cot for many months. After Declan's death, she lived at least some of the time in the flat, ate food there, drank alcohol and smoked heroin and cannabis.
8. She lied repeatedly to deceive others as to Declan's fate. She lied convincingly on the phone to Linda Flannigan after the middle of August 2009 about his progress with walking, how he enjoyed In The Night Garden (a television programme for young children), what he liked to eat, and how he liked to brush his teeth. She lied to her mother on countless occasions about Declan attending a nursery and making good progress. Subsequent to 17 April 2009 she lied to others that Declan was being looked after by her mother or her maternal aunt. She lied to neighbours that Declan was at 45 Bruce Road where her mother or her aunt were babysitting. She lied to Linda Flannigan that she had spent weeks in Oxfordshire visiting her father with Declan.

Section 6 (1)(c)

The reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided.

Realistic Assessment and the Exercise of Reasonable Professional Judgment.

- A. I did not accept the submission made on behalf of Renfrewshire Council that the professional judgments which were made during the assessment process up to the post-birth meeting were 'reasonable professional judgments'. Despite the lack of full information gathering, those involved in making those judgments were well aware of the history of the pregnancy, Kim Hainey's complete failure to prepare for the birth of her child, her reluctance to cooperate in the assessment process itself, the fragility of family relationships, her chaotic drug history and the instability of her life and housing situation up until only a few weeks prior to the birth of Declan.

They were aware of her consumption of alcohol on the day of her discharge from RAH on 29 January (to such an extent that she was smelling of alcohol the following day) and her refusal to accept the risks of such consumption while on a methadone programme, which had started only 6 days earlier. In addition, it was known that Kim Hainey refused to stay in for the first visit by Hugh Madden on 21 February 2008, despite the risk of her losing care of her child being explained to her by Hazel Martin. Had reasonable professional judgment been exercised, then Child Protection measures would have been taken

The risks to Declan were never analysed properly nor was any Discharge Action plan put in place, as it should have been. No review was fixed for three months from 21 April 2008 as it should have been. Far too much reliance was placed on Kim Hainey's stability on a 30 mls prescription of methadone. The level of that prescription alone should have raised concerns, given the self-reported addiction of 5 x £10 bags of heroin per day only weeks previously but there was no evidence that any professional ever questioned that self-report.

Had professional judgment been realistic, as opposed to over-optimistic then there would have been closer monitoring over a period of time after the move to 45 Bruce Road at the end of September 2008, especially with the additional information about the drunken incident at the end of June. Such monitoring would have ensured that the focus of services was on Declan, and not on Kim Hainey. New Expectations was an 'intensive support package' which focussed among other matters in meeting clients in their homes yet Hazel Martin managed to visit Declan only once at 45 Bruce Road and Family Matters, a 'child-centred service' saw him on only one occasion in a 7 month period. From as early as February 2008 there was a pattern of Kim Hainey failing to attend for appointments, failing to respond to telephone calls, and failing to allow home visits to take place. All of that called for extra vigilance in respect of Declan. An appointment cancelled beforehand or a failure to appear or allow access all mean that Declan was not being seen.

Important decisions were taken when no records were available, and no notes or minutes kept. Further when decisions were taken, it was often not easy to understand the basis of which they were taken. The quality of what was put on paper often left much to be desired e.g. the report prepared by Hugh Madden was inadequate and 'action plans' were either missing or of poor quality. Despite the terms of the GPR protocol, no Discharge Plan was prepared for Kim Hainey and her son in April 2008. The 'action' plan of 12 May 2009 at the end of the supervision session between Gillian Turner and Jill Stevenson contained 5 'actions' but in reality 3 of those were more or less identical, and all failed to mention Declan, despite the fact that Jill Stevenson had live concerns over the mother's ability to care for her son. Minutes (when they existed) were sometimes undated, unsigned and of dubious quality. There was no system in place within New Expectations or Family matters for circulating draft minutes

for approval, or for circulating dated and signed Minutes as soon as possible after meetings. Gillian Turner claimed on the third day of her evidence, having been questioned on the issue of note-taking that she had kept notes of this case and others in a personal notebook, which she later shredded after she left Family Matters. If that was truthful evidence, it seems an extraordinary and unprofessional action for a senior social worker to take. Notes about cases should be kept in files, not in a personal notebook which is taken from the agency and later destroyed.

Two examples of important meetings taking place in the absence of any documentation are (1) the meeting on 19 January 2008 when the case was transferred from New Expectations to Family Matters and (2) the meeting on 13 August 2009 at Family Matters when the decision was taken to close the case by a senior social worker who saw no paperwork, nor had any prior involvement with the case, apart from a brief discussion in March 2009 of which she had no memory.

Documents which were available were not always copied or passed on to those involved in Declan's case. It is little wonder that when it came to the evidence, there were many disputes over what was and was not communicated.

Medical Information

B. The lack of information about Kim Hainey's medical history which included her various contacts with the psychiatric services, as well as more detailed information about her long history of addiction issues meant that those making the initial assessment did so without a full picture (as Hugh Madden recognised). There was evidence of confusion in Social Work services as to what medical information might be obtained, on what authority and from whom. The social workers at RAH could – and should – have obtained such information from RDS, who had it from February 2008. Unfortunately, Dr Rosalind Barnes who worked with Kim Hainey at RDS throughout most of 2008 collapsed in the course of giving evidence and was unable to continue. The Inquiry was therefore deprived of any evidence from her as to when precisely she read the records and as to why none of this was discussed with Kim Hainey or made known to New Expectations. It was only in March 2009 when Dr Haigh took over the case that the history became known. While Helen Morley told the Inquiry that this information would have made no difference to her assessment of risk in relation to Declan (an intransigent position which she adopted throughout her evidence in relation to several matters where her evidence was at odds with that of others), Jill Stevenson very properly conceded that her approach would have changed to calling in senior staff to assist with the case. Irene Carswell also told the Inquiry that had she had this information in March 2009 then she would have re-categorised the case to one requiring intensive support, which would have meant amongst other things, that she would not have held on to the case when she left her full time post at the end of March.

Communication of Information and Communication of Instructions

C. The evidence elicited in the course of this Inquiry revealed a lack of basic communication between workers both within their own agency and with persons from other agencies who had a responsibility towards Declan. I do not intend to rehearse all of the occasions on which there was a failure/breakdown in the basic transfer of important information about what was happening (or not happening). The following are a few such examples

- a. There is a dispute between Hugh Madden and Helen Morley as to what his instructions were during the weeks prior to Declan's birth about obtaining Kimberley Hainey's medical records.
- b. Irene Carswell did not make it clear to Jill Stevenson that she had last seen Declan on 6th March 2009. That led to Jill Stevenson assuming that Declan was still being seen, though there was confusion about the detail of when she thought he was being seen.
- c. Dr. Patel told the Inquiry that he thought that the Health Visitors and Jill Stevenson were seeing Declan on a regular basis though it was never clear on what basis he came to that view
- d. There is a dispute between Gillian Turner and Jill Stevenson as to what information Jill Stevenson gave at the two supervision meetings
- e. There is a dispute between Hazel Martin and Jill Stevenson as to what was communicated at the hand-over meeting on 19 January 2009
- f. There is a dispute between Elizabeth Cochrane and Jill Stevenson as to what was communicated at the meeting in August 2009 when the decision was taken to close the file.
- g. There is a dispute between Dr Patel and Jill Stevenson as to what he was told about the EPNDS at the consultation on 6 March 2009
- h. There is a dispute between Elizabeth Cochrane and Jill Stevenson as to what information was given by Jill Stevenson to the senior social worker when the decision was taken to close the case to Family Matters.

Fortunately it has not proved necessary for a view to be taken as to whose recollection is accurate and whose is not. It is sufficient to observe that had proper communication taken place, and information and instructions noted accurately in the proper places, then these various – and unhelpful – disputes would not have arisen.

There were failures on the part of professionals to communicate instructions in a clear and unequivocal way. For example, Gillian Turner failed to communicate to Jill Stevenson at the second and final supervision which she had on 12 May 2009 that if no successful visit to 45 Bruce Road took place within 4 weeks of that date – i.e. by the middle of June 2009 – then there was to be social work involvement through the Area Team. Gillian Turner knew by 12 May 2009 that she was leaving Family Matters and that Jill Stevenson was going on annual leave more or less immediately after the supervision meeting. There would be no further opportunity to advise Jill Stevenson of her thinking. This failure was compounded by the failure on the part of Jill Stevenson to ensure that the second visit which had been instructed on 22 April 2009 did in fact take place. Some four months later, with no updated information about Declan or the situation at 45 Bruce Road, Family Matters closed the file. I have been unable to understand on the evidence I heard why that decision was taken when it was. There had been no opportunity to further assess the situation at 45 Bruce Road, nor Kim Hainey's ability to care for her child, over which legitimate concerns had been raised. Comprehension was not assisted by there being an inadequate entry on the Swift System and no entry at all of a Manager's Note as there should have been. There was the added difficulty of the dispute between the workers at Family matters as to what information had been communicated at that last meeting.

Section 6(1)(d) Defects in the System

In the formal part of the Determination I identified two defects in the system which were extant in 2008/2009. My understanding is that new procedures have been put in place by Renfrewshire Council identifying the 'lead agency' in all cases involving a substance abusing parent/parents and that co-ordination of all available information now takes place as a matter of practice. I am unclear as to whether a 'lead individual' is identified at the same time as 'the lead agency'. If this is not the case, then it is recommended that it should be, and that all councils adopt this system.

New procedures have also been put in place in respect of obtaining all necessary medical information, and no worker should now remain ignorant of the system by which such information can now be obtained.

Section 6(1)(e) Other relevant factors

(a) Staffing Levels

The Inquiry heard from several witnesses about difficulties in carrying out duties which were the result of low staffing levels, either as a result of decisions taken by management or by employees being off on sick leave, on leave, or leaving posts with the minimum of notice, and the resultant difficulties in finding replacements within a reasonable time. Two in particular are relevant to the circumstances of the death.

- (a) Between March 2009 and at least the end of August 2009 staffing level in health Visitors attached to the Love Street surgery which had responsibility for Declan's care were inadequate. During that period the hours allocated per week were reduced by management from 56.50 to 15, with the possibility of an occasional additional 5 on a Friday and some assistance from 'bank' nurses. The result was that those responsible for carrying out the day to day care of mothers and babies were not only working under considerable pressure, and feeling the stress of that, but were finding it impossible to give adequate attention to what are known as 'base-line' services, far less the 'additional' and 'intensive' cases for which they had responsibility.
- (b) Having been employed by Family Matters since October 2008 on a four day week, though she gave evidence that she worked 40 hours within those four days, Gillian Turner gave a month's notice at the end of April 2009. She left her employment sometime towards the end of May 2009. As at the end of August 2009 she had not been replaced. Elizabeth Cochrane took over her workload as well as retaining her own. She was not able to supervise the cases she inherited, nor could she possibly have devoted the same amount of time that Gillian Turner had done to the workload she had inherited. As a result no supervision of Declan's case took place after 12 May 2009.

(b) Notification of Concern in relation to an unseen child

On 8 March 2010 Linda Flannigan reported her concerns to the Social Work Department but a planned visit on 9 March was cancelled because no social worker was available. Eight days after the report was made, two attempts to gain entry to 45 Bruce road were made on 16 and 17 March without success. Another attempt was made a week later, on 24 March, again without success. Finally, on 30 March, three weeks after receiving the report, the Social Work Department made telephone contact with Mrs Rodden, and left it with her that she would go to the flat and report to them on 31 March. At a time when the Social Work Department should have been taking immediate action, there was no sense of urgency and no consideration was given at any time to calling on the police for assistance.

(c) Medical Records/Information

This is self-explanatory and is simply a way of guaranteeing that medical information is passed on to all other agencies involved in decision-making by placing the responsibility for that on the general practitioner.

(d) Mandatory training for general practitioners

The Inquiry was told that although general practitioners were aware of the guidance and protocols concerning child protection, training was not mandatory. As an additional safeguard, such training should be mandatory.

Two Additional Matters

Although the following matters form no part of my formal Determination in terms of the 1976 Act, I am conscious of the 'public interest' in this Inquiry and I consider it appropriate to make reference to these.

1. One of several puzzling aspects in this Inquiry has been the fact that neither John nor Elizabeth Rodden, nor Ann McNeillage contacted social work, health visitors, general practitioner (until Ann McNeillage mentioned to her doctor in the course of an appointment at the beginning of March 2010 that the family had not been seeing Declan), or the police, from 17 April 2009 until March 2010. As Declan's grandmother attention has tended to focus on Elizabeth Rodden and I consider it appropriate to make the following observations.
 - (a) Elizabeth Rodden was a loving grandmother and an extravagant provider for Declan. She described the few short months that Declan spent as Friendship Way as 'the happiest in our lives', and more than four years after Declan was found she clearly struggles with the burden of the knowledge of his death and the circumstances surrounding it.
 - (b) I came to the view that Mrs Rodden was frightened from her daughter, that she had been frightened from her for a long time and over the years had over-indulged her both materially and in giving into her demands when she might have stood firm. She was appalled to discover on her return from Portugal at the end of 2007/beginning of 2008 that Kim Hainey was still taking drugs when she was around 7 months pregnant. She took her concerns to her doctor. After Declan's first birthday she was apprehensive that if she pushed to see Declan, her daughter was capable of ensuring that she had no contact with her grandson. Her lie to Jill Stevenson was a product of that.
 - (c) There was a long history of friction between mother and daughter. Kim Hainey was at times abusive, violent and demanding, especially when she wanted money. The following is from Ann McNeillage's police statement, which she adopted in the course of her evidence to the Inquiry and relates to a time before Kim Hainey was pregnant with Declan. "Elizabeth used to work at the school at 3 pm. Kimberley would appear at 2 pm and ask for money and cause a fuss. She became quite violent. I used to have to go round to help Elizabeth. It was safety in numbers. One time she got so violent that police got called.'

- (d) There was evidence that the Roddens went to Bruce Road more than once, but never obtained an answer, though Mrs Rodden suspected that her daughter was in the flat. The Roddens had a key but never used it (until 30th March 2010). This suggests that there was reluctance on the part of Mrs Rodden to do anything which might antagonise her daughter. Kim Hainey reacted angrily to both Jill Stevenson and Linda Flannigan when they contacted Mrs Rodden (who was in a position to contradict much of what she was telling the various agencies). Kim Hainey was manipulative, and had an ability to manipulate her mother e.g. into thinking that she was confused about Declan's attendance at a nursery.
 - (e) From Declan's first birthday until at least Christmas 2009 Mrs Rodden continued to provide generously for Declan and her daughter. She cooked Sunday lunches regularly in the expectation that they would arrive, though they never did. She made up parcels of food and small items such as socks, nappies and babygros which she gave to her daughter for her grandson. She and her husband booked a holiday in Portugal for the four of them and at the beginning of 2009 gave her daughter money to obtain a passport for Declan. She brought toys back from Portugal for Declan. She arranged Christmas 2009 around him and according to John Rodden there was 'a roomful of toys' for Declan.
 - (f) There was evidence that the relationship between Kim Hainey and Mr Rodden could also be strained. I am satisfied that Mrs Rodden was told over a long period of time as to what was the right thing to do. I am in no doubt that she agonised over the situation for many months.
 - (g) In the course of giving evidence she told the Inquiry repeatedly that she did not ever think that Declan was in danger. She was nevertheless well aware of the character, and the history of her daughter, and I do not accept that she was unconcerned about Declan's welfare for that period of almost a year when she had no sight of him, despite the lies that her daughter was telling her about his progress, his attendance at the nursery, his visits to his grandfather in England etc. For whatever reason or reasons, she did nothing when a variety of avenues was open to her. Her failure to act is a burden of guilt that I have no doubt as a loving grandmother she will carry till the end of her life.
2. Various neighbours at Bruce Road gave evidence about their concerns that in 2009 Kim Hainey never seemed to have her son with her when she was out and about. They also realised that on occasions which they knew about she had left him alone when she was visiting neighbouring houses to drink. He was also heard crying for lengthy and regular periods of time. On at least 2 separate

occasions there was talk of 'the social work' being contacted but unfortunately that did not happen.

Child protection is not just a matter for parents, family or the various agencies who have statutory duties to meet. It is something which is the responsibility of us all – in our neighbourhood and in our society. It is incumbent on each one of us if we have what we consider legitimate concerns, to report those concerns to the relevant authority. Should those concerns prove groundless, then no harm will have been done. If they should prove justified, then future harm will have been prevented.

RECOMMENDATIONS

I consider it is appropriate that I set out here the 16 recommendations made by the authors of the Significant Case Review. Although a production in the Inquiry, I chose not to read the Review itself, though Appendix 1, the medical history, was referred to in evidence and I did read that.

1. When a substance misusing mother-to-be is being referred to maternity services this should be done using a pro forma which includes information on their substance misuse and any other relevant issues.
2. There should be an initial child protection case conference arranged in all cases of children being born to drug-using parents.
3. A health Visitor or School Nurse from the GP practice should be invited to all meetings concerning substance abusing parents and their child(ren).
4. The GOCR care plan should include specific reference to the level of direct contact to take place with the child(ren), who is responsible for maintaining this contact, and , in the event of any significant variation from the programme of planned contact, the requirement for an urgent review be arranged.
5. NHS GGC should introduce an unseen Child protocol in conjunction with its partner Local authorities.
6. Cases coming under the GOCR umbrella should be the subject of regular review and should not be closed or transferred without such a review taking place, including updating the parental Substance Misuse Report.
7. There should be put in place a monitoring system, such as exists in respect of Child Protection, to ensure that the process of completing GOCR Full Assessment Reports and conducting reviews can be tracked, and speedy

action taken where there is significant variation from the prescribed timescale.

8. Given that GP records are likely to be the most accurate and comprehensive source of the medical history of a substance-misusing parent it is recommended that it be made the responsibility of the GP to ensure that such information is made available to case discussions either by direct presentation by her/himself, or a representative of the practice e.g. a health visitor, or by the provision of a written report.
9. It should be mandatory for all staff and managers involved in this area of work, either directly or indirectly, including GPs, and consultants within the RDS, to undergo Gopr training, and each agency should maintain a Gopr training record, either on a stand alone basis, or as part of any existing training record.
10. A simple paper or electronic form of communication should be introduced to ensure that there is clarity of language and intent when staff from one agency are asking staff from another agency to carry out a specific task.
11. There should be a review of guidance for health Visitors on inter-agency working, including their responsibilities under recommendation 7, and consideration of a short period of “shadowing” as part of the induction programme for new staff.
12. Guidance should be introduced for Health Visitors on case handover practice, including an entry in the patient record, at least in all “additional” and “intensive” cases, of key issues and the date of handover.
13. There should be a review of clinical and management supervision arrangements for health Visitors with reference to frequency, recording of content and formalising sessions for all staff.
14. There should be a review of the nurse management structure to ensure that health visitors and other nursing staff receive appropriate support and supervision.
15. Steps should be taken to ensure that GPs are familiar with RCGP/SG guidance on the management of substance abusers.
16. Management of Social Work child care practice within the RAH should sit within Child Care rather than Community Care.

I also consider it helpful to repeat here in full the conclusion of the Care Inspectorate at the end of their review in 2012 of the progress made in response to the SCR Recommendations.

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

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

Against that background, and the changes in practice which have already taken place within the service provided by Health Visitors, I make the following four recommendations.

1. Management must ensure that there is regular and ongoing assessment of the staffing levels necessary to achieve at all times best practice in relation to the needs of the service which is provided.
2. Where a Notification of Concern in relation to an ‘unseen child’ is made to any social work department, such notification should be treated as deserving of the utmost priority and resources put in place immediately to assess the situation and take all necessary steps to locate and protect such a child.
3. General Practitioners should ensure that all relevant medical information on a substance misusing parent or carer is collated and provided timeously to social work and health staff involved in decision-making in relation to child protection/supervision. This recommendation endorses recommendation 8 of the SCR, and is made to emphasise its importance.
4. It should be mandatory for all staff, whether social work or health professionals involved in the care of the children of substance misusing parents to be trained in the latest guidance and protocols concerning child protection. This recommendation repeats recommendation 9 of the SCR because the Inquiry heard that it was not yet mandatory for general practitioners to undergo such training, though many did on a discretionary basis.

I was not advised in the course of the Inquiry what plans, if any, there were for the Care Inspectorate to be called in again by Renfrewshire Council to provide a supplementary report concentrating on those matters which were at an early stage of implementation when the inspection took place. It may be that this is the intention, but if not, there might be merit in having this done.

Conclusion

When the findings and recommendations of an inquiry such as this are produced, the expression 'lessons have been learned' is one which is perhaps often used without much thought to its practical application. Some 5 years have passed since Declan died, and those in positions of management responsibility, as well as all staff, have taken their duties and obligations seriously, and many changes have now been made to remedy defects and tighten procedures and channels of communication. It is appropriate that the Inquiry recognises those improvements and the work that has gone into achieving them and I do so now.

Finally, there is Declan, about whom so much has been heard during the Inquiry. After his body was discovered on 30 March 2010, his remains stayed overnight in his cot at 45 Bruce Road and a police guard was taken up outside the flat. The following day he was taken to Yorkhill Hospital for post mortem-examination. Declan's body was attended with consideration and respect through all the necessary procedures.

I am grateful to the Crown and to the representatives of all parties for the expeditious approach which was taken to the evidence, and for the courtesy shown throughout. I wish also to express my appreciation for the compassion and dignity with which Declan was treated in the course of the many days when the Inquiry sat.

Ruth Anderson QC

Sheriff of North Strathclyde at Paisley

3 September 2014.