DUNDEE CITY COUNCIL

REPORT TO: **POLICY AND RESOURCES COMMITTEE - 14 JUNE 2010**

REPORT ON: **UPDATE REPORT ON SIGNIFICANT CASE REVIEW AND INDEPENDENT REVIEW - BRANDON MUIR**

REPORT BY: **CHIEF EXECUTIVE/DIRECTOR OF SOCIAL WORK**

REPORT NO: **334-2010**

1.0 PURPOSE OF REPORT

1.1 To inform members of the Policy and Resources Committee of the progress reported in the Update Report on the Significant Case Review and Independent Review undertaken by Professor Peter Wilson.

2.0 RECOMMENDATIONS

It is recommended that the Policy and Resources Committee:

2.1 Note the content of the report.

2.2 Instruct the Children and Young Persons Protection Committee (CYPPC) to ensure that actions from the Update Report are subsumed within the Improvement Plan prepared in response to the HMIE Joint Inspection of Services to Protect Children and Young People in the Dundee City Council Area.

2.3 Ask the Chief Officer Group of Dundee City Council, NHS Tayside and Tayside Police to ensure that progress is monitored in respect of the recommendations, which are subject to on-going review, and progress reported upon.

3.0 FINANCIAL IMPLICATIONS

The Policy and Resources Committee on 1 July 2009 approved additional expenditure of up to £500,000 which has been identified from general fund balances to develop Child Protection Services. This funding has contributed to the developments acknowledged in this report.

4.0 MAIN TEXT

In March 2009 the Chief Officer Group for the Child Protection Authorities in Dundee commissioned Professor Peter Wilson, as an independent assessor, to consider all the information arising from the Significant Case Review (SCR) relating to the death of Brandon Muir. He was remitted to confirm the recommendations made in the SCR, to make any additional recommendations, and to oversee implementation of the recommendations, confirming progress as required.

The Significant Care Review, together with the Independent Review, was published on 19th August 2009 (see Report 418-2009). At paragraph 3 of that report Professor Wilson undertook to provide a report to Chief Officers on the completion of, and outcomes from, the Action Plan created in response to the SCR and Independent Review reports. This report, and its attached Appendix, provide that further assessment, which has been prepared for the Chief Officers Group.

Following publication of the SCR and Independent Review reports work was done to incorporate the recommendations from these reports into the Improvement Plan which had been drawn up and implemented as a result of the HMIE inspection. As a result, the multi-agency task groups formed by the CYPPC have undertaken work to ensure that the recommendations have been addressed and progress made.

In order to inform this review, Professor Wilson undertook a range of activities. These included:

- consideration of the revised Improvement Plan;
- attendance at the October 2009 meeting of the Chief Officers Group;
- a review of minutes of meetings of the Chief Officer Group, the CYPPC, the Task Groups and Task Group Chairs;
- consideration of other records of activity relating to the recommendations;
- meeting in May 2010 with the Chair of the CYPPC, the lead officer from the CYPPC, senior representative from Tayside Police and NHS Tayside and the Task Group Chairs;
- meeting in May,2010 with a cross section of staff involved in Child Protection work; and
- consideration of reports on specific child protection meetings.

The content of Appendix 1 demonstrates that progress has been made against all the recommendations, and that the majority have been completed. Where recommendations are about activities which will have to be sustained, this will be the subject of on-going review monitored via the CYPPC.

Professor Wilson has also chosen to comment positively about the leadership provided by the Chief Officers, improvements in the area of information sharing and the work undertaken in respect of Community Nursing. In his assessment he states that *'the work has been considerable and the impact, both on the organisational processes and the staff can be sensed in the mood of the workforce, and in their self confidence about their role'.*

He goes on to comment *'While it is impossible to extrapolate the analysis of the improvements into a future guarantee that children in Dundee will not come to harm in the future, I am confident in stating that children and vulnerable families can have a much higher degree of confidence in the provision of child protection services in the city'.*

5.0 POLICY IMPLICATIONS

This Report has been screened for any policy implications in respect of Sustainability, Strategic Environmental Assessment, Anti-Poverty, Equality Impact Assessment and Risk Management.

The major issues identified are the need for joint ownership of the issues and implementation of the recommendations as a result of this significant case review.

6.0 CONSULTATIONS

The Chief Executive, Depute Chief Executive (Support Services), Depute Chief Executive (Finance) and Head of Finance have been consulted in preparation of this report.

7.0 BACKGROUND PAPERS

Joint Inspection of Services to Protect Children and Young People in the Dundee City Council Area, (Committee Report 362-09).

Significant Care Review and Independent Review - Brandon Muir (Committee Report 418-2009)

David K Dorward
Chief Executive

Alan G Baird
Director of Social Work

UPDATE REPORT ON SIGNIFICANT CASE REVIEW AND INDEPENDENT REVIEW - BRANDON MUIR

Peter M Wilson
Scottish Institute for Policing Research
1st June 2010

1 Introduction and Background

1.1 In March 2009 I was commissioned by the Chief Officer Group for the Child Protection Authorities in Dundee as an independent assessor to consider all the information arising from the Significant Case Review relating to the death of Brandon Muir (conducted by Mr Jimmy Hawthorn), to confirm the recommendations made, to make any additional recommendations, and to oversee implementation of recommendations, confirming progress publicly as required.

1.2 The Significant Case Review, and my Independent Review were published together on 19th August 2009, and at paragraph 3 of my report, I undertook to provide an independent report to Chief Officers on the completion of, and outcomes from, the Action Plan created in response to the Reports.

1.3 This report, and the Appendix, provide that further assessment to the Chief Officers' Group.

1.4 In completing the work, I have taken cognisance of the findings contained in the published report by HM Inspectorate of Education (HMIE) (4th March 2010) on the Joint Interim Follow-through inspection of services to protect children and young people in the Dundee City Council area.

2 Methodology

2.1 Following the publication of our reports in August 2009, I was provided with an early copy of the revised Improvement Plan, which had initially been developed by the Children and Young Persons Protection Committee (CYPPC) to address those issues raised in the HMIE inspection, but had then been adjusted to include those matters raised in the Significant Case Review or Independent Review reports. I was therefore able to see at an early stage how the authorities in Dundee were intending to address the matters raised.

2.2 In October 2009 I attended a meeting of the Chief Officers' Group, and heard reports from the various Task Group Chairs, as to the development of each of the strands of activity within the Improvement Plan. It was clear at that stage that significant progress was being made, and I was encouraged to learn of both the organised and committed effort ongoing between the various organisations.

2.3 To determine how the recommendations had been advanced over a longer period, I returned to Dundee in May. I had asked for and been provided with Minutes of the regular meetings of the Chief Officers' Group, Improvement Plan Task Groups, and other records of activity relating to the recommendations. I met separately with the Chair of the CYPPC, the lead officer from the CYPPC, and senior representatives from Tayside Police, and NHS Tayside. I also met with the chairs of the Task Groups set up to deliver the Improvement Plan.

2.4 The documentation supplied in relation to the various meetings on policy and practice provided a valuable reference resource against which to assess the development of work against the recommendations made, but I was keen to cross check this information against the experience of staff, and through a limited study of casework. To achieve this, I asked to meet with a cross section of staff involved in Child Protection work, and I identified independently reports on two meetings where IRDs had been conducted, two initial case conferences, and two review case conferences.

2.5 The Review Reports had also identified issues of a national relevance, (in particular recommendation 23 of the Significant Case Review, and recommendation 4 of the Independent Review) and I sought from Scottish Government officials, information on these matters. It is also worth recording here that in the period since the publication of our reports Mr Hawthorn and I have presented our findings to a national meeting of Chairs of Child Protection Committees, and to a working group of the Multi-Agency Resource Service (MARS).

2.6 I have recorded a summary of the current position against each of the recommendations in the Appendix.

3 Analysis

3.1 While the Appendix provides the status of the response by the Dundee authorities to each of the Recommendations, and my assessment of each one, I also want to make comment on the other issues raised in the Significant Case Review and in the Independent Review which although not resulting in specific recommendations, invited attention by the relevant authorities. More importantly I hope to give a richer picture of the impact of the changes I have examined, which I have recognised through interviews with staff, and the examination of documentation.

Leadership

3.2 In my original report (paragraph 10) I made reference to the *lack of cohesion in understanding the experience of front line staff, to cause concern as to the effectiveness of the leadership of the CYPPC.* I also emphasised that *the Chief Officers' Group needs to do more than monitor the implementation of the (improvement) plan, it needs to demonstrate ownership and set the agenda for advancing child protection in Dundee.*

3.3 The Chief Officers' Group has met monthly since the publication of the Reports, and the minutes of the meetings provide ample evidence of real engagement with the agenda. The developing changes emerging from the Task Groups are scrutinised, and where appropriate approved, but more importantly forward planning and direction can be identified. Perhaps most significantly, the Chief Officers are clearly determined to be more visible, and at the time of my recent visit, two inter-organisational seminars were being held, to further advance the ethos of joint working, and demonstrable commitment.

Information Sharing

3.4 In light of the particular circumstances surrounding the distribution and management of information in so much as it related to the risks facing the well being of Brandon Muir, comment was made in both the Significant Case Review, and in the Independent Review about information sharing. It was also recognised that the future also involved changes to national practices and systems. In reviewing the various changes that have taken place in Dundee since the publication of the reports, it is worth commenting on a number of improvements.

3.5 An examination of resourcing has resulted in additional staff being provided by the three major services, Tayside Police, NHS Tayside, and Dundee City Council Social Work. The difference this has created is spoken to by front line staff who feel much more able to give appropriate time to assessing individual cases. The volume that had been creating pressure on staff, and led to a poorer quality of assessment and less well informed decision making, is now felt to be much more manageable.

3.6 The leadership given to shared assessment, and joint working, has created a refreshed environment. Specific examples can be seen in the weekly meetings which take place between police, social work and health staff, but a more qualitative and hopefully enduring benefit has been the attitude taken by staff who now have a better understanding of the priorities and responsibilities of colleagues in other organisations. There is now a greater willingness to develop the information known, before seeking to transfer responsibility for a case.

3.7 New joint processes for shared assessment are now well advanced (due for implementation shortly), and combined with improvements for pre-referral assessment within Tayside Police, there can be significantly increased confidence in the quality of information that is now being considered. The Children's Reporter spoke to me about the much improved quality of referral she was now receiving.

Community Nursing

3.8 At the time of the Reviews, a programme of national change to the model for Community Nursing in Scotland was being developed in a number of Health Board areas, including NHS Tayside. In view of the vitally important role which community nurses have in protecting children, I made two recommendations (3 and 4) which invited clarification at both a local and national level.

3.9 In respect of NHS Tayside I recommended that a process be identified to satisfy the Health Board as to the skill mix of Health Visiting Teams, so that a clearly formulated resourcing plan could be created. On my revisit I was provided with a briefing and documentary information on the work which had been undertaken. I was very pleased to see the careful assessment that

had been made to resource and support Health Visiting teams in four zones in Dundee. This assessment had taken account of the need to provide cover to allow for training and supervision, as well as for periods of leave. Additional Advanced Nurse Practitioners had been appointed to support Community Nursing in each of the Zones, and NHS Tayside had committed to train a further six Health Visitors in the current year, and two in the year ahead. Community Nursing staff spoke of the real difference which this investment had made. It was also clear that this had made a significant difference to the ability to attend case conferences, and other similar meetings where the welfare of individual children and their families was to be discussed.

3.10 I was particularly interested to hear of the development of practitioner forums being held in each of the four zones involving police, health and council staff (social work, education and housing), which seems to me to both demonstrate the shared commitment to protecting children, but also to ensure that those who are dealing with cases have an opportunity to contribute to organisational thinking in this field.

3.11 This example, taken with the cross-organisational briefing sessions referred to earlier, provides a confidence that my final recommendation on training (recommendation 5) has been meaningfully adopted. I was interested to hear of the evaluation of training, provided under the auspices of the CYPPC, which includes re-interviewing the staff after 3 and 6 months.

3.12 At the national level, the Modernising Community Nursing Board established by the Cabinet Health Secretary for Health in June 2009, has set as a priority - the need to ensure staff have the right skills to identify and support vulnerable families and children. Their work continues. The Review of Community Nursing in the Community pilots (of which NHS Tayside is one pilot area) is the subject of independent evaluation due to be completed later this year.

4 Assessment

4.1 My independent assessment of the developments that have taken place under the direction of the Chief Officers' Group, and the leadership of the CYPPC Chair, is that the work has been considerable and the impact on both the organisational processes and the staff can be sensed in the mood of the workforce, and in their self confidence about their role. The 'coming together' in sharing a common vision and commitment, has led to the introduction of new practices and approaches which will be the subject of learning for other child protection partnerships. While it is impossible to extrapolate the analysis of the improvements into a future guarantee that children in Dundee will not come to harm in the future, I am confident in stating that children and vulnerable families can have a much higher degree of confidence in the provision of child protection services in the city.

5 Conclusion

5.1 This report concludes my involvement in the review into the circumstances surrounding the death of Brandon Muir, and specifically the role of the Child Protection authorities. It is clear that the Chief Officers' Group is committed to ensuring that beyond the final completion of the Improvement Plan, their vision for Child Protection remains.

Peter M Wilson
Scottish Institute for Policing Research
1st June 2010

Significant Case Review: Brandon Lee Muir - Jimmy Hawthorn			
	Recommendations	**Response**	**Assessment**
Case Conferences			
1	All agencies must ensure the most up to date information is available to the case conference	Procedures updated	To be subject to ongoing review
2	The initial case conference minute should list risk and protective factors for the child, and these should be updated at subsequent review case conferences and identify any risks or protection that they present to the children	Procedures updated	While not explicit in limited sampling exercise, Scrutiny Group invited to determine style of report presentation for initial and review case conferences
3	Assessment reports for case conferences must consider all adult members in the household, whether or not resident at that address, and those with significant contact with the child	Procedures updated – also included in Integrated Assessment Framework	Quality will be reinforced by the implementation of the Integrated Assessment Framework
4	All review case conferences should ensure consideration of key issues raised in the Core Group meeting	Procedures updates	To be subject of qualitative review by Scrutiny Group
Initial Referral Discussions			
5	Any revision of the inter agency guidance on IRDs needs to clearly state that the IRD is part of the critically importance process of protecting children, and not a one off event	Procedures updated	Complete
6	An IRD should be considered where there is a cluster of concerns in relation to child care and domestic violence	Procedures updated	Complete
7	Where internal social work checks indicate that other colleagues have relevant information to share, they should be invited to the IRD, or if unavailable their views sought	Procedures updated	Complete – Sampling revealed presence of professionals who had knowledge of the case
8	Social work checks will also be made of other agencies, such as SCRA, housing and substance misuse services	Procedures updated	Complete – Creation of Child Protection post in Substance Misuse Services will also enhance the contribution
9	Where a health representative is attending an IRD, they will be responsible for undertaking relevant health record checks	NHS procedures updated	Complete
10	The IRD should identify actions, with timescales, to be taken to protect the child during any investigation, or in the period leading up to the initial case conference. Each agency representative will be individually responsible for recording and acting on any tasks assigned to them. Where the decision is taken to refer to SCRA, this should be done within 5 working days	Guidance on IRDs issued. Administrative support provided.	Complete – Sampling revealed significant improvement in documentation. Scrutiny Group invited to consider qualitative content of IRD records
Adults who cause concern			
11	Where any agency becomes aware of an adult causing concern who moves to a household with children, this information must be shared across all relevant agencies involved with children	Being addressed by the integrated assessment framework which support the Multi-Agency Assessment Team	To be subject of ongoing review

12	Social work must ensure that adults who cause concern are cross references with any known contacts and recorded on the social work database	Being addressed by the integrated assessment framework which support the Multi-Agency Assessment Team	To be subject of ongoing review
13	When social work staff are undertaking an assessment, they will carry out full system checks on adult members of the household	Being addressed by the integrated assessment framework which support the Multi-Agency Assessment Team	To be subject of ongoing review
Social Work Access Team			
14	On receiving any referral, access team social work staff will consider any prior social work contact with the child or family. Where the decision is for no further action, this will be recorded on the child's e record and cross references as appropriate	Procedure in place	Complete
15	Where a referral involves a pre school child the social worker will always contact the health visitor as part of their response	Procedure in place	Complete
Police			
16	Tayside police should reinforce the need for Family Protection Unit staff to produce up to date and accurate information to case conferences and IRDs	Additional resourcing to Family Protection Unit has allowed more detailed assessment of cases, and improved quality of record keeping.	Complete
17	Tayside Police should reinforce officers' awareness of the Force guidelines on Domestic Abuse	Police initiative on Domestic Abuse has led to new procedures and guidance	Complete
18	Domestic abuse referrals should be graded and clearly specify where children were actually present in a house when an incident took place	Additional resourcing of Domestic Abuse Officers and police initiative on Domestic Abuse has improved information recording and assessment. New force wide referral system being developed to inform Multi Agency Assessment Team.	Complete
Health			
19	NHS Tayside should ensure there is a system in place for tracking requests from or referrals to SCRA	System in place	Complete
20	NHS Tayside should ensure full consideration of the impact of domestic abuse and substance misuse on children when they review the implementation of the Family Needs Health Assessment Framework	FNHA reviewed and re launched Child Protection Nurse now appointed to Substance Misuse Services	Complete
21	The re launch of the Family Needs Health Assessment should emphasise the importance of assessment and care planning for health visiting teams, and the need for more objective record keeping	FNHA Reviewed and re launched Additional administrative support and supervision provided in each Zone	Complete
Monitoring changes			
22	All agencies must ensure that their self evaluation and auditing tools collect the relevant information to monitor their effectiveness in keeping children safe	Scrutiny Sub group being established by CYPPC Monitoring programme developed by Dundee CHP	To be subject of ongoing review

Significant Case Reviews			
23	The Scottish Government should further explore the systemic model for undertaking SCRs currently being developed by the Social Care Institute for Excellence, and include reference to this in their updated guidance on SCRs	A short life working group set up by the Multi Agency Resource Service at Stirling University to examine good practice in the conduct , reporting and potential dissemination of Significant Case Reviews in Scotland is considering alternative models for SCRs is due to report in June	National proposals to be subject to consultation

Significant Case Review: Brandon Lee Muir - Independent Review for Chief Officer Group - Peter Wilson			
	Recommendations	**Response**	**Assessment**
Information Sharing and Assessment			
1	The CYPPC establishes how to improve the quality of information shared between agencies with an increased responsibility taken to assess the risk associated with cases being referred so that receiving agencies might be better information as to the level of intervention required	Addressed through the creation of the Integrated Assessment Framework	To be subject to ongoing review
Initial Referral Discussions			
2	The CYPPC clarifies guidance on the management of IRDs, pending the publication of national guidance, and provides training to those involved	Guidance issued	Complete
Community Nursing			
3	NHS Tayside identify a process through which they can satisfy themselves as to the effectiveness of the skill mix based Health Visiting teams in delivering a quality of service in child protection, and if they determine that more specialist Public Health Nurse/Health Visitors skills are necessary, that they formulate a clear resourcing plan	Process established within Dundee CHP. Analysis complete, Recruitment and training to match the outcome of the analysis now well developed	Complete
4	The Scottish Government clarifies the arrangements for developing and assessing local and national standards in community nursing	The Scottish Government has advised that while the professional standards for Community Nurses are a matter for the Nursing and Midwifery Council, the Modernising Community Nursing Board has developed three workstreams to assist NHS Boards in Scotland to modernise and further develop community nursing services.	The specific work in relation to Child Protection services in Dundee has seen a significant enhancement in resources and procedures. The national evaluation of the Review of Community Nursing pilots is due to be completed later in 2010.
Training			
5	The CYPPC promotes a continuing series of cross agency training events to ensure practitioners and managers understand shared roles and responsibilities in Child Protection, inter-organisational processes and issues that affect the effectiveness of teams	COG emphasises that training should be cross organisational. Multi agency Chief Officer led events organised six monthly. Training evaluation process established by CYPPC	Complete

Significant Case Review: Brandon Lee Muir – Observations			
	Observations	**Response**	**Assessment**
1	Critical Incident Management Group to be established in consultation with the local Procurator Fiscal's Office to agree guidance on critical incident debriefing, management of press releases, the conduct of pre-trial management reviews etc.	Scottish Government advises that guidance on the interdependencies of criminal investigations, court proceedings and the conduct of SCRs will be provided for the consideration of Child Protection Committees when the short life working group on SCRs reports in June.	While national guidance is being developed, the district office of the Procurator Fiscal continues to consult on a local arrangement with the Dundee authorities. I would hope this can be concluded within 3 months.
2	The CYPPC to explore a shared approach to critical incident debriefing for multi agency staff	Protocol prepared and published	Complete