

Brandon Muir Review

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.

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