

Significant Case Review: Brandon Lee Muir

Born: 2 April 2006

Died: 16 March 2008

Part 1

Significant Case Review For Dundee CYPPC

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Part 2

Independent Review for Chief Officers Group

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INTRODUCTION

1 Following the death of Brandon Muir, those charged with leading and managing child protection services in Dundee commissioned two separate reviews. A significant case review was commissioned in line with national guidance to examine the particular circumstances surrounding the child protection issues, and the role of the various authorities involved. Separately, an independent review was commissioned by the Chief Officers Group to ensure validation of the Significant Case Review, but also to address wider issues which may emerge, not necessarily related to the death of Brandon.

2 The two reports are published together. Part 1 relates to the Significant Case Review and was conducted by Jimmy Hawthorn, an Independent Social Work Consultant. Part 2 relates to the Independent Review undertaken by Peter Wilson, a former Chief Constable, and now a Professor at the Scottish Institute for Policing Research.

3 In addition to the Reviews relating to circumstances surrounding the death of Brandon Muir, a separate inspection of Child Protection arrangements in Dundee was undertaken by a team led by HM Inspectorate of Education (HMIE). That report was published on 23rd June 2009, and is referred to within these reports.

SUMMARY OF FINDINGS

4 The Significant Case Review concludes that the violence of Robert Cunningham towards Brandon Muir could not have been predicted. In the period of less than three weeks that Cunningham became part of the family grouping with Heather Boyd and her two children, child protection staff had quickly embarked on a process of assessment and information gathering which would have led to a Case Conference on 18th March 2008.

5 In that time, both social work and health staff had seen Heather Boyd, Robert Cunningham and the children on a number of occasions, visited the home, and Heather had cooperated with a medical examination on Brandon in relation to a query about his gait.

6 The focus of attention in preparation for the Case Conference centred more on the well being of the children against the context of concern about Heather Boyd's wider parenting skills and the home environment, rather than the threat of violence from Robert Cunningham.

7 The Significant Case Review explored in considerable detail the information known to the authorities about Heather Boyd and her children, and about Robert Cunningham. The authorities had sought to offer Heather Boyd support in her parenting role. She never utilised this to any great degree, preferring to make use of the support offered her by her parents. While she had come to the notice of the police in the past, nothing was known of her activities in prostitution, and she had no recorded history of drug misuse. Experienced staff found no evidence of either a chaotic household or lifestyle that suggested she had a dependence on substances.

8 Both health visiting and social work staff consistently stated that Heather and her children did not stand out as giving great cause for concern. Whilst there were ongoing concerns, these never reached a threshold which prompted consideration of more formal intervention until shortly before Brandon's death.

9 Robert Cunningham had also come to the previous attention of the police, but more significantly in this case he was known to the police, social work services and to the Children's Reporter through his alleged involvement in domestic violence towards a previous partner.

10 The Significant Case Review explains what has changed in Dundee since the death of Brandon Muir, and where appropriate reference is also made to the Improvement Plan which has been developed in response to the recent HMIE joint inspection.

11 However, in examining the particular circumstances of the case, the two reviews identified a number of issues which have a continuing consequence for child protection policy and practice in Dundee, and some of which are of wider national interest.

These include matters concerning:

- The evaluation and sharing of information
- The need for full background checks on all household members
- The need for continual assessment and care planning
- The conduct of initial referral discussions,
- The impact of domestic abuse and substance misuse on children
- The need for clear multi agency ownership and leadership of child protection
- The capacity of resources in the Child Protection Team
- The capacity and resilience of community nursing resources

12 Recommendations are made in relation to these issues. While most affect the local child protection authorities, some matters have been discussed with the relevant personnel within Scottish Government, and will require attention at that level. Locally, the reports acknowledge that a significant amount of work has been ongoing in Dundee, especially in preparation for and in response to the joint inspection on child protection, although some further matters have been identified as a result of these reviews. At a national level, issues include in particular, guidance on child protection, the recognition of the problems of volume of child referral discussions now being experienced, and the assessment of the impact of changes to community nursing.

13 In the short three week period when Cunningham resided with Heather Boyd and her children, the authorities, while active in personal engagement with the family, were not able to assemble, process or assess all the available information on Boyd or Cunningham. The Inquiry revealed gaps and inaccuracies, some caused by pre-existing systems, others by a lack of available resource.

14 While the grandparents immediately raised their concerns, and prompt action was taken to discover what was known about the developing circumstances of Heather Boyd, her children and her new partner, the Significant Case Review concludes that there was little opportunity to prevent the fatal assault on Brandon, from which he subsequently died.

Furthermore, from the extensive consideration of information from records, from scrutiny of policies and procedures, and from discussions and interviews, it is also concluded that Brandon's death, which was caused by Cunningham, could not have been predicted by the Dundee authorities.

NOTES

1. During the course of the two enquiries, many staff were interviewed, most of whom had been involved in the case. Notwithstanding the impact which Brandon's death had had on them, each was open, candid, and in our view honest in their description and assessment of what had happened in this case, and about their role in protecting children in Dundee. It is clear that these are committed professional people, often working under a real sense of pressure. It is our hope that in the response which is made to the findings in these reviews and in the delivery of the Improvement Plan published following the HMIE inspection, that the members of staff in all organisations can recognise the value that is placed on their contribution. We recognise that their work already makes a difference to many children and young people in Dundee. The learning from this case will hopefully benefit others in this most complex and demanding area of work.
2. While the Summary describes the principal individuals involved by name, as the media coverage of the death and the subsequent criminal trial has consistently identified them, the actual reports adopt the standard approach of identifying individuals by letter. This affords some protection to other people involved, and helps to ensure that the focus is on learning about the policies and practices rather than the individuals.

Jimmy Hawthorn, Peter Wilson
August 2009

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Part I

Significant Case Review

EXECUTIVE REPORT TO DUNDEE CHILDREN AND YOUNG PERSONS PROTECTION COMMITTEE

1.0 Introduction

1.1 Brandon Muir was born on 2 April 2006 and was only 23 months old when he died on 16 March 2008. He was killed by his mother's partner, R, who was subsequently convicted of his culpable homicide and given a prison sentence of ten years. Charges against Brandon's mother of his culpable homicide, assault and wilful ill treatment were withdrawn following the judge's determination that there was insufficient evidence to place the charges before the jury.

1.1.1 The police investigation revealed a very distressing account of the circumstances leading up to Brandon's death in the early hours of Sunday, 16 March 2008. On Saturday 15 March 2008 mid afternoon, Brandon's mother had gone out shopping with R's sister and her three children, leaving Brandon and his older sibling in the care of R. Upon returning some 2 hours later, she found Brandon extremely upset and standing up against a wall in the flat. R told her this was a punishment for him climbing up onto the window sill. Mother told police later that Brandon looked very pale and tired, in contrast to how he had been when she left him earlier. Later the same evening mother took both children to R's sister's flat where, in the course of the evening, Brandon was seen to be very pale and unwell by a number of people present. He was placed on one of the bedroom beds where he was sick and then moved to a chair in the bedroom where he continued to be sick.

1.1.2 Around 20.00 hours mother had left the flat, saying she was going to visit an uncle. It was established subsequently that she went out prostituting herself along with a friend, leaving her children in R's care. She purchased two bags of heroin which she took home, and the police investigation established that R knew that she was intent on purchasing heroin for their use.

1.1.3 Brandon continued to deteriorate throughout the evening and although R and his sister had some discussion about calling a doctor when mother was still out, R said he did not want to phone as he did not know enough personal details about Brandon to pass on to medical staff were he to have called. Mother returned about 23.00 hours. Mother and R returned with both children to their flat at 01.30 hours and put the children down to sleep on the living room couch. Mother smoked some lines of heroin as did R but he soon fell asleep. According to her statement, mother remained awake to keep an eye on Brandon and about 04.10 when she noticed that he was not breathing she wakened R and they subsequently called an ambulance via 999. Brandon was taken to Ninewells Hospital and pronounced dead at 05.06 hours.

1.1.4 At the trial it was revealed that Brandon had died as a consequence of a ruptured duodenum caused by a blunt force trauma. In evidence, the specialist child pathologist who examined Brandon explained that he could have survived the injury if it had been recognised and treated in time. The pathologist also revealed that there was evidence of previous healing rib fractures of two to three weeks age found at the site of the injury.

1.2 Details of Family members and significant others referred to in this significant case review.

Throughout this report I will refer to family members and significant others by the following abbreviations:

1.2.1

- Brandon Lee Muir (dob 2.04.06)
- M-Brandon's mother (born 1985)
- J- Brandon's father (born 1986)
- Child C- Brandon's sibling (born 2004)
- Mr and Mrs B- Brandon's maternal grandparents
- R- mother's partner (born 1985)
- P- Ex partner of R (born 1989)
- Child Y- P's child (born 2006)
- Child Z – P and R's child (born 2007)

2.0 Remit of the Review

2.1 The Significant Case Review (SCR) was conducted in accordance with the 'Protocol for Conducting a Significant Case Review in Dundee (Dundee CYPPC in December 2007) which was itself informed by the national interim guidance for Child Protection Committees for conducting SCRs (Scottish Executive March 2007). The remit of the review was to:

- comprehensively assess the agency and inter agency discussions, decision- making and involvement with Brandon, his family and others relevant to his case
- establish whether there are lessons to be learned about how better to protect children and young people and help ensure children get the help they need when they need it in the future
- make any appropriate recommendations for action, and
- in considering the review report, the relevant local agencies shall, individually and collectively, consider how any recommended actions might be implemented. *'The review should be understood as a process for learning and improving services to children and as a means of recognising good practice.'*

2.2 Conduct of the review

2.2.1 In conducting this review I undertook interviews with those staff directly involved with Brandon's mother, M, and also with staff who had worked with her partner R when he was a member of the household with P and her 2 children prior to moving in with M in mid- late February 2008. I also had access to case records and reports held within health and social work services and the Scottish Children's Reporter Administration, as well as to the police investigation undertaken after Brandon's death. The interviews were undertaken between March and June 2009, following the conclusion of the trial.

2.2.2 In the interviews with health colleagues, in order to ensure the necessary expertise and understanding of the health context I interviewed jointly with an experienced Nurse Consultant Child Protection and Vulnerable Children from a Health Board in the West of Scotland. Similarly, the interviews with police colleagues were undertaken jointly with Peter Wilson who retired as Chief Constable from Fife in May 2008; again this ensured a fuller understanding of the police context.

2.2.3 Given my own background of over 30 years' experience in social work and my familiarity with the social work environment I conducted interviews with social work staff by myself. Throughout the preparation of this report, I regularly consulted with an experienced social work consultant.

2.2.4 All interviewees received a summarised account of the interview and were invited to confirm the accuracy of the record made. Where I had been unclear on any aspect of the interview, clarification was sought within the summarised account sent back to the interviewee.

2.2.5 I also met with senior managers in health, social work and the police to gain a fuller understanding of the organisational structures and working environment during the particular period of agency involvement with the family. This was important in helping me understand the working context for staff and the impact of this upon their ability to deliver a safe service to vulnerable children and their families.

2.2.6 I interviewed a total of 48 staff across all the relevant agencies as part of this review. This included staff who were off sick but who nevertheless were keen to meet me to share their views to help my understanding of Brandon's circumstances. Managers from all agencies ensured my ease of access to relevant reports and records. The staff whom I interviewed were open and reflective in their responses, and I was impressed by their determination to learn any positive lessons from the SCR for their future practice. From my extensive interviews with staff across all the agencies, I formed the impression of a committed, hard working group of professionals, seeking to offer the best possible service to their service users.

2.2.7 I was also grateful for the opportunity to meet with members of Brandon's family. Clearly, they have been deeply affected by Brandon's death and I recognise that the process of the SCR has necessarily exposed them to further sadness. Most of my contact has been with Brandon's maternal grandparents. They have shown enormous integrity and dignity throughout this process, and have been very measured in their responses.

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2.3 Report structure

2.3.1 This case is highly unusual and unlike many other child death inquiries in that the sustained inter agency involvement with M and R and M's two children was confined to the three week period leading up to Brandon's death on 16 March 2008, an extremely short timescale.

2.3.2 Due to the mounting concerns being expressed by M's parents over her new relationship with R; his known involvement in domestic abuse with his previous partner P; and M's lack of any real engagement with support offered, an Initial Referral Discussion was convened on 28 February 2008. Actions agreed at this meeting included a decision to make a referral to the Children's Reporter (this was not done before Brandon's death); a referral to the locality social work children and families team from the social work access team then working with the family; and a child protection case conference scheduled for 18 March 2008. This was a very prompt response to the identified concerns and will be considered in detail within the report.

2.3.3 However, to fully understand the context of the last three weeks of Brandon's life, it is necessary to consider earlier agency involvement with M and R. The first period covers the birth of M's two children, Brandon (dob 2.04.06) and his older sibling C (born 2004) when the health visiting team from Lochee Health Centre had most contact with M. Following the submission of a police concern referral in May 2006 in relation to C, social work staff completed an Initial Assessment Report for the Scottish Children's Reporter Administration on 31 July 2006. During this first period there was also some contact between health and social work staff and I will consider the effectiveness of the inter agency involvement with the family.

2.3.4 This particular period ends in mid February 2008 by which time M had moved with her two children from her flat in Douglas back to her parents' home in Charleston. This followed some difficulties over anti social behaviour at the Douglas flat- loud music late at night when M had friends visiting- but also reported concerns about her shouting and swearing at her children. At the end of this period in mid February 2008, family support centre staff from Charleston family support centre were attempting to engage M and Brandon in programmes within the centre.

2.3.5 The second period considers R's involvement with his previous partner P and her 2 children Y and Z. He was involved with this household from approximately August 2006 until the couple separated in early February 2008 by which time he had already commenced his relationship with M. (P and M knew one another). R was the father of P's second child, Z born in 2007. When the child protection case conference for unborn baby Z was held on 5 July 2007, R was a fully established member of the household and his role and involvement with the children and their mother, P, formed a significant part of the social worker's comprehensive assessment of the children.

2.3.6 The final period reviews the short time when M and R were caring for Brandon and his older sibling, C, in M's flat in Douglas.

3.0 Organisational context for health and social work staff

3.1 Getting it Right for Every Child (GIRFEC)¹ introduced a national framework in 2007 and 2008 for the delivery of children's services which aims to provide a common, coordinated approach across all agencies and one which supports the delivery of appropriate, proportionate and timely help to children as they need it. Experience of implementation of GIRFEC so far indicates that progress needs to happen across three fronts:

- Culture change
- Systems change and
- Practice change

These major changes at the national level have required every local authority in Scotland to meet the challenge of embedding GIRFEC in their services for children. The changes are far reaching and long term and provide the contextual background to inter agency work in Dundee at the time under consideration. GIRFEC also places increased expectations on universal services to support even very distressed families, and staff will require training and supervision to meet these new demands.

3.1.1 It is important to describe the working context for health and social work staff. Recent work undertaken by the Social Care Institute for Excellence² has begun to look at developing a systems based approach to SCRs which emphasises the value of a more focused examination on possible institutional weaknesses which may have contributed to errors, rather than a concentration on any mistakes which might have been made by individual workers. The authors argue that the systems approach is more helpful in identifying lessons to be learned for future practice, whereas the person-centred model very often leads to blame and fault finding, and is a less constructive model for learning.

3.1.2 The approach attempts to consider strengths and weaknesses within the wider system and how these may be improved in the future. In considering what can be learned from mistakes or system faults, it also looks at what is working well, and how that can in turn be strengthened. Thus, the working environment in which staff operate is seen as critically important as are the other mechanisms e.g. supervision; practice guidelines; caseload management which are in place to support staff in their work. I have tried to incorporate this perspective within the review.

3.2 Health

3.2.1 There had been significant staffing difficulties within the health visiting service in the Lochee Health Practice as far back as August 2005 and the health visitors' concerns were raised then and subsequently with their managers. The senior nurse child protection in her role as case supervisor to the health visiting team supported these concerns which were twofold; concern for their ability to adequately support the vulnerable families on their caseload combined with the impact of this upon their own health. Health records indicate that some administrative support and 2 additional sessions of senior health visitor time were made available to the team at that point. Administrative support to the health visiting team is limited, and the requirement on health visiting staff to complete reports e.g. for SCRA can be time consuming.

3.2.2 The staffing difficulties continued within the Lochee Health Practice, a combination of maternity leave; staff moving to other jobs; and staff sickness.

In March 2007, following the departure of one of the Band 6 health visitors the team was reconfigured and then comprised:- 2.3 whole time equivalent Band 6 health visitors and a 27 hour staff nurse post (Band 5). By September 2007, staff raised further concerns with their service manager about the combined effects of workload demand and a 37.5 hour health visitor being off long term sick.

3.2.3 Interim cover arrangements were put in place to try and address these new difficulties and included 2 sessions per week from a very experienced health visitor i.e. an extra 7.5 hours. More recent changes since Brandon's death mean that the current staff resource in Lochee is 2.8 whole time equivalent Band 6 health visitors; and 1.8 whole time equivalent staff nurses. A new Band 4 full time early years support worker has also recently been appointed and will have some input into the team. Given that guidance was issued very recently to health visiting teams across Dundee on the need to cut back on some of the public health work in order to prioritise those families categorised as 'intensive' the issue of capacity is still a very real one and will need to be followed up as part of the action plan from this Significant Case Review.

3.2.4 Senior health managers acknowledged that Lochee caseloads have always been challenging due to the high levels of deprivation represented within the practice population, but also that it is one of several such practices within Dundee. As well as the actions outlined above to help manage the demands on the health visiting team, in October 2007, eleven vulnerable families were transferred from Lochee Health centre to health visitors in other practices throughout Dundee.

3.2.5 The health visiting staff described a very fraught and pressurised working environment over the period in question. They drew a lot of informal support from one another, particularly at the start of the day before the telephones started ringing. They described good links with the GPs in the health practice, with good lines of communication; they were able to consult with GPs if necessary in between patients during surgery, and there was a notebook used to ensure messages were passed between GPs and health visiting staff.

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They were very positive about the help and support offered to them by the senior nurse child protection, and received supervision from her on their child protection cases approximately 6 weekly. She was always available for telephone consultation and would return calls quickly.

There were regular weekly meetings held in the practice, and these would sometimes be joined by community psychiatric nurses and drugs and alcohol workers. Although child protection and other relevant training opportunities were available and were valued by staff, they said that pressure of work often limited their ability to attend.

3.2.6 During 2007 when the workload demands were at their highest due to the long term sickness of a full time health visitor colleague, the health visiting staff were asked by their managers to assess their cases in line with the new surveillance and health care programme being introduced by Health for All Children (Hall4). This introduced three categories: universal core programme, additional support programme and intensive support programme, depending on need.

The NHS Tayside Family Needs Health Assessment Framework³ was being developed within Tayside in 2007 and the use of this framework was designed to help the health visitor, in discussion with the family, assess and determine the appropriate programme and thereby the level of visiting to the family. However, in assessing which category to place a family in, there was no standardised assessment tool available to aid this process, and the health visitors believed that this was too subjective, relying solely on their professional judgment with no external checks. It allowed for varying interpretations of thresholds and therefore lacked consistency of approach.

3.2.7 Within the three categories of core, additional and intensive, and in order to cope with their workload, the health visitors were advised by their manager to prioritise their priorities i.e. give priority to those in the intensive category. This would include families where the need required a multi agency intervention, for example where a child was on the child protection register.

3.2.8 The Family Needs Health Assessment Framework was not introduced in Dundee until June 2008, after Brandon's death.

3.3 Social work

3.3.1 The majority of M's contact with social work services was through the social work access team. The team was first established in 1997 and for the whole of the period in question it operated a city wide referral screening and short term intervention and assessment service. It offered an extensive range of information and advice, and received referrals from the public and professionals across all areas of children's services apart from the Children's Reporter. Responses could include no further action; referral to another service; or short term assessment before passing on for allocation to the relevant children and families social work team. Referrals to the team for adult services were usually transferred directly to either a mainstream provider or one of the mainstream adult social work teams for assessment.

It was managed by a senior social worker.

3.3.2 The same senior social worker also managed the First Contact Team which had become operational in 2004, following a review of the referral and assessment processes in place across health and social work. A key function of the team was to reduce the time between referral and assessment and the provision of a service, and to simplify the referral and access routes into services for older people (65+). Both teams were then based in the Nethergate Business Centre in Dundee, providing a single point of access to the public.

3.3.3 Within Dundee, a weekly multi agency pre referral screening group was established in August 2006 which involved discussions between social work, police, health and education staff to consider the needs of children who had come to attention through police concern referrals. The majority were linked to domestic abuse and the meeting discussed what further services, if any, were required and which agency would provide these. The access team was involved in these meetings which support an early intervention approach.

3.3.4 The primary aim of pre-referral screening is to share early information about children who may be in need, and to assist the police in deciding which children to refer to whom if that is necessary. The pre-referral screening group enhances information sharing and allows agencies to target their interventions. One consequence of this targeted inter-agency approach is that the referrals now received by the Children's Reporter are likelier to require compulsory intervention. Previously, due to the sheer volume of work, many of these referrals might have been with SCRA for some time before an assessment was possible. (However, depending on the nature of the referral, some children and families may receive a service in the intervening period.) Similarly, some children's cases would not have been referred to SCRA but would have remained known only to Tayside Police. Others would have come to SCRA but if the decision was not to investigate further, they would have bypassed the pre-referral screening group.

3.3.5 Wider structural changes to children's services had already commenced throughout 2005/6 with locality teams set up within each of the nine secondary school cluster areas. This was part of a strategic plan to ensure more effective working between different agencies in Dundee, based on improved inter-agency information sharing and collaboration; this was further strengthened by the establishment in 2007 of 10 Joint Action Teams (JATs). The JATs bring together health service, social work and education personnel and other partners working together to assess children's needs to agree a single or inter agency response to identified need consistent with the GIRFEC principles.

They try to ensure that the most effective use is made of universal services before considering whether further multi agency response is required. These structural changes were and continue to be significant, and highlight the complex task facing authorities as they attempt to put the GIRFEC principles into practice, and the changes to the access team should be understood within this wider context.

3.3.6 By 2007, it was accepted that the access and first contact teams needed to be restructured, with the proposal that the access team provide an intake/ access service to respond to issues for children and families, and the first contact team's remit extend to cover both adults and older people.

Within children's services there had been a substantial increase in volume and complexity of work. The Director of Social Work established a working group in early 2007 which reported in December 2007. This work identified the need for changes in both adult and children's services; it highlighted a significant increase in contacts to the access team for children's services. These included police concern referrals and an increasing level of identified needs of children whose parents were misusing substances (including during pregnancy). This mirrors the increased workload being experienced by health colleagues in 2007.

3.3.7 The changes came into effect in June 2008, with a new post of senior social worker established with each team now separately managed. Prior to the change, the single senior social worker had been responsible for the management and supervision of 15 social work and administrative staff across both teams; this was far too wide a remit for a single manager. For much of 2007 the access team was operating at 50% of its established staffing level with 2 full time social work vacancies from an establishment of 5-one vacant from November 2006 and the other from September 2007- and one full time social work assistant post vacant from March 2007.

The 2 social work posts were filled in December 2007 and January 2008 and the social work assistant post has since been upgraded to a social work post. Since the publication of the HMIE inspection report, a further 2 social work posts have been seconded into the access team.

3.3.8 From my interviews with access team staff, then and now, and examination of case notes concerning M and her children, I found no identifiable or robust structure in place in 2007 and early 2008 for the management of referrals coming into the team. It appeared to be left to individual workers to determine responses to particular situations and perhaps not surprisingly these varied between workers. Staff received supervision and support on an ad hoc rather than planned basis from the team manager, and although they saw this as far from ideal, they also recognised that her remit was too large and that she provided the best support she could in the circumstances.

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3.3.9 The access team was supportive of one another under difficult circumstances, but the situation then meant that there was little or no managerial oversight of their work. There was also a difficulty in moving work onto the children and families teams at that point due to volume and pressure of workload on these teams, with the result that social workers in the access team therefore held onto cases longer than was intended in their remit. The service manager then responsible for the access team recognised these intense pressures on the team and on the manager and had led the review group in 2007 which sought to address this. The service manager had also attempted to establish a transfer protocol to help ease the issue of onward transfer of cases, but it is unclear how effective this was.

3.3.10 In discussion with the Head of Service then responsible for children's services, he acknowledged that the necessary changes to the access team did not receive his full attention until 2007, and that the changes took longer to implement than he had anticipated. This was partly connected to the work involved in establishing the back office system necessary to ensure a single entry point within the city centre to both the access team and the first contact team. The Head of Service accepted that there was a lack of clarity about what was then expected of the access team and said that prior to the changed remit of the team in June 2008, their role was to make a speedy initial assessment to decide whether action was needed or to pass the work onto the locality team. Cases were not allocated to staff but rather picked up and responded to by the staff member on duty on a particular day.

He recognised my description of the access team prior to its changed remit in June 2008, that there was a lack of reference to previous referrals and a lack of consistency in terms of the team's responses to referrals. The changing complexity of the work now coming through the door, particularly in the area of assessment, required a more robust approach. The new focus for the team was designed to address all of these issues and to ensure a more consistent approach to assessment in line with the department's Evidence Based Assessment Framework⁴ which was being introduced to staff throughout 2007/8

4.0 Agency involvement with M and R

4.1 This covers three distinct periods all of which are relevant to Brandon.

- **Period 1 - From M's experiences as a parent to C (born 2004-Brandon's older sibling,) and Brandon (dob 2.04.06) up until mid February 2008 when all three had moved back to maternal grandparents in Charleston** {analysis in section 5.0}
- **Period 2 - R's involvement with his previous partner P and her 2 children Y and Z from approximately August 2006 until their separation in early February 2008. R was the father of P's second child, Z.**{analysis in section 7.0}
- **Period 3- considers the period from mid / late February 2008 when M and R had started to live together up until Brandon's death on 16 March 2008** {analysis in section 9.0}

4.2 Period 1-M and the children: September 2004-mid February 2008

4.2.1 Information from social work records indicates that M had a record of educational need, opened when she was at primary school. She later transferred from her mainstream secondary school in Perth to attend Glebe School in Scone a provision for children with special education needs. The educational psychologist recalled M's literacy and numeracy as being poor for her age but that she was able to read. In his view, her placement in Glebe School, was more influenced by parental concerns around M getting into trouble and being disruptive than to do with her learning difficulty. She stood out within Glebe School as one of the most able pupils there and was well supported by her parents. *(This is the first recorded reference to M having any learning difficulties. From time to time in my interviews with staff, references were made to M's learning difficulties. To my knowledge, however, to date there has been no formal, completed assessment of M).*

4.2.2 M received social work support in her youth. Issues involving drugs, alcohol and offending behaviour were noted in Perth social work records in November and December 1999. She was referred to the Children's Reporter in Perth on offence grounds in January and November 2000. *(There was no recorded assessment of her parenting skills or capacity throughout period 1).*

4.2.3 Brandon's older sibling, C was born in 2004. In trying to ensure the sibling C's confidentiality and anonymity, I have tried to avoid too much by way of reference to C's specific circumstances within the family, confining the report to comments which highlight more general issues relating to M's parenting.

Initial contact with M was through health services. Immediately prior to the birth of C, the hospital midwife noted that mother had *definite learning needs: dyslexia* and that appropriate information would *need to be related verbally and in terms mother readily understands*.

This echoed comments made by the community midwife in the birth plan which observed that *mother cannot read or write but can copy*. References made to mother's learning difficulties within health records appear to have been based on observation of her presentation at times rather than on any formal assessment or checks with any earlier records. Notwithstanding this, all health and social work staff interviewed believed that M understood what was being said to her, and there was a consistent observation by staff that she did not stand out in relation to other adults being worked with, either in her ability to engage in discussion, or to care for her children.

4.2.4 Following C's birth, C and M lived with maternal grandparents in Charleston, Dundee for the following year prior to moving to take up her own tenancy in a flat in Douglas, also in Dundee, in July 2005. Health records note that M's mood had been low in November 2004 and she had admitted to shouting at the baby. She was offered and accepted support visits from the health visitor and it was noted that she continued to receive good support from her parents. There are occasions noted where M was not in, when the health visitor visited, but case record quotes grandmother saying she had no concerns about M's parenting and reported that her daughter appeared to be coping well with the care of the baby. Grandmother was clearly recognised and used appropriately by the health visiting staff as someone who provided support to M.

4.2.5 On 2 March 2005, C was brought by mother to A&E at 00.22 hours with a diagnosed pulled elbow. The A&E record notes that mother had picked C up from the baby walker, had heard the arm click and had therefore taken C to A&E.

4.2.6 Following her move to her own tenancy in Douglas on 11 July 2005, the introductory health visit was not made until the end of September 2005 when the staff nurse discussed MMR with her and left her an explanatory leaflet to consider. She was not interested in the suggestion of attending a mother and toddler group. The health record stated that mother and C were both well and that there were no parental concerns.

4.2.7 On 15 October 2005 C again attended at A&E with M at 00.28 hours having fallen over whilst still in the buggy. M had contacted NHS 24 when this had happened earlier in the evening and had been advised to go to A&E to have C checked. C had sustained a minor injury and was noted to be well, smiling and interested in the surroundings.

C was discharged home and M was given a head injury advice card. There is no mention of health visitor follow up in the records.

4.2.8 In November 2005 M's GP told the staff nurse that mother had been too firm with C during a surgery visit. The staff nurse followed this up in a home visit and discussed behavioural management with her; she observed a good bond between mother and C and recorded no parental concerns. M was now pregnant with her second child, Brandon, and had reported to the midwife in September 2005 that the pregnancy was unplanned and that she was happy to be pregnant.

M reported that she was organised for the new baby and did not require any assistance with baby equipment; the only piece of equipment she still needed was a pram. No risk factors had been identified and it was left that M would contact the health visitor as required.

4.2.9 On 11 January 2006 C was again taken to A&E following an incident where C had been dropped four feet onto the ground by a friend of M's who had been holding C. Mother had been visiting friends and the male and female friend had left the house with C, with the male friend holding C. Another male had left the house and become involved in an argument with the first male, punched him and in the ensuing argument C had dropped to the pavement. No injury was sustained.

The maternal grandparents had been contacted by M's brother who had telephoned M during this incident. The grandparents telephoned the police and took mother and C to the hospital. The senior house officer had queried whether this was neglect and had noted that mother appeared to be of low intelligence. Police attended this incident and a man was charged with assaulting the male who was carrying C. The police crime report stated that a Child Concern Report was being submitted, and the enquiry officer is certain he completed this process, although no trace of this Concern Report can be found.

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4.2.10 The incident was reported later that same day by the hospital paediatric liaison visitor to the local health practice and the social work access team. The health visitor visited the following day and found C to be well fed and nourished and appropriately dressed with evidence of lots of toys around the flat. The health visitor discussed the visit with the access team social worker and agreed to contact the access team if there were further child care concerns. She thought that M would need support when the second baby arrives.

4.2.11 This was followed up by a social work office appointment in January 2006, undated, attended by M, grandmother and C to discuss the circumstances of the incident with the access team social worker. M did not accept the suggested offer of support from the family support centre but did indicate that she might reconsider after the new baby was born. The case record notes that M's parents were very supportive and that grandmother was of the view that M *lacks confidence as she has learning difficulties*. The social worker concluded that there were no child care concerns and gave mother the social work access team's telephone number for future contact if required. No mention was made in the referral to social work of previous A&E attendances. There is no record of feedback to the health visitor following this interview.

4.2.12 By early February 2006, the community midwife had raised her concerns with health visiting colleagues about M's poor ante-natal clinic attendance i.e. in respect of Brandon. The health visitor left a card at M's flat on 24 February 2006, inviting her to attend clinic on 28 February 2006; when she failed to attend grandmother was telephoned on 1 March 2006 to encourage her to come and mother attended the following day.

The staff nurse referred M to the local Family Support Centre (FSC) in Douglas, a 15 minute walk from her flat, on 22 March 2006. The referral gave brief background details of the couple, i.e. mother and Brandon's father, J, and described mother as having learning difficulties; dyslexia; poor parenting skills; and lacking confidence. The referral had been discussed with the family. M attended 2 sessions with Brandon in July 2006; Brandon's father received no further mention.

4.2.13 The staff nurse visited mother at home on 28 March 2006, four days before Brandon's birth and described M as being *defensive*. She had friends staying with her who were using a mattress on her floor and there was a smell of alcohol. The staff nurse noted that C was well.

4.2.14 Brandon was born on 2 April 2006 following a normal delivery and was discharged home the same day. All reports were normal and the health visitor noted on a home visit on 13 April 2006 that mother had changed Brandon's surname from hers to that of his father, J. No post natal depression check was undertaken with M following Brandon's birth; this is usually done when the baby is 5-8 weeks.

4.2.15 On 25 March 2006, three days before the staff nurse's home visit to M and C, M had come to the attention of the police whilst she had C in her buggy. She was heavily pregnant with Brandon at this time. A police referral was made to SCRA on 5 April 2006. On 31 May 2006, SCRA contacted the social work department requesting an Initial Assessment Report (IAR) on C. On 7 July 2006, Brandon's father, J, had also come to the attention of the police whilst he had Brandon, then aged 3 months, with him in his buggy. As a result, Brandon was referred to the social work department as a cause for concern. This cause for concern was initially picked up by the access team and passed to the social worker allocated to carry out the IAR in respect of C; the IAR was completed on 31 July 2006 and included consideration of the circumstances of both children.

4.2.16 The IAR described the relationship between M and J, Brandon's father, as an on/ off relationship for five years, M stating that sometimes J lived with his parents and occasionally stayed with her. The social worker noted that the flat was clean when she had visited and that the couple appeared to take good care of the children. J in particular was described as being caring and supportive towards the children; mother's parenting skills were described as adequate but a bit regimental.

4.2.17 The Reporter had also requested a health visitor report and the health chronology notes that a report was sent to SCRA on 14 June 2006, detailing concerns about poor clinic attendance; poor interaction; low intelligence of mother; and a history of two falls for C in infancy.

There is no record of the report having been received by SCRA and although a late report reminder had been sent to the social work department on 10 July 2006 by SCRA, no similar reminder was sent to health.

4.2.18 In compiling the IAR, it would appear that no contact had been made by the social worker with the health visitor. SCRA chronology notes that a no further action decision was made by the Children's Reporter on 2 October 2006 and that on 12 October 2006 mother, police and social work department were notified of the decision(not health). *All Children's Reporters have now been instructed to acknowledge every referral upon receipt (separate arrangements are in place for police referrals). SCRA support staff now send late report reminder letters to any agency or individual from whom a report has been requested and not received at a set point after the date due. Every agency or individual from whom a report is requested is also sent a standard letter outlining brief details of the referral outcome.*

4.2.19 Following the decision of the Children's Reporter, the case was closed to social work and health visiting staff remained involved. Between August and December 2006, M had twice failed to attend for Brandon's immunisations-these were followed up by the health visitor- and also for his eight month screening. He was seen on 7 December 2006 by the health visitor who noted he was *well, crawling, pulling to stand and smiling*. M reported that she had separated from Brandon's father and that she and the children would be staying with her parents until after Christmas. Brandon was then brought for his eight month screening on 14 December 2006 when his development was noted to be normal.

4.2.20 On 9 March 2007, M's GP contacted the social work access team, informing them that mother had brought C to the surgery accompanied by an aunt, concerned about C's well being.

4.2.21 When mother did not attend the office appointment offered by the social worker for 20 March 2007, SW contacted the health visitor who was unaware of the referral, having not been advised of the surgery visit. The social worker and health visitor made a joint home visit on 26 March 2007 when both parents and children were at home.

They were advised by mother that she was now no longer concerned and that she had accepted the assurances given by the GP. SW observed that C appeared to be happy and interacted well with the parents and noted in the case record that the health visitor would monitor and contact SW if any future concerns; there was no further role for SW at this time. The health visitor recorded no further action and no follow up by social work and that M had said she had no further concerns. Neither worker had confirmed in writing or by telephone their understanding of what had been agreed following this joint visit.

4.2.22 Apart from 2 further entries in the health chronology regarding immunisations for Brandon in May and June of 2007 there is no further health visitor contact in respect of either of the children until 11 February 2008 when the family support centre manager telephoned the health visitor to update on the recent referral from housing with respect to M's alleged inappropriate language towards the children. When Brandon was seen by the health visitor at the clinic on 12 June 2007 he was fully up to date with his immunisations.

4.2.23 Although the next referrals concerning the children are made to social work access team by the housing support officer from the anti social behaviour team on 16 and 22 October 2007, the same housing officer had already had earlier contact with M with regard to a neighbour's complaints about noise. The first referral was in June 2006 and concerned loud music being played through the day in mother's flat; M was advised of the complaint and accepted the need to keep the music down. On a follow up to a similar complaint in August 2007 from the same neighbour, M was a bit more defensive, asking the officer why the neighbour had not come to see her directly to complain. The housing officer recalled M's friend being present on this occasion, and the children playing naturally around the flat. M had been folding her washing and the flat was tidy. On neither occasion had there been any sign of drugs misuse in the flat.

4.2.24 By October 2007, M appeared to be involved with a new group of friends and started having parties later at night in her flat. The neighbour who had made the previous complaints now expressed his concern to the housing support officer that the new friends were having a negative influence on M.

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He also reported hearing M shouting and swearing at the children and was asked by the housing officer to keep a log and report any further such incidents. This log led to the referrals from the housing officer to the social work access team on 19 October 2007, highlighting M's alleged verbal abuse of her children.

4.2.25 Because of the increased noise, M was issued with a final warning on 25 October 2007 in connection with her anti social behaviour, and was asked by the housing officer if she needed any support or help; she said this was no longer needed as the friends had now gone. She accepted the warning and was advised that the concerns about her shouting and swearing at the children had been forwarded to the social work access team.

The housing officer explained that prior to the complaints in October 2007 in respect of her reactions towards the children there had been no concerns about her tenancy. Similarly, the housing officer was experienced in working with tenants who were misusing substances and was familiar with the signs and symptoms of substance misuse; she had never seen any sign of this in her contact with M.

4.2.26 In response to the two housing referrals in October 2007, M was offered an office appointment with the social work access team for 24 October 2007 which she did not attend; she called to request a rearranged appointment for 30 October 2007 when she turned up at the office but no staff were available to see her. A further appointment was made for 6 November 2007 which again she failed to attend; further attempts were made to contact her and she came to an office appointment on 20 November 2007, 5 weeks after the original referral. This delay in actually seeing M was attributed to the sickness of a back up duty social worker as well as the vacancies currently within the access team; M had also failed to keep two of the arranged appointments.

4.2.27 The case notes for this interview completed by the team manager of the access team indicate that after discussion, M agreed that it was not appropriate to shout or swear at her children, and that she needed to be calmer in her response to them. As she had now moved back to live with her parents in Charleston, she agreed to approach the local Family Support Centre (FSC) there- a five minute walk from her parents' flat- for support and help and was told that the access team would check with the FSC that she had followed this up.

Although not recorded in the case notes, the team manager's view was that M was now returning with her children to the maternal grandparents who were known to be supportive. M was also being encouraged to attend the family support centre with the children, a combined response which was seen as measured and appropriate by the team manager. The follow up telephone call to the FSC the next day confirmed that M had visited as agreed, further confirming the team manager's view of M as being compliant and amenable to help and support.

4.2.28 M attended the FSC the following day with C to complete the service request form and said that her reason for coming was that she got short with the children sometimes and that she '*wasn't speaking to them right.*' As she was completing the form, M suddenly got very angry with C when C had turned over an inset board and emptied the pieces on the floor; the FSC manager had calmed M, reassuring her that C was just experimenting and it was okay. The manager observed that C had sat with legs straight out and arms and head down for a couple of minutes, as though having done something wrong.

4.2.29 The manager suggested that M apply to get C who was now over 3 years of age into nursery school (M took the form away) and also offered attendance at the Friday afternoon family playtime for M and both children until such times as C started nursery school and Brandon could attend a programme at the FSC. M said that she would be interested in attending a Mellow Parenting⁵ course which was due to commence in January 2008. She never attended a Friday group but was handed a letter at the FSC on 15 January 2008 offering sessions for herself and Brandon, and asked to respond by 21 January 2008; she did not respond. (C had been offered a nursery place for 5 sessions a week which was taken up in mid January).

4.2.30 In line with the FSC's normal practice, the manager contacted the health visitor on 11 February 2008 to update her on the referral and the concerns about M's inappropriate language and behaviour towards her children, and to inform her that the family were now living with the maternal grandparents. The health visitor explained that she had had no contact since the March 2007 joint visit with the access team social worker when M had been living in her own flat.

As M had now moved to a different area, covered by a different health visitor, she would pass the information on to the new health visitor who would follow up with a home visit. (The Lochee health visiting team covered 3 different geographical areas to provide their service to the health practice population).

4.2.31 On 13 February 2008, two FSC staff met with M at her parents' flat to discuss the mellow parenting programme with her; grandfather was present for this meeting and tried to encourage her to take part in the programme and M agreed to meet with the lead workers for the programme at her parents' flat on 19 February 2008. However, she was not in when they visited and grandfather explained she was in town- he was looking after both children. This was the first time that Brandon had been seen by any statutory agency staff since the office appointment on 20 November 2007.

4.2.32 The health visitor covering the Charleston area had made an unannounced visit on 14 February 2008; nobody was in and she sent a letter offering a home visit on 21 February 2008. Grandfather rang the health visitor on 21 February 2008 to cancel this visit as the letter had only just been received. He said he would get M to phone and rearrange the appointment.

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Significant Case Review - Analysis of Period I

5.0 Analysis of Period I

Parts (i) and (ii) of the remit from Dundee Children and Young Person's Protection Committee required me to

- **Comprehensively assess the agency and inter agency discussions, decision making and involvement with Brandon his family and others relevant to his case**
- **Establish whether there are lessons to be learned about how better to protect children and ensure they get the help they need when they need it in the future**

5.1 Among the most critical aspects of inter agency working with children and their families are the collection and sharing of information; the assessment of that information; and then deciding how to respond. Effective decisions depend on good information. Professional staff need to ask themselves, *What information do I already have; have I checked my agency's own records; and once I've done this do I need to share this information with someone else, and if so, whom?* It might be their supervisor or manager, a colleague within their own agency in a specialist role e.g. specialist nurse child protection, or a colleague in another agency. An equally important question is, *Who might have some information that I need access to, to gain as full a picture of the situation as possible?* For example, where a social worker is concerned about a school aged child, that school should be one obvious point of contact when gathering information. Assessments depend for their effectiveness on access to the fullest possible information.

5.1.1 There are several examples of the effective application of this approach in the first period under consideration both at agency and inter agency level

- *The health visitor's prompt response offering a support visit in November 2004 when M was low and admitted shouting at C. She had also involved the nursery nurse in a joint visit the following month to advise M on age appropriate stimulation for C*
- *In November 2005 when M had presented as overly firm with C on a surgery visit, there was good liaison between the GP and the health visitor which resulted in a prompt follow up visit by the health visitor.*
- *The housing support officer's referral to social work access team, in October 2007, raising concerns about M's inappropriate language towards her children led to these concerns being discussed with M and a response made to meet the children's needs. The housing officer had also shown great awareness of the children's situation in the first place by recognising that the previous anti- social concerns now had a child welfare dimension which needed a response.*
- *The Charleston family support manager telephoned the health visitor on 11 February 2008 to alert her to M's current circumstances and agency concerns.*
- *The health visitor responded to the above call on 11 February 2008, by informing her colleague covering the patch. That colleague promptly followed up with an unannounced visit three days later.*
- *The Charleston family support centre staff made persistent attempts to address the concerns raised by the referral from the access team. This included visits to the grandparents' flat.*

5.1.2 There are also important examples where this did not happen, for example C's attendance at A&E in January 2006. The information about the previous attendances at A&E in March and October 2005, was not passed on to the social worker by the community health visitor. This latest A&E attendance was therefore the third within 10 months. This was significant information that should have been shared with the social worker; instead it was treated as a single discrete referral by the social worker. It was also the second A&E referral since M's move to her own flat in Douglas, in July 2005. It would have been reasonable to consider whether this was an indication that she was struggling without the same level of support from her parents. Previous Inquiries have shown that such attendances could be a cry for help on the parent's behalf; it should have merited a review by the health visitor.

5.1.3 It should be noted that all C's attendances at A&E and hospital were reported to the HV and these can be seen in her records; the correct procedure had been followed by the Paediatric Liaison HV. *Guidance has recently been issued to health practitioners regarding response to the receipt of such information indicating that practitioners need to exercise their professional judgment as to whether any action needs to follow which could include reassessment of the health programme (core, additional and intensive); no further action; or entering the event on the child's chronology if it is seen to be significant.*

5.1.4 The social worker's account of the office meeting attended by M, maternal grandmother, and C, in January 2006, added little in terms of an understanding of the circumstances. It was more a report of what was said rather than an analysis of the information which could offer the basis for an assessment. The basis of the conclusion that there were no child care concerns was far from clear. For example, given the circumstances of the attendance at A&E and the late hour, further information could usefully have been sought on the following:

- Why was another couple caring for C and who were they?
- What was M doing during this time?
- There was mention that M's parents were very supportive but no mention of how or what they did, or how often?
- Maternal grandmother commented that M lacked confidence due to her learning difficulties- this was not followed up in discussion

This reflects earlier comments about how work was then managed and processed within the access team. M was, however, invited to consider FSC support and was given the telephone number of the access team for future reference. There was no suggestion, based on M's circumstances at this stage that more formal intervention would have been appropriate. Grandmother had come to the office with M and C, demonstrable evidence of her continued support.

5.1.5 The Initial Assessment Report for SCRA, completed by the social worker on 31 July 2006, addressed the two separate causes for concern with respect to both children but provided a very limited account of the family's circumstances. No mention was made of the January 2006 A&E incident and more significantly there appears to have been no contact made with the health visiting service. Given the ages of the children, C then under 2 years and Brandon aged only 4 months, contact should have been made. *Who might have information that I need?*

5.1.6 Having requested a report from the health visitor, SCRA should have followed this up when it was not forthcoming. They had previously done this when the social worker's report was late. SCRA should have recognised the primary importance of the health services, given the ages of the children, and ensured access to this information in making their assessment.

5.1.7 The health visitor too, having submitted a report which detailed past and current concerns, could have been more pro-active in trying to find out why there had been no acknowledgement or response from SCRA. As the agency most involved with the family at this stage, they had a responsibility to ensure their views were heard. Fundamental to the philosophy of GIRFEC is that *all* agencies must be alert to the needs of children and must be ready to act to improve a child's situation.

It would have been beneficial, and much more demonstrably child centred, if the social worker and the health visitor could have shared information in compiling the report.

5.1.8 The possibility of convening a professionals' meeting in summer 2006 should also have been considered, as a useful forum for pulling together information. This would have gained the health visitor's perspective of the recent concerns, following the visit shortly before Brandon's birth, as well as gaining a view from the family support centre. It would have also raised the profile of Brandon's father within this family; this was an opportunity missed. It was concerning to hear from a manager of a family support centre that the pressure and restrictions on workers' time had led in her view to fewer such meetings being convened.

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Significant Case Review - Analysis of Period I

As well as providing an opportunity to share information leading to a coordinated plan, they also provide an important forum for professionals to develop their working relationships. This should not be viewed as an unaffordable luxury for staff, but rather a key mechanism for effective information sharing and decision making, and supportive of the GIRFEC approach.

Brandon's father

5.1.9 In a visit to M on 7 December 2006, (then living back with her children at her parents' flat in Charleston until after Christmas) the health visitor noted that M had separated from her partner. There is no mention, however, of any further discussion about why; the impact on her; or the impact upon the children. When the health visitor and the social worker made a joint home visit to M on 26 March 2007 when she was back living in Douglas, the record mentions the partner being present. Again though, what brought about the reconciliation or what the impact was on the children is not discussed. It is also unclear from health and social work records whether the role of Brandon's father was shared with the social worker by the health visiting team.

These are important events in the lives of families and have an impact on children. There is a real danger that, because some families seem to be subject to continuous 're-forming,' it becomes so commonplace that its significance is overlooked.

Housing referral in October 2007

5.1.10 Busy social work access teams are the first point of contact for service users, members of the public and partner agencies. Individuals contacting access teams will do so for a variety of reasons which include requesting support, seeking advice, highlighting concerns or sharing relevant information about vulnerable individuals who may be in need of protection, care or support. Social work access systems need to be robust and effectively managed to adequately reflect the importance of this area of social work practice.

A balance has to be struck between assessing referrals and passing them on to other support services (quite appropriately in this case to the FSC); and, between recognising when a more comprehensive assessment is required, based not only on the current referral but the pattern of referrals. This would also take into account the family's response to previous offers of support.

'Lack of parental cooperation or an unwillingness to accept help raises problems for interventions below the threshold of child protection, where parental consent is required. Failure to take up a service needs to be taken into account as part of the assessment and may raise the level of concern so that child protection procedures need to be followed.'
(Research report 2008 – Dept for Children, Schools and Families)⁶

5.1.11 This referral to the social work access team was significant for a number of reasons. It took 5 weeks from the point of referral to M actually being seen for the office appointment on 20 November 2007 (the reasons for this have been explained above). The written account by the team manager of M's visit to the office is problematic. M actually attended with both children and the receptionist informed social work staff that she had been alarmed by M's language and behaviour towards the children within the reception area, prior to them being seen by social work staff. There was no mention made of this in the case record and therefore there was no reference to the children's responses to their mother, a particularly important oversight. In interview with the team manager, it was evident that she had taken some account of this and said that she was particularly concerned that if this was M's presentation in a public arena, how might she behave at home? This should, however have been recorded and pulled into an assessment of the circumstances. Anyone else picking up the file would have had little understanding of the reasons for the family support centre referral.

5.1.12 There was no reference in the write-up to prior contacts with the social work department. Therefore, the earlier joint visit made by the access team social worker and the health visitor, on 26 March 2007, was not considered, nor were the referrals concerning the A&E attendance or the circumstances which led to the cause for concern referrals in April and July 2007.

Apparently, the social work department papers relating to the IAR were only retrieved after Brandon's death. It was also unclear from the write-up that two members of the access team had met with M and her children

5.1.13 In effect, the appointment was managed as a discrete one-off visit, with no benefit of information gleaned from previous contacts. M had already been referred to Douglas FSC in summer 2006 and had only attended for two sessions. No contact had been made with the health visiting service; C was now over 3 years old and Brandon 20 months. There was no contextual account offered for M's behaviour, whether this was M's normal way of managing the children (i.e. shouting and swearing at them) or whether there had been particular stresses for her recently which had led to this. A telephone discussion with the housing support officer could have provided some useful background. She viewed M as a good tenant who had encountered some recent difficulties.

5.1.14 Fuller consideration of all of the available background information including contact with the health visitor could have raised genuine doubt as to the likelihood of M cooperating voluntarily with what was being proposed, i.e. attendance at the family support centre. The staff who met with M knew that she had moved back, for the time being, to her parents in Charleston and quite reasonably saw this as protective for the children as well as supportive for their mother.

5.1.15 With hindsight, the access team in making the referral to the family support centre could have arranged for further contact with the FSC to take place in 2 to 3 weeks. This would have confirmed M's attendance, and that she was actively seeking help for herself and the children. Given the pressures on the service and the staffing shortages within the team however, I can understand why this did not happen. Equally, although M's language and presentation towards her children in the social work office gave cause for concern, it was not an event which 'raised the stakes' in terms of child protection thresholds.

5.1.16 It may well have been the case that the impact upon the access team of staff shortages led to the offer of an office appointment rather than a home visit.

As well as building in a delay, it also missed an opportunity to see the children back at their grandparents and to enlist the grandparents' support for their daughter. When the family support centre staff finally met grandfather in February 2008, it was significant that he was unaware of the support already offered to M and the children. M was able to make good and appropriate use of the support on offer from her parents, but she did not always share significant issues in her life with them.

5.1.17 It was difficult from reading the health visitor's case notes to gain an impression of the focus of their work with M. It was evident that numerous efforts had been made to try and encourage M to attend parent and toddler groups, or indeed other groups at the family support centre, and they are to be commended for their persistence. However, beyond stating that she was not keen to attend -as indeed was her right- there was no real exploration or understanding given as to why. There was little reference made to her interactions with the children and, similarly, it was hard to get an impression of what the flat was like. No outcomes of work were noted. The staff nurse's notes provided a welcome exception. She was clear that her work was directed at lessening M's isolation as she had moved to a new area. She was trying to help M build her confidence in her parenting role with her children. She made good use of the action plan section in the record.

5.1.18 There was some doubt raised during M's first pregnancy about her ability to read. It is reasonable to expect the health visitor to ensure that a parent was receiving the appointments and was able to read them irrespective of whether a learning difficulty was suspected or not.

5.1.19 At the time under consideration, the only recording guidance for health visiting staff was the Nursing and Midwifery Guidance which had been last updated in 2004. The Family Needs Health Assessment Framework was being developed but was not introduced in Dundee until June 2008. The use of chronologies and recording of significant events was not yet common practice, and mention has already been made of the serious workload pressures on the health visiting staff.

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The lack of a rigorous approach to record keeping and, by extension assessment (the former being an essential pre-requisite for the latter) meant that health visiting staff did not respond to some situations which they should have.

All engagement with a child and their family requires to have a clarity of focus; this was not clear enough from the health records.

I have already indicated where changes in M's circumstances should have led to a review (e.g. the A&E referrals in 2005/6, and the separation and reconciliation with Brandon's father in 2006/7). The home visit in March 2006, so soon before Brandon's birth, when M was defensive and there was a smell of alcohol, should have prompted a contact with the access team.

5.1.20 Similarly, there should have been more effective and pro-active information sharing between social work and health, around the time of the IAR request i.e. May 2006. A professional network meeting could have been convened (there is useful guidance on the purpose of these meetings contained in Dundee's multi-agency guidance on child protection) to share what information the different agencies then had in relation to M. This was also the case in October 2007 when things had started to get more difficult for her with the children. With hindsight, such a meeting could have involved health, housing, social work, family support centre, M, and maternal grandmother (with M's agreement). This would have been a proportionate response to changing circumstances, still below the level of formal intervention. A full check on previous family contacts with social work, for example, would have revealed that there was little to indicate that M would respond positively to offers of voluntary support.

5.1.21 Accurate and relevant recording, information collation and sharing, and assessment and review constitute essential elements of a structured response for professionals working with vulnerable children and their families. Staff need to be alert to changes in a child's circumstances (most often this is more commonly connected with the impact on them of changes in their adult carer's circumstances, on whom they are so dependent). They should be mindful of the need to share this information, and be ready to actively intervene where this might be necessary.

Procedures, guidance and training opportunities are important in helping staff incorporate this approach into their work.

5.1.22 In addition, however, staff require supervision, to have

- the opportunity to critically reflect on what they are seeing in a family and make sense of it
- the encouragement to acknowledge and trust their professional intuition
- the professional support and challenge of their decisions
- support to learn from any mistakes they make

⁷ Lord Laming notes

'It is vitally important that social work is carried out in a supportive learning environment that actively encourages the continuous development of professional judgment and skills. Regular, high quality, organised supervision is critical, as are routine opportunities for peer learning and discussion. Supervision should be open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children rather than meeting targets.'

His comments are equally relevant to all agencies working in child protection.

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5.2 Changes in practice since Brandon's death

5.2.1 Nowhere in my reading of period I did I find a comprehensive account of the children's circumstances. Throughout this whole period I could find no recorded assessment of M's parenting skills or capacity.

5.2.2 There have been significant changes within agencies since Brandon's death, some linked to work that was ongoing already; some as result of internal reviews linked to Brandon's death; and others which have already been put in place as part of the action plan in response to the most recent HMIE Inspection. I will mention the ones most relevant to Brandon's circumstances.

Health

5.2.3 NHS Tayside introduced the Family Needs Health Assessment Framework (FNHA) for health visiting staff during 2007/8, implementing it in June 2008. The framework introduced the use of an assessment record and chronology of significant achievements and events in a family, and is intended to provide a clear plan of action of work with the family, including monitoring and evaluation of the work being done. This is a significant development since Brandon's death and relevant in helping address earlier comments about the lack of focus on outcomes in health visiting records. It stresses the need to consider the impact of wider family events on the child and for work with families to be subject to ongoing planning and review.

5.2.4 The FNHA is informed by the Framework for the Assessment of Children in Need and their Families (Dept of Health 2000) and the Framework for Standards (Scottish Executive 2004).

It is designed to be participative with families and to enable agreement on the appropriate health care programme i.e. core, additional or intensive.

The information gathered through this structured approach *'will populate the Integrated Assessment, once in place, where enduring needs or risks have been identified and where more than one agency/ professional will be involved over time.'* (NHS Tayside FNHA- guidance notes, September 2007)

5.2.5 A review of the application of FNHA in Dundee has recently been completed by the nurse consultant for vulnerable children and child protection and it has now been migrated onto NHS Tayside's computer system (MiDIS) which will make it more accessible and usable. Further training on FNHA and the use of chronologies and significant life events will be provided to relevant staff by the end of 2009. The need for health staff to ensure more objective and descriptive record keeping which both informs and justifies decision making will be included in the training for FNHA. The nurse consultant emphasised that the training must also acknowledge the importance of practitioners' intuitive responses and feelings when meeting families in their own homes and capture this in the record.

5.2.6 Written guidance on visiting patterns in respect of the three different health programmes, identified by HALL 4 (2002), was introduced a year ago. The minimum 'core' visiting pattern has recently been re-issued in order to help health visiting staff prioritise their time and target their services at those individuals and families identified as being the most vulnerable. This has meant a recent suspension of Drop in Clinics, a recognition of the continuing pressures on the service as well as capacity issues in meeting this demand.

5.2.7 NHS Tayside is about to introduce a major service redesign of its community nursing service which will involve all children and adult community nursing services being delivered from four zones across Dundee. By aligning the zones more closely with the local authority structure, it is intended that closer inter agency working relationships will be developed; health practitioners will build up a greater knowledge of services available; and the intended aim is that service users will benefit. Opportunities for co-location of staff and services will be considered as part of this redesign.

5.2.8 The introduction of 3 further Advanced Nurse Practitioner posts- one in each of the 4 zones- is intended to provide greater support and supervision to the health visiting service and to strengthen the health responsibilities around child protection. A further 14 health practitioners across NHS Tayside will be offered training in child protection case supervision which will provide 20 in total of which Dundee will have the majority. These are all positive changes.

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5.2.9 However, if the 3 advanced nurse practitioner posts are recruited from the existing Band 6 staff, there is a danger of further depletion of this most skilled resource. Similarly, the Band 6 staff who will be trained to offer supervision will require a time allowance and again this could reduce their available capacity to work with the most complex cases. These issues will need to be carefully monitored in implementing the service redesign.

5.2.10 Supervision for health visiting staff is now mandatory, with a minimum frequency of 3 monthly supervision and a target of 6 weekly. I understand that Lochee staff, as one of the most pressurised practices, receive supervision 6 weekly.

5.2.11 The health visiting teams in Dundee were increased by 13.5 whole time equivalent staff between April 2007 and April 2009. This increase has been in Band 5 (formerly known as staff nurses), and Band 4, early years support workers. The intention is to increase the range of responses to assessed needs by increasing the skills mix of the health visiting teams. Thus the Band 6 staff (formerly known as health visitors then public health nurses) would be responsible for assessing the child or family and then determine the care plan and response. Where appropriate, Band 5 and Band 4 staff could be deployed, leaving Band 6 staff with greater capacity to manage the most complex cases.

The success of this approach is still to be tested, and part of the action plan from this report will involve a follow up with health visiting teams to obtain their views on the changes. Any changes need to be clearly based on the health needs of the Dundee community and not resource led.

5.2.12 The changes outlined are significant and there are others included within the action plan for HMIE such as recording and case file audits which will also address some of the concerns identified.

The critical test of the success of the changes is whether the community of Dundee receive better services as a result and this aspect is more appropriately the provenance of the HMIE action plan. The other test is whether the staff involved in delivering the service feel more supported and safe in their practice and are able to demonstrate the authoritative practice necessary for this most demanding area of work.

Social work

5.2.13 The most significant change within social work since Brandon's death relevant to this phase has been the establishment of the access team in June 2008 as a dedicated team for children, from unborn babies to 18 years. The team now comprises social work staff with extensive and current child care experience and has a dedicated team manager, who also has a background in child care and had moved to the post from a locality children's team in Dundee. Only two social workers remained from the previous team, and had joined the team during the final six months of the old structure.

5.2.14 Of the other two social workers who left, one retired and the other resigned. The team then comprised 5 full time social workers with the vacant social work assistant post about to be upgraded to a social work post. Most recently, and as an immediate response to some of the criticisms of the HMIE report, a further 2 social workers have been seconded into the team for the foreseeable future to address the issues of capacity and help ensure more timely responses to referrals.

5.2.15 The HMIE report was critical of the fact *that children who were referred to the social work access team did not always receive help at the right time. Too often children were referred back to staff who had raised initial concerns to monitor their circumstances.* I will confine my own responses to the significant differences in approach and organisation which were evident in my interviews with the team manager and in discussion with team members who had worked in the previous team as well as the current one.

5.2.16 My comments should not be construed as a criticism of the previous management of the team.

The team was under significant pressure linked both to volume of work as well as staffing shortages; there was major organisational change being undertaken within the wider children's services which affected the work of the team; and, finally, the team itself was about to change its focus as part of that wider structural change.

5.2.17 It was recognised that the team had become subject to bottlenecks elsewhere in the system i.e. where case were unable to be transferred on to the locality teams, they were held for longer than was intended within the access team with the result that there was not the throughput of work that there should have been. The team manager and her colleagues worked hard to ensure the service continued to function in that challenging context.

5.2.18 The service manager who was then responsible for the access team was aware of these difficulties and was clearly trying to address them and was honest in recognising that these changes were taking time to implement. She was also trying to address similar capacity problems within the child protection team for which she had responsibility, problems which had been recognised and referred to in the Social Work Inspection Agency Performance Inspection⁸ in 2007. (SWIA). It should be noted that following the HMIE inspection a further 2 social work staff have been seconded into the child protection team to address work pressures.

5.2.19 In the interviews conducted with social work staff, those staff who had been directly managed by or consulted with this service manager were extremely appreciative of the support and professionalism which she offered.

5.2.20 Changes were introduced to the access team to ensure greater consistency of approach and response to referrals. Most notably, all cases requiring further work involve discussion and agreement between the worker and the team manager as to follow up. This is designed to ensure consistency around thresholds. The duty system has been changed so that one worker undertakes this for the whole week, making the telephone calls and doing the necessary follow up work; other staff will help out if it gets really busy. This is a contrast to the previous arrangement where a social worker might decide to take on a piece of work from their duty day without any reference to the team manager; this previous arrangement meant there was not enough managerial oversight of the work coming through the team.

5.2.21 This new approach ensures a greater professional accountability for the work, where both the social worker and the team manager know and agree the basis for decisions and recommendations made. The manager commented that she had come across cases where it was unclear whether they should have been passed on for further work or closed. One of the new workers to the team said that, within the old system, individual workers determined whether referrals were marked for no further action or for follow up work to be done. Some pieces of short term work were not necessarily written up other than 'home visit, no concerns' on the event recording and previous papers were not always accessed prior to undertaking an interview. It was an approach characterised by inconsistency; it did not mean that the work had not been done but rather it had not been evidenced.

5.2.22 The other major difference described by the team manager and confirmed by team members is that supervision takes place regularly now. This offers staff a chance to reflect on their practice and for there to be an overview of their work. Staff spoke of the team feeling more organised now.

5.2.23 I was impressed by the description of the team manager's attempts to encourage the staff not just to write down all the information given by the referrer, which by definition will always be concerning, but to make sense of it and to analyse it so that there is an audit trail for decisions made.

5.2.24 A duty log is used to keep track of work going through the team, and work can easily be marked for follow up action later. In the work with Brandon and family, this approach could have built in a follow up contact with the family support centre after the referral from the housing department.

5.2.25 The team manager and current service manager separately commented that a lot of access team referrals from that period ended with 'health visitor to monitor'. (this was written on the event recording after the joint SW/HV home visit in March 2007). The new practice is for the social worker to detail what the health visitor has actually agreed to do. Similarly, when health visitor colleagues refer to the access team, they are encouraged to do this in writing, confirming what has already been done with the family; that the family is aware of the referral, and what the access team is being asked to do.

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It is appropriate that all professionals are asked to be clear about what they are asking other colleagues to do, explain what they have done already and that this is recorded.

5.2.26 As with the FNHA framework being applied in health which involves families in the assessment, all families being worked with by the access team will have a copy of any assessment or plan which is written up. This is consistent with the GIRFEC approach.

5.2.27 Brief mention should be made of the rollout of the Evidence Based Assessment Framework to social work staff. As with the FNHA, the framework has been greatly influenced by the Department of Health Framework 2000, Scottish Executive Guidance, and work already undertaken by Dundee City Council. The framework was first launched in February 2007, and training rolled out to relevant staff from November 2007. It offers a comprehensive guide on assessment to staff and is supported by a range of assessment tools which staff can access from a drop down menu on their personal computers.

5.2.28 It is significant that the very different changes introduced by health and social work following Brandon's death address similar points of concern e.g. case recording; care planning; assessment; information sharing ; and working openly with families. These are all core elements of GIRFEC and part of the necessary changes which agencies and organisations need to address to make GIRFEC a reality in day to day work with individual children and their families.

6.0 Period 2-Agency involvement with R and P and her children Y and Z for the period August 2006- mid February 2008

6.1 R's involvement with P and her two children immediately preceded his relationship with M. It is relevant to consider what was known about R from his involvement with this family and how much of this was shared when he began living with M. Because of the need to respect confidentiality, I have confined my comments in this section to consideration of relevant aspects of R's behaviour.

6.1.1 A significant amount of inter-agency work with P involved intensive support to her and her 2 children as part of a rehabilitation assessment. Child Y was born in 2006 and child Z in 2007: R is the father of Z.

The relationship between P and R appears to have commenced in August 2006 and although this was punctuated by separations over the coming months they were clearly seen as a couple by the time of the initial unborn baby child protection case conference for Z on 5 July 2007. An important aspect of the work with P, therefore, included an assessment of R's role within this family, including his behaviour towards P's 2 children.

6.1.2 R had been given 200 hours of Community Service for theft by housebreaking in December 2005, which he breached. As a result, he was sentenced to 3 months imprisonment on 8 December 2006, and was released on 19 January 2007. (Social work records indicate that staff had checked the client database when R's name had first been mentioned in connection with P in June 2006, and had been aware of his earlier involvement with the criminal justice services team).

6.1.3 R had been released from custody in mid January 2007 and by early February 2007 social work case notes refer to him helping decorate the flat of P's new tenancy. On 8 March 2007, P's mother told the social worker that R and P were on the verge of splitting up; P's mother had been told that they were having loud and aggressive arguments in P's flat.

6.1.4 By end of April 2007, they had separated again but were described by P as friends, but no plans to get back together again. By the end of May 2007, having reconciled again, the social worker advised P that if R was going to be involved in the care of her children-P was now pregnant with R's child - he would have to be involved in the ongoing assessments. On 25 May 2007, P's mother expressed her concern to P's social worker about the resumption of the relationship with R, having noticed a bruise on P's forehead the previous week and having been told by P reluctantly, that she and R had had an argument; the bruise was dismissed by P.

6.1.5 As P was pregnant with R's child, a pre birth child protection case conference was held on 5 July 2007; it was largely positive. By this stage, P had worked very positively with the different agencies and was cooperating with the inter-agency plans.

6.1.6 R attended the pre birth case conference. His relationship with P was described as '*quite fiery*' at times.

The worker from the Supported Accommodation for Young Families (SAYF) had helped them develop an anger management strategy whereby they could recognise the particular trigger points which could set off an argument; they both agreed that this helped prevent situations from escalating.

R was due to attend a young fathers' group commencing August 2007 in the Douglas FSC and was said to be keen to attend. The case conference minute also described R as being *incredibly good* in caring for Y. This ability was understood as being linked to coming from a large family and his experience of younger nieces and cousins.

6.1.7 The social worker's report to the initial unborn baby Z case conference on 5 July 2007 was comprehensive and outlined the risk and protective factors. Risk factors included a perception that R would face challenges placing a child's needs above his own as well as mention of P's own past behaviour. Protective factors included:

- P and R actively seeking advice to improve their communication
- P's active involvement with the inter-agency plan and the assessment, particularly since February 2007.
- Commitment shown by both P and R to addressing Y's needs and the provision of a warm and comfortable home environment

6.1.8 At the initial unborn baby case conference on 5 July 2007, police reported 2 assaults in March 2007; P had been the complainer and had not wished to make any formal complaint. Police also provided details of a previous serious criminal allegation against R dating back to 2003 where he had been charged but not prosecuted. This information was in fact inaccurate as the case had resulted in a criminal trial during which R was found not proven and thereby acquitted. No mention was made of any previous convictions, or of his recent imprisonment at the end of 2006/beginning of 2007.

6.1.9 The unborn baby returning home from hospital was placed on the child protection register under the categories at risk of emotional abuse and physical neglect.

The progress made by P in particular was highlighted in reports and although continued stresses in the couple's relationship were acknowledged, the general impression given was that they were cooperating with agencies and preparing appropriately for the birth of the new baby. Given this perceived progress, the direction of the work was towards unborn baby returning home to the couple in a planned, phased approach rather than considering more formal intervention through referral to the Children's Reporter.

6.1.10 Subsequent core groups supported this plan and commented positively on the couple's continued cooperation with agencies and the increasing stability in their relationship. It was noted that R was to start the fathers' group in January 2008 and they were to re-commence their work with the SAYF worker to ensure continued support for them as a family.

6.1.11 The review child protection case conference on 7 November 2007 unanimously agreed to remove Z's name from the child protection register. Police were not present and unusually did not provide a report for the meeting. The comprehensive report provided by the social worker was the first social work assessment report to specifically address R's role within the family. It referred to his *'very good parenting skills'* and his determination to provide a happy and stable home for both children. At the case conference, the health visitor reported that R's involvement and interaction with both children were appropriate and that based on the three home visits she had made to the family home when both parents were present, she had no concerns for the care of the children.

6.1.12 On January 8, 2008 P informed the SW that she had separated from R because of his unreasonable behaviour and that he had been removed by the police. A police concern referral was submitted to the social work department on 10 January 2008. SW said that if they got back together again, as had happened previously, then the SW would need to think about the impact of this upon the children. On a home visit by the social worker the following day she found R back in the flat with P saying that she was crying every day but unable to be specific about the reasons for the arguments.

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Challenged about the need to think about the effect on the children, P accused the SW of making her choose between R or her children. The case note record confirmed the SW view that whilst there was no evidence of physical abuse or neglect towards the children, the continuing element of domestic abuse needed to be addressed.

6.1.13 Three days later the family support worker closely involved with P informed the SW that R had left again and P was blaming the social worker for her situation. The social worker tried to refer the couple to a specialist domestic abuse worker but was advised that work would only be undertaken with P as a victim as the service did not work with perpetrators of domestic abuse. Following a distressed office visit made by P on 14 January 2008 and after being unable to contact her, the social worker made contact with P's mother. P's mother expressed her concerns about the couple's current relationship and said that following R's removal by the police the previous week, P had admitted to her that R was verbally abusing Y all the time and had screamed in Z's face to shut up because Z was crying. This was the first mention of any direct verbal aggression towards the children.

6.1.14 On 2 separate occasions in January 2008, the social worker had noticed bruising on one of the children's cheeks. P gave similar explanations on each occasion- 9 January 2008 and on 15 January 2008-for these bruises. However, on the second occasion, R had been in another room and had not heard P's account of what had happened; he offered an entirely different account.

6.1.15 Major improvements to the flat were noted by the family support worker who visited on 23 January 2008 following the back payments which had been held up for several weeks, finally being processed by the benefits agency.

R had fitted a laminate floor throughout the flat and a washing machine and tumble dryer had also been delivered. A double buggy had been ordered for the children with plans for buying a cot for Z. The worker took the opportunity to remind R that the fathers' group was to start the following week; he said he was unhappy about having to attend.

6.1.16 R failed to attend the group on 4 February 2008 and in a telephone conversation the following day with P, the social worker reminded P of the importance of R addressing his issues with anger and his relationship with P. She also said that a referral to the Children's Reporter would need to be considered to protect the children's welfare. R was heard in the background saying he wouldn't go to any group.

Two assaults by R

6.1.17 On 11 February 2008, P contacted the social worker, alleging that R had assaulted her the previous day. She stated that both children had been present. P did not want R to be charged as she was afraid that R might come after her when released. The social worker advised her that child protection procedures would be instigated if R were to return to live in the house due to the very serious concerns for the children's safety and well being. She also told P that there was now evidence to show that both children were at risk with R and that she would now look to restrict contact between him and the children.

6.1.18 On 18 February 2008, P told the social worker of another alleged assault by R the previous day when he had come to visit Z. She had informed the police but refused again to have him charged. She said that Z had been asleep in the bedroom throughout the assault. Referral to the Children's Reporter was again discussed with P by the social worker who said that future contact should be supervised by the social work department due to his assault against her during a contact P had arranged.

6.1.19 In preparation of this report we asked senior police staff to re-examine the circumstances of these two domestic abuse incidents. They constituted the eight and ninth report in less than 12 months relating to R and P, yet none of the reports had led to R being charged. (It appears that the police only informed the allocated social worker of the incident on 17 February 2008) In each incident, police had been contacted by P, and each time the police attended R had already left the flat. On 10 February 2008, P had initially wanted R to be charged; she then changed her mind and said she only wanted him to be warned. On 17 February 2008, when police attended she did not wish to make any complaint. On this occasion police had interviewed neighbours and been informed that the couple were '*as bad as each other.*'

6.1.20 The social worker and her team manager met with P in the social work office on 21 February 2008. The manager explained to P that, following the 2 recent assaults carried out in front of one or both children; the nine referrals from the police within the past 12 months; and the impact of all of this on the children, a referral would now be made to the Children's Reporter with respect to baby Z.

6.1.21 A referral was sent to the Children's Reporter on 25 February 2008 recommending that a Children's Hearing be convened and that baby Z be made subject to a home supervision requirement with the condition that all contact with R be supervised by the social work department.

Part I

Significant Case Review - Analysis of Period 2

7.0 Analysis- Period 2

Parts (i) and (ii) of my remit from Dundee's Children and Young Persons Protection Committee require me to

- ***Comprehensively assess the agency and inter agency discussions, decision making and involvement with Brandon and his family and others relevant to his case***
- ***Establish whether there are lessons to be learned about how better to protect children and ensure they get the help they need when they need it in the future***

Social work involvement

7.1 R's involvement with P started to become more apparent from April 2007 onwards. Prior to that he had been in prison from 8 December 2006 until his release on 19 January 2007 for breach of his Community Service. This latter information was never presented to any subsequent child protection case conference by police or social work staff. Its significance was therefore not considered in any subsequent assessment of R. His inability or unwillingness to comply with a court order would have raised doubts about his likely voluntary participation in the young fathers' group in Douglas FSC, particularly as he missed the first opportunity to attend this group in August 2007. This information should have been included in future reports, and considered as part of the assessment of R.

7.1.1 The social worker prepared a comprehensive assessment report for the review child protection case conference on 7 November 2007. It was evident that much work had been undertaken to address areas of concern within the couple's relationship, for example to help prevent arguments escalating and to help them communicate more openly with one another. There were examples cited of R's positive interaction with Y (remarked upon by the health visitor, midwife and project worker) and this was particularly relevant as Y was not R's birth child. The social worker's report highlighted the stability of the couple's relationship, stating that there was no evidence of domestic violence.

7.1.2 In situations like these, there is often an optimism evident when parents are seen to be trying to address known difficulties.

Staff try to work with parents to gain and build the trust necessary to effect sufficient changes in their parenting, and to ensure a comprehensive risk assessment is made. However, such an assessment needs to be based on an analysis of all of the circumstances. R's role within the family and his relationship with P were not analysed as fully as they might have been.

7.1.3 No mention was made of the couple's separation in April /May 2007 or the reason behind this or of the allegation made by P's mother, on 25 May 2007, that P had received a bruise following an argument with R. There was no reference to the fact that R had not attended the recent young fathers' group in August 2007 as he had agreed to do. This had been seen as an important demonstration of his commitment to P and the children. This was not picked up by the case conference either, an important oversight.

7.1.4 The social worker notified the case conference of two police concern referrals received by social work on 20 and 29 October 2007, in the week prior to the case conference. She had discussed the incidents with the couple and explained to the conference that the arguments were connected to the very real financial pressures they were facing and had not involved domestic violence. No-one from the Family Protection Unit was present at this case conference and unusually, the FPU had failed to provide a report.

7.1.5 The assessment report should have drawn together all of this relevant background information. This would have included the information from police and criminal justice services about R, including the serious criminal allegation dating from 2003 and subsequent court acquittal. There were positive indicators of progress in the child protection care plan but the evidence of progress was much more pronounced for P than for R. In fact, the social work assessment contained very little background information on R.

7.1.6 In their review of serious cases, Reder and Duncan⁹ found few descriptions of parents' relationship histories..... *an important omission from the majority of files was information about the personal and family histories of the parents, since this restricted our ability to make sense of their relationship with other adults and their children.*

7.1.7 This may not have changed the decision to proceed with the inter-agency plan and to de register Z, but it would have avoided an overly optimistic view of this immature young couple. R in particular was seen as plausible and caring in his support of P and the children when a more balanced assessment would have considered the possible risk factors which were also present.

Inter-agency work

7.1.8 There was some very effective inter-agency work undertaken when baby Z was discharged home from hospital to P and R. A tight care plan was in place which involved the community midwife, health visitor, family support centre and social worker. This had been discussed fully with P and R who were very aware that this formed an important part of the inter-agency assessment of their parenting capacity. The level of communication and planning for Z's discharge was particularly impressive.

7.1.9 The staffing pressures within the Lochee practice were a feature in this phase of work. The social worker's case record notes several telephone calls in October 2007 to the health visitor at Lochee to discuss the care of baby Z. After several unsuccessful attempts, she was then informed that, due to staff shortages, the case had been allocated to another health visitor in a different surgery. Health managers should have informed colleagues in other agencies of such changes, particularly when this concerned children on the child protection register.

7.1.10 It is important to recognise that the unanimous decision to deregister Z did not affect the support offered to the family. Agencies are often criticised for withdrawing their support when children are deregistered. In this case, agencies did remain involved, with social work as the key agency.

7.1.11 As the situation between the couple began to deteriorate there is evidence of a change in approach by the social worker in response to the changed circumstances. The growing concerns around the domestic violence were tackled very openly with P as were the future implications if there was no positive change in the relationship between P and R.

The children were being exposed to domestic violence, both verbal and physical and in the meantime R was now beginning to withdraw from contact with the social worker.

Although there were increasing concerns about domestic abuse, R at this stage had not shown any aggression towards staff who visited the family.

7.1.12 There is clear evidence on the social work case file of planning and discussion with the team manager on the focus and direction of the work; case records were signed regularly by both the social worker and her team manager. There was a chronology of significant events contained in the file. As domestic abuse became more prominent, the social worker referred P to a specialist domestic abuse service in Dundee for victims of abuse. However, the case notes show that the social worker retained a clear focus on the needs of the children.

7.1.13 The bruises on the child's cheeks noted by the social worker on 9 January 2008 and then again on 15 January 2008 would have provided grounds for convening an initial referral discussion. On the second occasion in particular, the parents had offered contrasting accounts for the bruise, and grandmother had informed the social worker the previous day about R shouting at both children.

Health

7.1.14 Although the health visitor's involvement had reduced after the decision to deregister the children she and the previous health visitor had been actively involved in the work with both children.

Child protection case conferences and core groups

7.1.15 On 5 July 2007, the initial child protection case conference on unborn baby Z only contained one recommendation i.e. to place Z's name on the register. Dundee Children and Young Person's Protection Committee inter agency guidance states that where a case conference has decided to place or retain the name of a child on the child protection register, *the conference should specify what it considers to be the essential points to be included in the child protection plan.*

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Significant Case Review - Analysis of Period 2

It was not evident from the case conference minutes exactly what the conference members expected from the child protection plan, or indeed what the core group was being asked to address in its work with the family.

This link between the case conference and the core group is a critical one. As well as establishing the essential points to be included in the child protection plan, at the initial case conference stage, the case conference then needs to consider the effectiveness of the work of the core group at review case conferences. What has changed and been achieved in work with a family? What are the protective factors and what are the risk factors? The case conference has to satisfy itself that these factors have been considered and that risks have reduced before agreeing to remove children's names from the child protection register.

Police

7.1.16 As a result of questions raised with senior police officers during the course of this Significant Case Review, they re-examined the records relating to the two reported assaults against R on 10 and 17 February 2008. On the first occasion P had wanted R to be charged but then asked for him to be warned. On the second occasion she stated she did not wish to make any complaint. The Domestic Abuse guidelines for Tayside Police state

Where the victim is making no complaint but there is otherwise sufficient evidence available, officers will take appropriate action, arrest the offender and report the circumstances forthwith to the Procurator Fiscal for consideration of prosecution. Where the victim requests that a warning be given to a suspect then this should only be at the victim's express request in a minor case and not viewed or suggested as an easy option by the Police. Officers will ensure that all possible lines of enquiry are rigorously pursued and all available evidence secured. Consideration should be given to detention and interview of the alleged perpetrator in order to secure further evidence. (20 October 2006)

7.1.17 The internal police investigation concluded that the guidelines had not been followed in either incident as R had not been traced, cautioned, interviewed or warned.

This should have been carried out by officers regardless of no complaint having been made and, as a result, opportunities were missed to detect R for acts of domestic violence. Clearly, this could also have added further information to the risk assessment of R as he formed a new relationship with M and her children. The impact of the domestic abuse on the children may not have been given sufficient consideration.

Part I Significant Case Review

7.2 Changes in practice since Brandon's death

Social work

7.2.1 Several improvements to practice have been made by social work since Brandon's death. Most of these have been incorporated within the social work department's Evidence Based Assessment Framework referred to earlier, which was launched in February 2007, but has been revised and updated since then. As part of the improvement plan in response to the HMIE findings, Dundee's Children and Young Persons Protection Committee will establish systems and processes to review, update and assess the impact of multi and single agency child protection guidance and procedures. This will be in place by the end of 2009. This will also include any necessary changes to guidance following the findings of the SCR and the Independent Review.

7.2.2 The Framework¹⁰ notes that *One of the fundamental components of assessment is information gathering. As well as undertaking this with other agencies such as health and education, social workers should undertake direct checks with other personnel in the social work department (access team, community care and criminal justice services) as well as other parts of children's services (e.g. child protection, family support teams) to ensure all the relevant information is gathered. Invitations should be made to workers from other services/ teams to child care professional meetings.*

The importance of information gathering is therefore firmly embedded within the Framework which social workers will use. This directly addresses the need to check back on previous contacts; and the need to check out prior involvement with other families i.e. R with P.

7.2.3 Later within the Framework, workers are advised that child assessments and shared information and planning documents, e.g. core group minutes, should contain information, analysis and recommendations regarding all adults within the household; with consideration given to regular visitors. This would have ensured fuller consideration of R's role within the family.

7.2.4 Staff undertaking assessments are advised to discuss any concerning incident or offence that comes to light about a household member with that household member, as part of the assessment process.

This allows them to obtain the person's view on the relevance and truth of any allegation, and strengthens the risk assessment. It then enables the worker to discuss these concerns with any potential partner. It is particularly important, however, that such historical information is accurate. (see 8.2.6)

7.2.5 Team managers have been instructed to ensure that all assessments are based on evidence, and should contain reference to risks and protective factors. They should also ensure that assessments are neither wholly negative nor positive. This would address the criticism that the assessment of R's relationship with P was not comprehensive enough in its consideration of all the information which was then available. No reference had been made to his police history, or to previous separations from P, or to earlier allegations that he had assaulted her.

7.2.6 Team managers have been advised to ensure that where domestic abuse has been raised as an issue, it should receive specific attention when assessing children's needs. Linked to this, an initial referral discussion should be considered where there is a cluster of concerns in respect of child care and domestic violence. The guidance also recommends an IRD be considered where there is bruising with no clear or plausible explanation. (I would substitute 'any injury' for bruising). An IRD would therefore have been considered either when 2 separate incidents of bruising had been noted in January 2008 or when there had been the cluster of domestic violence referrals around the same time.

7.2.7 All of the above changes, if followed through and implemented fully, will have a positive impact in terms of protecting children in Dundee.

Police

7.2.8 The failure of police officers to comply with Tayside Force Domestic Abuse Guidelines has been noted earlier. Since 2009, a more robust approach, consistent with the guidelines, has been followed with regard to a hostile or reluctant witness. The position now is that a suspect will be charged with an offence, other than in the most minor of cases where the complainer specifies that they do not wish any action taken.

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Where the Domestic Abuse Officer or Detective Inspector deems that there is sufficient evidence available to report the suspect to the Procurator Fiscal, they will return the cases to officers to undertake the necessary follow up. The child's circumstances will be considered, and decisions made about possible referral to other agencies.

7.2.9 Where it is noted on a Crime Report that a complainer of domestic abuse wishes contact with the Domestic Abuse Officer (DAO), the DAO will make contact with the victim either by a telephone call and/ or a home visit. If unable to make contact this way, a letter will be sent out inviting the victim to make direct contact with the DAO. Appropriate leaflets will be enclosed with the letter alerting the victim to the Tayside Joint initiative on Domestic Abuse. If there are children present within the home, details of the pre-referral screening meeting are also enclosed. There are several further leaflets which may be included as deemed appropriate by the DAO.

7.2.10 Since January 2009, over 400 complainers have been contacted by telephone and had advice given to them. Over 40 complainers have met with the DAO either within their home or at police headquarters. A further 95 had home visits carried out and a calling card left as there was no reply. Over 200 letters have been sent out to complainers where the DAO has been unable to make contact with them either by phone or by carrying out a home visit. Where a complainer resides or moves to another Force area, the DAO sends details of the incident to that area for their information and attention.

7.2.11 Once the DAO has made contact, the report on the police crime recording system is then updated with any pertinent information. The Domestic Abuse spreadsheet which contains information on all domestic incidents during 2009 is currently in the process of being made available to all police officers in a read only capacity. This will be available to Control room operators who can then update officers regarding recent domestic abuse incidents whilst that officer is en-route to a domestic abuse incident. The DAO is currently examining ways to place 'flags' on all addresses linked to a domestic incident and contained within the spreadsheet. This would again highlight to control room operators the need to check the spreadsheet.

The police establishment in the Family Protection Unit has been increased by 1 full time Detective Constable, and at present, 2 part time Detective Constables. Uniformed officers are also receiving regular secondments to the FPU. A police representative will now attend all review child protection case conferences. From 27 July 2009, the police establishment within the FPU was to be enhanced with the creation of a further Detective Sergeant post. This increase in capacity should also ensure more accurate, up to date information is presented to child protection case conferences and IRDs.

8.0 Period 3-Agency involvement with M and R

This section of the SCR covers the period from late February 2008 when maternal grandparents first raised their concerns about M's inconsistent care of her children as well as her involvement with R. It considers the circumstances leading to the Initial Referral Discussion and agency contact throughout this period up until 14 March, two days before Brandon's death.

8.1 The first significant contact in this period commenced with an allegation by P in a parents' group at the Charleston FSC on 21 February 2008 that she had witnessed M smacking Brandon on the bare bottom until her hand was sore. Though the detail of the information provided by P was quite muddled at this stage, the smacking was alleged to have been witnessed by a neighbour who was a mutual friend of both P and M. P was upset when relaying this, saying she should have come forward sooner.

8.1.1 The Charleston FSC manager contacted the child protection team the following morning 22 February 2008 and was asked in the first instance by a social worker from the child protection team to make a home visit to discuss the allegation with M. The manager and senior family support worker visited the family home and met with grandfather who was caring for both children as M had gone into town. He explained that M was spending most days back at her flat in Douglas, returning to her parents at night.

He was concerned at how M handled the children at times, but said that he and his wife tried to support her as best they could. He said that she disciplined the children by a smack on the back of the hand or legs or on the bottom, over the nappy and said she would be in trouble with him if she did anything more than that. Grandfather's view was that it was time that M and the children moved back to her flat. Both workers recall that during this visit, both children were all over them and indeed tried to prevent them from leaving by sitting rigidly together at the front door.

8.1.2 This information was reported back to the team manager of the child protection team with the additional information from P that M smacked Brandon like this all the time, the last time being about two weeks earlier. The team manager noted that even if the smacking allegation were true, there was unlikely to be any evidence of bruising by this stage, and the FSC manager agreed to enquire further of M if she came to collect C from nursery (this was shared between M, her father and sometimes a friend whose child also attended).

8.1.3 Maternal grandmother phoned the social work access team on 25 February 2008, to voice her concerns about her daughter's care of the children and a home visit was made by social worker access team 1 and social worker access team 2 (SWAT 1 and SWAT 2) that same day; both grandparents were present. Grandmother said that M had now moved back to her flat in Douglas having stayed with them for 5 months; both grandchildren had remained with grandparents. They described M's parenting skills as inconsistent and that despite their support, she took little responsibility for the children. They had been unaware of the various supports offered by the FSC and believed that if she could arrange a tenancy nearer to them they could support her to attend.

They were also worried about her recent new relationship with someone whom they had seen have violent arguments with his previous partner. This referred to R and P whose ground floor flat was across the road from and immediately opposite the grandparents' flat. Grandmother referred to her daughter as vulnerable and impressionable and said the relationship between M and Brandon's dad J, had been turbulent. She had separated from him shortly before returning with the children to live with her parents.

The social workers told the grandparents that given the concerns as outlined by the grandparents, it would probably not be in the children's best interests to be cared for by M at this point.

8.1.5 The social workers gave grandparents the name and telephone details of the welfare rights officer as they had indicated their willingness to consider caring for the children in the longer term, but as they both worked they thought they would struggle to pay full time nursery fees. They were advised to check out the possibility of a full time day nursery place for C with C's current nursery.

8.1.6 Grandparents' recall of this visit is very different. They said that R was known to the workers, and that the workers had revealed his surname, and that given what was known about him, i.e. by social work, the children would be better remaining with them. The grandparents' view was that they had been positively encouraged by the social workers and felt that they therefore had the added support and authority of the social work department behind them in their subsequent dealings with their daughter about the children. (this is analysed in 9.1.2)

8.1.7 On 26 February 2008, grandmother telephoned SWAT 1 who was now the case holder, advising that M was now agreeing to move back to her parents' flat with the children and that she would take up support from the family support centre. Shortly after this call, M rang SWAT 1, demanding to know what was going on as she had just been told by her mother that she was not allowed to have the children. A male voice could be heard in the background, prompting M. She was invited to the office the next morning to discuss the situation.

Grandfather then rang SWAT 1 saying that M was now refusing to return to them and was remaining in her own flat in Douglas with Brandon. He said that R was now with M and that R had been texting him from M's phone- he knew that it was not his daughter as she had literacy difficulties and did not text. He was advised that a home visit would be carried out to M's flat that evening. SWAT 1 and team manager visited that evening and found no-one in; the out of hours team were contacted and were asked to visit and were similarly unsuccessful.

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8.1.8 On 27 February 2008, M and R came in with Brandon for the arranged office appointment and were seen by SWAT1 and SWAT3. The social workers met with M alone first and told her they were concerned about her living with R, and informed her of the nine police concerns linked to his previous relationship. It was also explained that her parents were very concerned about the current situation. M was asked if she could understand people's concerns, but the overall impression was that she was not taking any of this seriously and was 'smirking' throughout the discussion. When seen on her own, M said that she had known R for years whereas in contrast R said he had known M and the children for a couple of months. In an interview with me, SWAT3 reflected in retrospect that M had been embarrassed at this information coming out i.e. that she had actually only known him for a short time before agreeing that R could move into her flat. R's response to the 9 police concerns was denial that he had been violent towards his ex partner, but rather that he had defended himself from her violence towards him.

8.1.9 M was told that in light of the concerns discussed, a referral might be submitted to the Children's Reporter and she was told what this would entail. (No referral was made prior to Brandon's death) She agreed to make contact with her local family support centre in Douglas that afternoon and to check out what support might be available. SWAT1 telephoned the FSC to advise that M may call in and also let them know of Charleston FSC's unsuccessful attempts to engage her.

8.1.10 The SWAT team manager saw the couple as they left the office and was concerned at the marked change in M's demeanour from the previous office visit in November 2007. She had overheard M angrily declare that nobody could tell her what to do about her children, a very different presentation from the young woman who had appeared compliant and cooperative after the interview with social work staff in November 2007. Following discussion with the two social workers and in particular their observation that M did not appear to have taken seriously the various concerns raised, the team manager decided to convene an initial referral discussion which was arranged for the following day.

8.1.11 As a follow up to the allegation made by P that Brandon's mother had smacked him on the bare bottom, the FSC manager had visited the neighbour referred to by P on 27 February 2008. As P's social worker had also worked with the neighbour she agreed to accompany the FSC manager on the visit. The neighbour categorically denied that the particular allegation had happened. She described this as sour grapes and jealousy on P's part as Brandon's mother, her former friend, was now in a relationship with R. The explanation was accepted as plausible but the neighbour also stated that M did shout and bawl at the children who always appeared hungry; she also said that she had taken smack i.e. heroin.

8.2 Initial Referral Discussion- 28 February 2008

8.2.1 Dundee's Children and Young Persons Protection Committee multi-agency child protection guidance (1 June 2006) states

'The purpose of the IRD is to decide how best to proceed, once initial information has been gathered.'

IRDs are jointly convened and led by the police sergeant of the FPU and the team manager of the child protection team though where a case is allocated to a particular social work team, then that team manager would chair the IRD. The guidance makes clear the IRD should be accorded similar status to a child protection case conference and staff asked to attend should give this priority.

8.2.2 The IRD on 28 February 2008 was attended by

- SWAT1
- SWAT team manager(chair)
- Child protection team manager
- Detective Constable- Family Protection Unit
- Health visitor I
- Team manager Charleston FSC

8.2.3 The meeting discussed mother's lack of engagement with services and failure to take seriously the concerns expressed to her; concerns about her moving in with R in light of the known nine domestic abuse referrals; her over-chastisement of the children; M's fall out with her parents when they had been a significant protective factor for her and the children; the frequent moves for the children; and M's recent marked change in demeanour and presentation when seen at the social work office with R.

8.2.4 The health visitor had only become aware of M's involvement with R shortly before the meeting. From discussion with her health visitor colleague at Lochee Health Centre who had previously worked with R when he was in a relationship with P, she was made aware of the history of domestic abuse between the couple.

8.2.5 The SWAT team members were already aware of the nine domestic abuse referrals from checking the social work database and the child protection team manager had made a similar check in advance of the meeting; he had noted that the children in the household had been de-registered whilst R was still a member of the household. No direct contact was made by social work staff attending the IRD with the social worker for P and her children, and the meeting was unaware of the most recent events between P and R that had led to the referral of Z to SCRA by P's social worker.

8.2.6 Police information shared with the IRD referred to the nine domestic abuse referrals in respect of R and further information in respect of previous serious criminal allegations involving him. The information provided by the police in respect of the previous criminal allegations was inaccurate, although had the correct information been provided, it would not have heightened any risk assessment in respect of R.

There was no information presented on M's previous police history and no information that highlighted the more serious aspect of the two most recent domestic abuse referrals i.e. the alleged physical assaults by R upon P. Therefore not all current available information was shared though it should be borne in mind that the meeting itself had been convened within 24 hours.

8.2.7 There was consensus that the following actions were agreed at the end of the meeting:

	ACTION
<ul style="list-style-type: none"> • Write up referral and pass to social work children and families locality team 	SWAT I
<ul style="list-style-type: none"> • Access team to complete Child Protection I (CPI Report), requesting urgent case conference 	SWAT I
<ul style="list-style-type: none"> • Access team to refer matters to SC RA 	SWAT I
<ul style="list-style-type: none"> • Emergency measures considered by the meeting and not thought to be necessary 	
<ul style="list-style-type: none"> • No role identified for child protection team 	

The IRD was discussed with the relevant service manager that same day and agreement was given for an urgent case conference to be convened for Tuesday 18 March 2008. (this was within the guidelines set out in Dundee City Council's Social Work Child Protection Procedures June 2006 i.e. within 14 working days). In later discussion with Peter Wilson and me, staff who attended the IRD were clear that while there were serious concerns, there were *no red lights or alarms* around this case.

8.3 Family Support Centre involvement

8.3.1 *The referral of M to the FSC was fast tracked by telephone as a priority. As well as the contact made by SWAT I with Douglas FSC, both centre managers i.e. Charleston and Douglas discussed the situation as a means of ensuring relevant background information was shared between the centres. Usually a more formal transfer meeting would take place when someone was moving from one centre to another; the fact that this referral was accepted over the phone with the paperwork to follow was a measure of the priority given in view of the concerns then identified. M attended on 28 February 2008, and the service form was completed with her then.*

8.3.2 M attended the local FSC in Douglas on the late afternoon of 28 February 2008 with Brandon in his buggy- 'because I've been told to see what you've got for me' - and was seen by the senior family support worker.

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There had been a series of telephone calls to the FSC from SWAT I before M actually attended and the senior was aware of the most recent background events. She knew there were concerns over the recent move from her parents; that there were child protection concerns around her handling of the children; there were issues around parental attachment; and she knew M was now with R but did not know a great deal about him.

She had also known P who had attended the mellow parenting programme at the FSC and was aware of the domestic abuse issues between her and R- she recalled that these had always been played down by P. She was unaware of the full extent of his most recent violence towards P.

8.3.3 The senior was aware of a level of urgency behind the referral to the FSC, reflected by the fact that unusually the centre had started to engage with mother before receiving the written referral which is the usual starting point for beginning work with a family. She also recalled M from her previous attendance at the FSC in 2006 with Brandon and her view from the earlier involvement was that M hadn't take on board what was said by staff. When asked about M's possible learning difficulty, the worker's view was that this was not apparent, and that M was able to involve herself in conversations and discussions.

8.3.4 On the visit on 28 February 2008, the senior described Brandon as being unhappy in his buggy and nipping his mother for attention- M kept slapping his hand away and complained that he whinged from the moment he woke up until he went to bed. The senior had e mailed SWAT I that afternoon with a brief account of this meeting stating that she had been concerned about M's response to his needs. The e mail wasn't seen by SWAT I until 5 March as she had been on leave.

8.3.5 On 5 March 2008, M came to the centre with Brandon for the family fun session and completed the family support plan with the senior. The no smacking policy within the centre was explained to her, specifically because of the senior's concerns about M's actions on 28 February- this elicited no response from M. On this occasion she told the senior that she now had C back living with her as well as Brandon. During the family fun session, one of the family support workers present recalled M being '*happy enough*' and chatting to other mums before the group started.

She had smacked Brandon on the hand when he threw juice but the worker had been more concerned by a later incident when she had heard a loud slapping noise when she was in another part of the playroom.

She had returned to find Brandon lying crying on the floor, and when she asked what had happened, one mother offered the implausible explanation that the noise had been made by the strapping of her baby into the buggy. The worker recalled M lowering her gaze and not making any eye contact; she had not attempted to console or comfort Brandon. The worker reminded the group about the no smacking policy and put a written account into Brandon's electronic case file.

In interview, the FSC manager was confident that had M returned to the centre after the 5 March 2008 incident, that she would have been closely monitored by centre staff.

Week commencing 10 March 2008

8.3.6 On 11 March 2008 an unannounced visit was made by SWAT I and the team manager; M and both children were there. When the workers first arrived, they were told by M that the children were in their bedroom tidying their toys. The flat was reasonably tidy but sparsely furnished and M was making the children's tea. There was bedding on the living room settee which M said was used by her and R – the children slept in her bedroom. There was a sheet on the mattress used by the children but no bedding other than pram and buggy blankets. M said that her parents had the children's beds and bedding but as she had fallen out with them she was unable to get these. Though M said there was heating in the bedroom, social workers saw no evidence of this (in interview the team manager recalled that at this point the weather was neither hot nor cold). The workers offered to obtain sheets from the local supermarket but were told that R was organising this, and they advised her that she needed to sort this out. M said she was due to attend the FSC the next day and the workers stressed the importance of her using these services.

8.3.7 Although in subsequent discussions with me the workers separately recalled seeing a graze on the side of Brandon's cheek, level with his eye, this was not recorded within the case notes.

The team manager recalled a spherical graze with a scab in the middle and thought this was consistent with the explanation given by mother i.e. that Brandon had fallen off the mattress which he slept on.

8.3.8 Both children had approached the workers to be picked up which they had felt was unusual; and would have expected a 2 year old in particular to be looking out from behind the safety of mother's legs rather than approaching relative strangers so easily.

Having picked Brandon up, the team manager pointed out to M that he was wet and she responded that R had changed him shortly before he went out; the clear message being conveyed was that she was not going to change him again. Both workers were clear that there was no evidence in the flat of any drugs paraphernalia. There was no reference made to the incidents reported by family centre staff on the 28 February 2008 or 5 March 2008.

8.3.9 On 12 March 2008 the health visitor (now referred to as HVI for clarity) who had attended the IRD made a home visit with her health visitor colleague (HV2) to M and the children, having ascertained in a telephone call to grandmother on 7 March 2008 that C was also now living with M, Brandon and R in the flat in Douglas. The health visitor had telephoned M and left a message on the answerphone to confirm the visit on 12 March 2008. The explanation given for the visit was to complete Brandon's 2 year screening.

8.3.10 On arrival they met briefly with R who then went into a bedroom where he remained for the rest of the visit. Brandon's screening was completed and his height and weight were satisfactory. He was examined naked from the waist down- HVI wanted to check his bottom in particular in light of the earlier allegations that M had regularly smacked him on the bare bottom-and no bruises were noted on his lower body. A round scab was noted at the side of his left eye which M did not explain other than to say that he must have fallen off the bed. Both health visitors noticed abnormal gait as Brandon walked between them, and a turning in of his left foot, and upon further examination noted one leg shorter than the other. M said she had not noticed this before and agreed to attend the drop in clinic the next day for the GP to have a look at this.

8.3.11 Dried blood was also noticed in his left nostril; again M thought it likely he had fallen off the bed. One of the health visitors recalled C as being very chatty and that Brandon was on her knee within seconds of her arrival, with his arms around her neck. Throughout the examination the children were not near their mother and there was no contact made by her with them. As the health visitors went to leave Brandon got his coat and made as if to follow them.

8.3.12 After the visit, they discussed their concerns:

- his gait which they both felt was abnormal
- his craving for attention
- the mark by the side of his eye which they appeared to have accepted had been caused accidentally though they did seriously consider whether it might have been a cigarette burn

8.3.13 HVI's case notes state that upon return to the office she telephoned SWAT I to share the visit. HVI's record notes that SWAT I had also seen the scab near the eye the previous day and felt that they would take the opportunity to see mother and the children at the surgery the next day. HVI recalled in interview that she had specifically discussed the query cigarette burn with SWAT I. She also recalled that M had given the same explanation the day previously i.e. Brandon had probably fallen off the bed.

8.3.14 SWAT I had no recall of any discussion about the graze/ scab by the eye possibly being a cigarette burn but did recall that the health visitor had told her that M was due to attend the clinic the following day, and that she had said she would use that opportunity to discuss concerns with M. The SWAT team manager had no recall of any discussion about a possible cigarette burn having been raised with her.

8.3.15 On 13 March 2008, M attended the drop in clinic with Brandon as arranged. The GP (same GP referred to throughout) manipulated his leg, taking his trousers down but not his nappy to do this. Although the GP did not notice any abnormality of Brandon's leg she did refer Brandon onto orthopaedics based on the health visitors' concerns. The GP commented that Brandon was more familiar with her than she would have expected from a two year old in such a situation, coming over to sit on her knee after the examination rather than go to his mother who was nearby.

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The staff nurse immunised Brandon after this consultation.

8.3.16 Health visiting staff have a different recall of communication around the medical consultation. HV 1 recalls sharing 3 concerns with the staff nurse for her to pass on to the GP:

- Brandon's gait
- His clinginess
- The query cigarette burn

HV 2 recalled HV 1 advising the staff nurse to tell the GP about

- Brandon's gait
- The query cigarette burn

8.3.17 The staff nurse recalled that HV1 thought the mark was not a cigarette burn whereas HV2 thought it might be, but that both were concerned about his gait. She therefore asked the GP to check his gait and assumed that her health visitor colleagues had kept the GP in the loop about the other concerns. The staff nurse commented on the lack of a bond between M and Brandon and that this was different to how she had seen her behave previously with him; she didn't see any bruises other than the mark by his eye which appeared to be healing and described Brandon as *'boisterous, curious, well dressed and running about.'*

She also recalled in interview that M had lost weight since she had last seen her. Her teeth seemed to be in a poorer state than she remembered and she had wondered then, for the first time, whether M might be taking drugs.

8.3.18 After the GP had assessed Brandon's gait, SWAT I and the team manager met with M to go over the CPI (child protection report) for the case conference scheduled for 18 March. The team manager covered this in some detail with M as she said that she could not read. In discussing the report, M acknowledged that the allegation about her smacking Brandon on the bare bottom until her hand had *tingled* had actually taken place. She had done it to discourage Brandon from biting, and the team manager's clear impression was that she had seen this as appropriate.

The team manager discussed this particular issue with her supervisor that same afternoon, and following this, raised her concern with the Detective Sergeant from the FPU the following morning. He advised that as the incident had happened some time ago there would be no physical evidence, but that it should be raised at the forthcoming child protection case conference. (discussed more fully in 9.1.33)

8.3.19 The team manager also shared with M the police information about R presented at the IRD on 28 February 2008, but this elicited no real reaction from her. The following day, SWAT I received a telephone call from R, angry that she had shared this information with M; he also telephoned the police to complain that the social worker had slandered him.

8.3.20 In discussion with M, the social workers suggested that her parents should be invited to the child protection case conference given their important involvement with her and the children; she reluctantly was persuaded, with the concession that they would only be invited in for the initial part of the meeting. The social workers arranged for a taxi to bring M to the child protection case conference and for a worker from the FSC to look after the children. The maternal grandparents were visited to update them on the situation and were informed that M had been persuaded to let them attend the first part of the child protection case conference.

Part I

Significant Case Review - Analysis of Period 3

9.0 Analysis-Period 3

Parts (i) and (ii) of my remit from Dundee's Children and Young People's Protection Committee require me to

- ***Comprehensively assess the agency and inter agency discussions, decision making and involvement with Brandon and his family and others relevant to his case, and***
- ***Establish whether there are lessons to be learned about how better to protect children and ensure they get the help they need when they need it in the future***

9.1 M began living with R in her flat in Douglas on 19/ 20 February 2008. By 26 February Brandon was also living there. It was a period of 20 days until Brandon's death on 16 March 2008.

The actions of agency staff need to be viewed and understood within the context of this extremely short time frame. (C joined them on 29 February 2008).

Social work response

9.1.2 The social workers' home visit to maternal grandparents to discuss their concerns about M's new relationship with R was important. The grandparents clearly believed that they had been given 'social work department approval' to keep the children with them and this was based on the workers' direct knowledge of R. As a result they were more assertive with M in saying that she and the children should stay with them, and that M should take her time getting to know R before deciding whether to take the relationship any further.

My assessment from discussion with the social work staff involved was that they were trying very carefully to help the grandparents reach their own decision based on the doubts they were then expressing about M's parenting as well as their concerns about her developing relationship with R. The grandparents had already witnessed R in a violent altercation with his previous partner P when she and R lived together in the flat across the road from the grandparents.

They also alleged that M's previous relationship with Brandon's father, J, was volatile. This was the first mention of any domestic abuse in relation to M.

I felt from discussion with the maternal grandparents that they were understandably torn in their views about what was best for M and her children. Social work staff would have been aware that ultimately M as the children's mother had parental rights.

9.1.3 It is important to note that since moving in with R, M had become more oppositional in her attitude and responses both to her parents and to social work staff. It is likely that this in large part was due to the increasing influence of R over her, for example the texts to grandfather on M's mobile phone. On 26 February 2008, in her telephone call to the access team social worker, when she was demanding to know what was going on, the social worker could hear a male voice- almost certainly R- prompting M in the background.

9.1.4 This was the same day that R had gone to the social work office in Lochee demanding to see the social worker for Y and Z. He was insistent that he should have contact with both children and equally insistent that this should not be supervised. Due to his unreasonable behaviour, shouting and swearing, he was asked to leave the office. As he did so, he continued to shout and swear, threatening to assault the social worker. Throughout this incident another woman was present outside the office, with a child in a buggy and was seen to leave with R; it is highly probable that this was M with Brandon. Police were called and informed the social worker that he would be issued with a verbal warning. (Police officers did make attempts to trace R, but had been unable to see him prior to Brandon's death).

9.1.5 This was the first real display of aggression from R towards any staff. Significantly, it occurred as a result of him being thwarted in his demand to have unsupervised contact with Y and Z.

9.1.6 M's demeanour at the office appointment on 27 February 2008 with R and Brandon was in sharp contrast to when she was seen in November and had appeared to listen to the social worker's advice and suggestions. Now she was smirking and dismissive of the concerns raised.

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Significant Case Review - Analysis of Period 3

9.1.7 Following the contact with maternal grandparents and the subsequent telephone call to the access team from M, she had been invited to the office the following day to discuss the situation. When grandfather then telephoned to say that M had now refused to return home, social work staff responded quickly and attempted twice, unsuccessfully, that evening to visit M and Brandon at her flat in Douglas.

9.1.8 At the office visit on 27 February 2008 the social workers interviewing M and R knew of the nine police concern referrals in respect of his relationship with P. They had not made contact with the social worker for Y and Z which would have provided a much fuller and current account of the circumstances. In interview with me, one of the social workers remarked that Brandon had appeared settled in R's company. He was in no way fearful of R who was more attentive towards him than was M. This was very similar to the early impressions of R gained by those staff working with him when he was involved with P.

9.1.9 The social workers were of the view that M had complied with what was asked of her i.e. she had kept the appointment, and having been told of the concerns about the children and that this might result in a referral to the Children's Reporter, she had also then attended at Douglas Family Support Centre the following day as she had been advised to do. The Douglas FSC had been contacted by the access team social worker allocated to the children and had accepted the referral as urgent and that the background paperwork would follow in due course.

Initial referral discussion

9.1.10 This meeting had been convened at very short notice by the prompt and appropriate intervention of the team manager of the access team. The circumstances were unusual in that there was already a lot of information available whereas most IRDs considered a known incident or allegation and met to discuss and plan the next steps in the child protection investigation. In this case, there was enough information available to seek the appropriate service manager's agreement to proceed to an initial child protection case conference, and the team manager for the access team should be commended for such a timely response.

9.1.11 It was noted earlier in the report that there were *no red lights or alarms* around this case at the IRD. However, not all relevant information was made available to the meeting, particularly

- Full background of R's previous police history
- Full details of the nine police concern referrals, including R's recent assaults against his former partner as well as verbal threats to Y and Z
- R's verbal threats to Y and Z's social worker on 26 February 2008 over the issue of supervised contact
- M's previous police history
- Feedback from the health visitor involved with P and her children

M and R had come together but not all available information had come with them. This was all information that was pertinent to the assessment of risk to the children.

9.1.12 A fuller check of social work records would have established the connection between R and P and, in particular, the circumstances surrounding their recent separation. This information should have been made available to the IRD or established soon after the meeting as part of ongoing enquiries. Similarly, the police information presented was inaccurate and incomplete. He was given 200 hours of Community Service for theft by housebreaking in December 2005, which he breached. As a result, he was sentenced to 3 months imprisonment on 8 December 2006 and released on 19 January 2007.

9.1.13 This was information that could and should have been available to the IRD on 28 February 2008. It would have allowed a full and current risk assessment of potential risks to the children. However, R's fatal assault on Brandon which led to Brandon's death on 16 March 2008 could not have been foreseen.

9.1.14 The meeting was chaired by the team manager of the access team who by this stage was in effect co- working this case with her social worker. With hindsight, it would have been more appropriate for either the service manager or the child protection team manager to have chaired the meeting.

This would have afforded a greater measure of objectivity, with someone at one remove from the case. On the basis of the information shared and the concerns discussed, the IRD concluded that there was not sufficient evidence to consider the emergency removal of the children, but that a child protection assessment was required, registration would be sought and a plan put in place to support the children. A referral was also to be made to the Children's Reporter, although there was no timescale stated for this. It would be sensible for this to be a 5 day timescale, consistent with national standard for referral to Children's Reporter following a child protection case conference.

9.1.15 This was a reasonable set of decisions, but the IRD did not identify any interim action plan to protect the children during the intervening period. Sensibly, a fast track referral had already been made to the Douglas FSC and M first attended on the same afternoon as the IRD. The IRD did not identify specific issues that required to be managed. For example, no explicit arrangements were discussed for the need for agencies to keep in touch during the interim period.

What would happen if new information came to light; who would be responsible for sharing this and with whom?

9.1.16 No actions were identified for the health visitor and no contingency plans put in place. All the actions identified were for the access team social worker and to that extent the IRD became a one off discrete event rather than a critical part of the child protection planning process. There was no discussion about the need to continue to collect any relevant information. I am mindful that the IRD occurred during a period previously described, as one of high volume of complex referrals for both social work and health, and where there were significant staffing pressures.

9.1.17 The decision of the health visitor to make a home visit to undertake Brandon's 2 year screening was a sound one but was taken after the IRD and not shared with social work colleagues.

9.1.18 There was no minute of the meeting produced before Brandon's death and it is unclear what expectations the IRD participants would have had as to any future actions following the meeting.

It lacked proper coordination or direction and nobody was identified from the meeting to visit the family in the week following the IRD. Home visits were made by social work and health visiting staff on consecutive days on 11 and 12 March 2008. The IRD should have agreed an interim visiting pattern for the following 2 weeks and highlighted the importance of information sharing between the agencies over this period.

9.1.19 It must be noted in saying all the above that Dundee's guidance on IRDs in the extant inter agency child protection guidance offers very little by way of detailed direction as to the intended outcome of IRDs. Moreover, at the time under consideration there was little in the way of administrative support for the person chairing; they were expected to chair and produce a minute of the meeting. There had also been no training provided for those staff who might be expected to chair IRDs.

Contact with M and the children after the IRD

9.1.20 M took Brandon to the Douglas FSC on 28 February 2008, the day after her office appointment.

The senior family support worker had been concerned enough by her presentation to send an e mail to the access team social worker. This was good practice on her part but should have been reinforced by a telephone call to confirm her concerns and an entry on Brandon's electronic case file(event recording). It is critically important that staff take direct responsibility for making sure children are alright i.e. ensure the message is conveyed and heard. The Serious Case Review¹¹ on Baby Peter in Haringey noted

'It is important for professionals to trust their feelings when they perceive children to be suffering, and not to make assumptions that others have also perceived it and are better placed to act. It is simpler to lift the telephone than to live with the regret of not having done so.'

9.1.21 Earlier reference was made to the pathologist's report that there had been evidence of previous healing rib fractures at the site of the fatal injury to Brandon. I sought expert medical opinion on this and shared the senior family support worker's account of her meeting with M

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and Brandon and especially her description of him being 'whingey and unhappy' from the moment he woke up in the morning, which M had interpreted as Brandon trying to get her attention. The medical opinion was that it was highly possible that Brandon's behaviour could have been the result of the first rib fractures. As well as being painful and given that pre verbal children, such as Brandon, cannot articulate their pain, this would be shown by 'non specific' signs such as crying, irritability or restlessness or being off their food. Rib fractures would be diagnosed by performing a chest x- ray and this would only have occurred had there been any report or clue about possible trauma. There was no suspicion of any such trauma to Brandon.

9.1.22 The incident on 5 March 2008, when the family support worker heard but did not directly witness the loud slap was significant for several reasons. The worker was clear that the explanation given – of a buggy being strapped- was highly implausible, all the more so as it coincided with Brandon lying on the floor crying. M had made no eye contact when the worker had sought an explanation for the noise, nor had she consoled Brandon. (At the subsequent trial two parents confirmed that she had slapped Brandon on his leg).

This was only a week after M had been reminded of the centre's no smacking policy.

9.1.23 Again this incident should also have been confirmed by a follow up telephone call. *What information do I have that I might have to share with someone else?* An initial child protection case conference had been arranged to share all concerns with respect to both children, and to consider registration. Staff needed to be more alert to the importance of sharing information in such circumstances.

9.1.24 With hindsight, the access team social worker should have discussed both incidents at the family support centre with the health visitor with consideration given to making a joint home visit. The inter agency guidance which I found otherwise extremely useful and clear in the range of professional advice offered, did not help staff think ahead or plan for that period between the IRD and the case conference. *What information do I have that I might need to share with someone else?*

The access team social worker's assessment was that both of these incidents would have been dealt with at the time by FSC staff, but no discussion took place to confirm this.

9.1.25 The team manager and access team social worker made an unannounced evening home visit on 11 March 2008, and saw M and both children. Such unannounced visits are recognised as a useful way of checking on children's safety where there are child protection concerns.

9.1.26 Both workers separately recalled the inappropriate clinginess and attention seeking of both children as well as the graze which was level with Brandon's eye, although there was no reference to this in the case notes. They had accepted M's explanation that the graze had been caused by him falling off the bed. Given the recent concerns which had led to the decision to convene a case conference, an account of the graze should have been entered on the case notes. No discussion of this visit had taken place with health visiting colleagues prior to or after this home visit. *What information do I have that I might need to share with someone else?* The two health visitors from Lochee health centre visited M on 12 March 2008, having obtained her new telephone number in a telephone call to grandmother on 7 March 2008.

HV I's case record referred to a mark on the left side of Brandon's face and that no explanation had been given by M, other than he might have fallen off the bed. Reference had also been made to his gait and that he had raised his arms to be picked up as soon as they had arrived. It refers to a telephone conversation with the access team social worker and the plan that *'Following a telephone call with social worker and passing on information , planned social worker to come to GP clinic to see M'* (i.e. the appointment arranged for the next day).

9.1.27 The record does not specify what information was passed on to the social worker but, in interview with me, the health visitor recalled mentioning Brandon's gait; his clinginess; and the possible cigarette burn. (Her colleague health visitor recalled hearing this conversation). HV I also recalled that the social worker remembered a similar account given by M for the graze the previous day.

9.1.28 There was clearly some doubt remaining as HV 1 recalled asking the staff nurse to mention all three concerns to the GP who was due to check out Brandon's gait the following day at the clinic. As was explained in the chronology, each of the three health visiting staff had different recall of what the GP had been asked to consider. This conversation should have taken place directly between the health visitor and GP either in person or by telephone; the staff nurse would not have been in a position to answer any supplementary questions from the GP.

9.1.29 The health visitors acted quickly in referring M to the drop in clinic the following day. In retrospect, HV 2 said that they would probably have taken action had M not turned up the next day i.e. her attendance indicated cooperation, nothing to hide, thereby lessening any anxiety.

9.1.30 The final contact with the family took place on 13 March 2008 when M attended the drop in clinic with Brandon. The GP examined Brandon's gait and referred him onto orthopaedics as a result of the health visitors' concerns. She knew a case conference had been arranged but did not know the reason for this. The GP should have confirmed the reason for the case conference. Each individual has a professional responsibility to ask questions of colleagues to ensure their assessment is conducted with a thorough knowledge and understanding of the facts.

The GP commented on the fact that Brandon had sat on her knee rather than go to his mother who was nearby. During her examination of Brandon, the GP did not notice any graze or mark on his face.

9.1.31 The record keeping by health and social work staff of relevant discussions was not as robust as it should have been, and at some distance from events, recall is very different. From the separate interviews with the health visitors they clearly differed in their views of the graze, an entirely acceptable and understandable professional position. In view of this element of doubt and mindful of the recent IRD and the decision to convene a case conference, with hindsight, they could have consulted further on this.

9.1.32 However, a wider consideration of the circumstances reveals that the 2 social work staff had accepted M's account which was the same as that offered to the two health visitors. The GP had examined Brandon's gait the following day, and also had him sit upon her knee. Any mark there was, was not so significant for the GP to make comment on it.

9.1.33 An initial case conference was taking place within three working days when this would be considered in the health visitor's report along with the other concerns already discussed at the IRD. In effect the staff involved saw a process taking place within a very short timescale which would consider all the elements, and put a plan in place to protect and support both children.

9.1.34 The salient point about M's admission to smacking Brandon on his bare bottom is that this should have been discussed with her sooner. It got 'lost' at the time of the IRD. That meeting should have clarified how the allegation was to be followed up and who was managing it i.e. the access team manager or the child protection team manager.

9.1.35 However, the access team manager responded very appropriately to M's admission about smacking Brandon on his bare bottom and discussed this the following morning with the Detective Sergeant from the FPU. His advice that this could wait until the case conference as there would be no physical evidence of any smack was understandable. In interview, the Detective Sergeant explained that M appeared to be cooperating with SW by admitting that this had occurred, and the incident had been mentioned at the IRD.

He believed that criminal investigation of that incident was less appropriate than M being supported through formal case conference decisions.

9.1.36 R telephoned Dundee police HQ and the access team social worker on Friday 14 March 2008 to complain angrily that he had been slandered by social work staff who had shared details with M of past allegations of his criminal behaviour.

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9.2 Changes in practice since Brandon's death

9.2.1 Social work and police knowledge about the domestic violence in P's family was not shared at the IRD. This could potentially have raised people's awareness of R's capacity to be violent, but up until then his violence had been directed at P and not the children in the household. Fuller information on R's relationship with P as well as his increasing verbal threats towards the children would have helped the IRD decision-making. The changes made by police and social work to address these issues were referred to in section 7 (i.e. improved management of, and response to, domestic abuse referrals; and more rigorous checks now undertaken by social work staff)

9.2.2 Other more general changes relevant to Brandon are covered by the inter-agency improvement plan in response to the HMIE joint inspection report. It is not appropriate to cover these in detail here. However I welcome the inter-agency commitment to provide supervision, staff development and support to all professional staff involved in child protection.

9.2.3 Similarly, I welcome the inter-agency commitment to fully implement a framework for integrated assessment that has single agency assessment activity as its starting point. This is consistent with GIRFEC principles, and will I believe, make a significant contribution to ensuring the safety of Dundee's children and young people.

9.2.4 The Evidence Based Assessment Framework produced by the social work department notes that all professional meetings including Initial Referral Discussions will be minuted and include an action plan with timescales and named person responsible for progressing each action. This represents an improvement on the previous guidance on IRDs. I am aware that there is work ongoing to improve the management of IRDs and I will refer more fully to IRDs in the section on recommendations.

9.2.5 The standard of agency recording has been a theme running through this report. The strongest evidence of effective recording was in phase 2 and related in particular to the social worker's records with respect to Y and Z. A clear focus had been maintained on the children's needs, and it was evident from the records that regular discussions on the case had taken place in supervision between the social worker and her team manager. Case records were regularly signed by both staff.

The records of the health visitor attached to the family between October 2007 and February 2008 were also of a good standard.

9.2.6 However, I found the standard of record keeping generally to be below an acceptable standard. This made it difficult to understand the focus of work with M and her children. In period 3, I found examples of important discussions not being recorded on case files. The response to the graze on Brandon's face illustrates this. There was no mention at all in the social work case notes, and the health visitor records did not reflect the discussion which had obviously taken place. There were other situations where information had been recorded on C's file but not on Brandon's. All agencies need to ensure more detailed recording, particularly of critical issues.

10 Conclusions

10.1 In all of the interviews undertaken with staff, I stressed that I had the benefit of hindsight. Anyone reviewing events after a period of time has the advantage of having the whole set of records of contacts to refer to. These can be laid out at the one time, checked and cross referenced. They provide a picture that is more comprehensive than any one worker could have had while directly involved with the family.

10.1.1 It is probably impossible not to be influenced by the knowledge of what happened to Brandon and as the reviewers of Carla Nicole Bone¹² noted:

When one is aware of the tragic outcome for Carla, some of the information takes on a significance that it was unlikely to have had at the time when it was first gathered and recorded.

10.1.2 The workloads of the health visiting team and the social work access team throughout the period were high. They also both faced significant staffing pressures and vacancies. The decision by health managers to transfer 'vulnerable families' from Lochee Health Centre to other surgeries in Dundee was an understandable attempt to address staffing shortages. However, it meant discontinuity of service for the families concerned.

10.1.3 Experience suggests that the most vulnerable families can also be the ones who give most cause for concern, and the most hard to reach. They are the families who require familiar faces and continuity of care to help develop trust, to reach a point where they may feel able to disclose domestic abuse or drug misuse.

If such action proves necessary in the future, I would recommend that help is transferred in rather than families transferred out. In this case it had the unintended consequence of severing local, informal intelligence between health visitors on P's relationship with R, when P's case was transferred to another practice.

Details on M's lifestyle and domestic circumstances were scant. There was no information about the role of Brandon's father within the family. Both M and her parents had alleged that the relationship between M and Brandon's father was a volatile one. It should be stated that no such information had come to the attention of any of the statutory agencies. Thus, it was not known, for example, whether M feared him. The housing officer had no knowledge of him or contact with him and he was mentioned only in passing within health records. When maternal grandmother contacted the social work access team in February 2008 she was particularly concerned that the children should not be exposed to any *further* volatile relationships i.e. through M's new relationship with R. This was the first reference to any alleged volatile relationship in respect of Brandon's father being shared with any agency.

10.1.4 The presence or absence of a partner is significant for both the adult and the children in a family. Some exploration of the changes in relationship of M and Brandon's father could have helped offer a better understanding of M's care of the children and whether the separation increased M's vulnerabilities and consequent ability to protect her children.

10.1.5 On the single occasion when I met M, she described as her greatest regret that she had not asked the social work department for help and support when she was experiencing difficulties in her relationship with Brandon's father, J.

She said she had not asked for fear that her children would be removed from her. M also said that some of the arguments between her and J had been witnessed by neighbours but no one had ever intervened.

All of this serves to highlight the fact that statutory agencies are dependent upon receiving and sharing information if they are to act to protect vulnerable children who may be at risk. The information may come from the family or a neighbour, or other services. In M's case when the neighbour did come forward, the information was acted upon.

10.1.6 The extent of M's own parenting capabilities was also unknown. Little was recorded in detail of her interactions with her children, or of the state of her flat. Although there had been an early mention in the access team write up of the grandparents being supportive, this was never spelled out in any detail. Grandmother had referred to M's lack of confidence, linked to her learning difficulties, but this was not explored further by the social worker.

10.1.7 Throughout the period of M's contact with health visiting and social work services, there were some opportunities for more formal sharing of information. For example, in summer 2006, several agencies were beginning to have concerns about M and her children. Whilst not of a nature that required immediate protective action, a full sharing of information could have led to a more coordinated approach and a plan for the future care of the children.

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These opportunities were not taken but there were no indicators that M and her children were in the at risk category. M appeared to have been competent enough in her parenting of the children not to come to any agency's attention. Both health visiting and social work staff consistently stated that M and her children did not stand out, and that there were many more worrying families on their caseloads. Whilst there were ongoing concerns, these never reached a threshold which prompted more formal intervention until shortly before Brandon's death.

10.1.8 Maternal grandparents supported her and also protected her. This perhaps prevented them telling agencies that M had dabbled in drugs around end of 2006 when she had a separation from J and perhaps also stopped them telling anyone on her behalf, or their grandchildren's, that this relationship, in their view, was volatile. The grandparents spoke powerfully of a protective net of support around M and the children.

M appears to have used this very effectively and appropriately until her relationship with R led to the first ever estrangement from her parents.

10.1.9 There had been different concerns about M's parenting from the birth of her first child, and attempts made by agencies to offer support to help M manage. She mostly chose not to take these offers up, preferring instead to utilise the support of her parents. Developmental checks on both children had been normal with no concerns identified.

Although she had failed to attend for immunisations with Brandon, these had all been followed up and completed, some with maternal grandmother's help. M had also shown herself to be responsible in taking C to A&E and also to the GP when she had been concerned about her well being. On the surface, M was coping better than many other parents, and unlike many other parents known to the statutory agencies, enjoyed the extensive support of her own parents.

10.1.10 At different stages of involvement with agencies, M appeared to cooperate and accept agencies' concerns. She attended the family support centre in 2006 following referral by the health visiting team. She turned up at the Charleston family support centre the day after being seen for an office appointment in November 2007. M did the same again at the Douglas family support centre on 28 February 2008. This gave workers a sense of optimism that she recognised the concerns for the vulnerabilities of her children. With hindsight, this was only partial compliance, and there was no robust managerial oversight or supervision in place to challenge workers' optimism. Additionally, her contacts with social work were responded to as discrete, one off events.

10.1.11 When Peter Wilson and I met with M she acknowledged that she had used drugs and had been involved in prostitution for some time; the frequency and timescales were unclear. She was skilful in managing to hide this from the agencies involved with her, and also managed to conceal this from her own parents and wider family.

10.1.12 The family was not on an 'intensive' health visiting programme, and there was little consistent or sustained contact throughout 2007.

Given the volume and nature of other work which the health visiting team was faced with, linked to substance misuse and the protection demands arising from this; the demands upon staff (*concentrate on your intensive cases/ prioritise your priorities-health*), then it was entirely consistent that Brandon was not on the radar.

The visiting pattern would only be changed if there was a change in family circumstances and this was brought to the attention of the health visiting team. This is what happened when the family support centre manager informed the health visitor in February 2008 of the most recent referral from housing.

10.1.13 If the full information had been available from police and social work to the IRD, this *may* have led to more pro-active involvement with M and R which challenged them both and *might* have led to an insistence on closer involvement with the children. This is said with the 'benefit' of hindsight, and can only be based on speculation. In reality, this only covered a period of 17 days until Brandon's death.

10.1.14 I recognise that in revising and updating the work on the Evidence Based Assessment Framework, social work managers have already sought to strengthen the structure around initial referral discussions. This has included allocating some much needed extra administrative support to these meetings.

The ethos underpinning the IRD process in Dundee is a sound one and in this case, it allowed police, health and social work staff to come together at less than 24 hours notice to decide how best to proceed on the basis of the information shared at the meeting.

10.1.15 This IRD was unusual in that it was not considering a specific incident or allegation. It involved consideration of a shift from family support to more formal intervention of a child protection nature. Indeed, whilst staff who attended the IRD recalled that there were no alarm bells ringing, they also recognised that the attempts to engage M voluntarily had been unsuccessful, hence their unanimous decision to convene a child protection case conference.

10.1.16 I think there would be merit in reconsidering the management of those IRDs where there is no specific incident, but concerns based upon changes in family circumstances.

In these instances, more senior personnel from the relevant agencies should become involved to ensure greater oversight and objectivity of the family's circumstances. The establishment of 3 further Advanced Nurse Practitioner posts in Dundee offers a clear opportunity to NHS Tayside to be more fully represented in these meetings. Clearly this will require further detailed consideration and discussion by relevant inter agency managers.

10.1.17 The lack of any substantive information about R is particularly telling. Although his short involvement with M and her children had such far reaching and tragic consequences, little of any substance is known about R, his past, or his previous relationships. He remains a shadowy figure throughout this report.

During his involvement with P, the significance of his failure to start the fathers' group in September 2007 was not recognised or acted upon.

From interviews with staff, it would appear that attempts to get him to start the group in January 2008 were often conducted through P rather than directly with R. There is a real danger that abused women, as well as being held responsible for the protection of their children can also be held responsible, albeit unwittingly, for the behaviour of their abusive male partner.

10.1.18 Dr John Devaney helpfully addresses this point, referring to the need¹² for a clearer refocusing of professional effort which holds men accountable for their violent behaviour. His findings refer to a study conducted on children in the child protection system with long-term and complex needs as a result of experiencing domestic violence. The paper argues persuasively that Government policy and professional practice should primarily be concerned with assessing *the risk that men present, rather than the risk that children are at*. Such an approach is likelier to challenge men to accept responsibility for their behaviour and the consequences for their families. The Dundee authorities should reflect this thinking in future training on domestic abuse.

10.1.19 There was nothing that stood out from the events of the last weeks of Brandon's life which could have signalled the violence that he was to suffer. (On the last occasion when Brandon was observed for any length of time in R's company i.e. the office visit on 27 February 2008, he was seen to be at ease with him, and not at all fearful). There were no indications either of the likelihood of such a significant violent occurrence. The only indication of this came from the post mortem, when the full extent of R's violent outburst became apparent. Similarly, there were no external reports or police intelligence that linked M to prostitution or drugs, and which made her less protective of her children.

10.1.20 Equally, in all of M's contact with statutory agencies (health, housing and social work), there was no evidence either of a chaotic household or lifestyle that suggested the needs of her children took second place to their mother's dependence on substances.

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10.1.21 The actual circumstances surrounding R and his short time as a member of the household with M and her children, left little opportunity for the authorities to prevent the fatal assault on Brandon.

10.1.22 From my extensive consideration of information from records, from scrutiny of policies and procedures, and from discussions and interviews, I have reached the conclusion that Brandon's death, which was caused by R, could not have been predicted.

11.0 Recommendations

11.1 My remit for the SCR was to assess the agency and inter-agency discussions and decision making with regards to Brandon and others significant to his case; and to establish whether there were any lessons to be learned about keeping children safer. I have not identified any areas which require wholesale changes. My recommendations are specifically targeted at strengthening identified gaps in practice or procedures that could leave children exposed to risks.

I have not replicated any actions relevant to Brandon's circumstances where the Dundee authorities have already addressed these in the improvement plan in response to HMIE.

Case conferences

11.1.1 *All agencies must ensure the most up to date information is available to the case conference.*

11.1.2 *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.*

11.1.3 *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.*

11.1.4 *All review case conferences should ensure consideration of key issues raised in the Core Group meetings.*

11.2 Initial Referral discussions

Any revision of the inter agency guidance on IRDs needs to clearly state that the IRD is part of the critically important process of protecting children, and not a one off event.

11.2.1 *An IRD should be considered where there is a cluster of concerns in relation to child care and domestic violence.*

11.2.2 *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.*

11.2.3 *Social work checks will also be made of other agencies, such as SCRA, housing, and substance misuse services.*

11.2.4 *Where a health representative is attending an IRD, they will be responsible for undertaking relevant health record checks.*

11.2.5 *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.*

Adults who cause concern

11.3 *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 the children.*

11.3.1 *Social work must ensure that adults who cause concern are cross referenced with any known contacts and recorded on the social work database.*

11.3.2 *When social work staff are undertaking an assessment, they will carry out full system checks on adult members of the household.*

Social work access team

11.4 *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 referenced as appropriate.*

11.4.1 *Where a referral involves a pre school child, the social worker will always contact the health visitor as part of their response.*

Police

11.5 *Tayside Police should reinforce the need for Family Protection Unit staff to produce up to date and accurate information to case conferences and IRDs.*

11.5.1 *Tayside Police should reinforce officers' awareness of the Force guidelines on Domestic Abuse.*

11.5.2 *Domestic abuse referrals should be graded and clearly specify where children were actually present in a house when an incident took place.*

Health

11.6 *NHS Tayside should ensure there is a system in place for tracking requests for reports from or referrals to SCRA.*

11.6.1 *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.*

11.6.2 *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.*

Monitoring changes

11.7 *All agencies must ensure that their self evaluation and auditing tools collect the relevant information to monitor their effectiveness in keeping children safe.*

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11.8 *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.*

Resources

11.9 I fully endorse the commitment by the Dundee CYPPC member agencies to continue to implement and expand

- *a multi agency staff development programme*
- *a framework for integrated assessment (actions 10 and 11 of the Inter-agency Improvement Plan, June 2009)*

and recognise that such assurances, as with other actions, will also need to be resourced.

All agencies need to ensure that they have skilled and well supported workers in place, with the necessary capacity and time to be effective in their work with vulnerable children and their families. Chief Officers and senior managers across the agencies need to listen to their staff and involve them actively in any changes to the service. Senior managers need to ensure that any resource issues or gaps in service are made known to chief officers, elected members and health and police board members.

It is essential that the Chief Officers' Group accepts responsibility for the sufficiency of resources available to keep children safe. This is not solely about financial resources, but also the confidence, morale and authoritative practice of their staff. Procedures, policies, guidelines and assessment frameworks are all vital components of effective practice in the complex task of keeping children safe. The most important resource however is the staff.

Jimmy Hawthorn
August 2009

Notes

Part 2

Independent Review for Chief Officers

Part 2 Independent Review for Chief Officers

OBJECTIVE

1 To ensure public confidence in local child protection services is maintained by engaging an independent assessor of experience and standing to consider all information emerging from the Significant Case Review (SCR) relating to the death of Brandon Muir, to confirm the recommendations made, make any additional recommendations, and to oversee implementation of recommendations confirming progress publicly as required.

An Overview

2 From an early stage of my involvement in this Review, I considered whether the principles of the current Scottish policy on child protection *Getting it Right for Every Child* provided an opportunity to approach my work from the viewpoint of Brandon Muir. While such an approach could provide a legitimate set of questions to the Dundee child protection authorities, I recognise that a report in that format would not only require questions to be asked of a community much wider than the statutory authorities, it also runs the risk of sensationalising the nature of the report, and losing the potential benefit of the analysis. Brandon's unspoken questions still have a relevance however.

3 My work was, in significant part, in support of the Significant Case Review (Part 1) undertaken by Jimmy Hawthorn. My remit however, was to expand upon the particular case of Brandon Muir, and to consider emerging issues in a wider context. In due course I will also provide comment on the Action Plan to be prepared in response to the Review, and in a timescale yet to be finalised, provide an independent report to the Chief Officers Group on the completion of and the outcomes from that Action Plan.

4 In fulfilling the objectives set for me by the Chief Officers Group I have, since my appointment, worked alongside Mr Hawthorn, and agreed with him how he might involve professional support in his interviews of staff involved in the case, who come from different professional disciplines and organisations. While I have not been present at all of the interviews, I have been present at key sessions and have participated in the discussions with lead officers from Dundee City Council Social Work Department, Tayside Police and NHS Tayside. I have detailed my methodology more fully elsewhere in this report.

5 Mr Hawthorn and I also engaged an external Reference Group, with recent or current experience of Child Protection matters at a strategic executive level, with whom we benchmarked our information gathering, analysis and recommendations to ensure relevance and proportionality in both the local and national context. Accordingly I believe the combination of the two studies, and the recommendations, can be viewed as having independence, rigour and relevance, notwithstanding that they were commissioned by the Dundee authorities.

6 As my work commenced at the conclusion of the criminal trial of Robert Cunningham and Brandon's mother, an announcement was made that the publication date for the HMIE led joint inspection of child protection arrangements within the Dundee City Council area was to be brought forward. That Inspection Report was published on 23rd June, and while the two pieces of work were carried out separately, I maintained appropriate contact with the lead officer to ensure unnecessary complications of overlapping enquiries were avoided for the sake of the staff in Dundee, and to ensure that the family understood the distinction between the investigative work involved, given the anticipated level of media coverage.

Findings

7 In accordance with my remit I am in a position to endorse and support the findings, conclusions, and recommendations contained within the Significant Case Review as detailed in Part 1 of this Report.

8 My additional recommendations appertain to the following areas

- Clarity of Leadership and Joint Working
- Information Sharing and Assessment
- Management of Initial Referral Discussions (IRD)
- Community Nursing
- Domestic Abuse
- Training

I provide a short introduction to these recommendations below. Fuller analysis is provided within the report.

9 Two further Observations relate to the workings of the Children and Young Persons Protection Committee (CYPPC) with regard to

- Procurator Fiscal Liaison
- Welfare Support for Joint Teams

Clarity of Leadership and Joint Working

10 As in all local authority areas, a shared responsibility is held for Child Protection, involving the three main statutory authorities (Dundee City Council, NHS Tayside and Tayside Police), and the Children's Reporter, the Procurator Fiscal and some voluntary sector participation. A full time lead officer is responsible for the mechanics of the meetings, policy documentation and advice. The multi-agency Child Protection guidance documents are of a good standard, the CYPPC has to its credit commissioned a number of reviews on processes and sought to implement the findings, and yet there are sufficient examples of a lack of cohesion in understanding the experience of front line staff, to cause concern as to the effectiveness of the leadership given through the Committee. An example of this would be that different organisations made plans in isolation as to how they would deal with pressures of resourcing rather than discussing how these plans might impact upon other services, or how they might work more collaboratively to cope with the pressures being faced. There are a number of actions listed within the Improvement Plan which has been published in response to the HMIE Inspection which will go a long way to address this matter, but it is perhaps indicative of the existing approach that staff in each organisation were briefed separately on the findings of HMIE, rather than the opportunity taken to set a new tone by arranging joint briefings. The Chief Officers Group needs to do more than monitor the implementation of the plan, it needs to demonstrate ownership and set the agenda for advancing child protection in Dundee.

Information Sharing and Assessment

11 In recent years there has been a government-led policy initiative to reduce the overall number of cause for concern referrals made to the Children's Reporter. This is in large part because the Reporter has been increasingly overloaded with referrals with widely varying degrees of risk (impacting on the needs of the child).

The sheer volume created unacceptable delays in the collation of information upon which a decision could be made. While the Getting it Right for Every Child policy agenda has attempted to create a common approach to the needs of children at risk, the step change in reduced referrals to the Reporter is raising another issue across Scotland which is relevant to the Brandon Muir case. The Scottish Children's Reporter Administration (SCRA) still retains the unique statutory authority to require information from the local authority upon which a considered judgement can be made. With the understandable pressure to reduce referrals, child protection partnerships are now trying to find more effective mechanisms to pool information, and to make earlier assessments in the interests of the child. Different models are emerging across Scotland, and it would appear that some real improvements can be identified. However there remain significant problems in inter agency cooperation through a lack of shared language, threshold levels, and approaches to risk. This is a national and local issue.

12 In the Brandon Muir case, as in many others, information was identified, recorded and passed but principally on an event by event basis, rather than being developed within the source organisation. In addition, the lack of shared chronologies, using common language, meant that information was not conveyed accurately between those with an interest in the same families.

13 It is encouraging to note that with the progression of national computer systems to support the management of vulnerable people, such as E care, and the Vulnerable Persons System, multi agency workshops on a national scale are being organised to develop national standards.

Management of Initial Referral Discussions (IRD)

14 A key stage in decision-making concerning Brandon and his family was the Initial Referral Discussion held on 28th February 2008. It has to be understood that the decision that such a discussion was necessary was based upon the prompt professional assessment of a senior social worker who was concerned about a change in behaviour and attitude of Brandon's mother, and immediately decided that further information was necessary.

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The IRD was held within 24 hours and attended by staff from Social Work, the joint police/social work Child Protection Team, and the family Health Visitor. While some of the information presented by the police to that meeting was found to be lacking in accuracy, and fuller Social Work and Health information regarding Robert Cunningham was not brought to the table, the meeting concluded that there were sufficient grounds to call an early Child Protection Case Conference. As is reported in the Significant Case Review, the lack of an agreed approach to the management and record keeping of IRDs in Dundee exposes the question as to whether more immediate steps to gather information, or to continually assess the needs of Brandon and his sibling might have led to more immediate child protection activity.

15 While there is minimal guidance on IRDs in the Dundee policy documentation, we have seen an example in existence in another area (which we have shared with the Dundee authorities), which provides for a much more effective process. I have raised with Scottish Government a recommendation that future national guidance on child protection matters ought to point to good practice in relation to the management of IRDs.

Community Nursing

16 It is important to be clear that the death of Brandon Muir was not in any way consequent of the involvement of NHS Tayside as a pilot site in a changed national policy on community nursing. However, prior to Brandon Muir's death, significant resource issues had been raised by nursing practitioners in Dundee about the capacity of Health Visitors to cope with the demand appearing in their caseloads. In pursuing this matter further a number of concerns emerged.

17 While management had taken steps to address the concerns raised, staff remained of the opinion that not enough was being done. In addition, by allocating some of the cases from areas of high demand to Health Visitors from other GP Practices, a consequence was that new problems of information sharing emerged. In this case, child protection information concerning another family with whom Cunningham had been living was not immediately available to the Health Visitor attending the IRD, nor did it appear to have been identified in time for sharing at the child protection case conference which had been scheduled following the IRD.

18 The policy change 'Visible, Accessible And Integrated Care' which focuses on the merging of traditional roles in Community Nursing to a 'generic' Community Health Nurse role has an understandable logic, however it raised real concerns amongst practitioners in Dundee. In addition, anecdotal evidence from both practitioners and management of the training of the Public Health Nurse qualification (introduced in 2001), highlighted dissatisfaction that there was insufficient focus on child development and assessment.

19 In response to the HMIE report, NHS Tayside has indicated that they intend to add significant resources to the 'Health Visitor Teams' across Dundee, are implementing a process of mandatory supervision for child protection cases, and restructuring the Service to better align boundaries with local partners. However they have found it difficult to recruit additional Health Visitors (in part due to the change in training arrangements which followed the policy change), and intend to build the teams with staff nurses. A question remains as to the capacity of nurses trained and experienced in child protection and assessment, and in implementing the Improvement Plan, the Chief Officer Group will need to seek evidence that the difficulties experienced in recent years have been effectively addressed.

20 On 27th June 2009 it was reported that the Cabinet Secretary for Health has decided not to pursue any further merging of community nursing roles in Scotland, and intends to look at other ways of modernising the sector through the formation of a Modernising Community Nursing Board. Government support will however continue to be given to those pilot sites who wish to develop the model further, and NHS Tayside has advised staff of an ongoing programme for Staff Nurses to allow further training to be given and evaluation to be completed. This will be an area I will be keen to revisit in my follow up to this Review.

Domestic Abuse

21 There is a recurring feature of domestic abuse within the sequence of relationships described in the Significant Case Review. Both the individuals themselves, and their families, accept or acknowledge the turbulent environment within which the children were living at various times.

While the police were sometimes called, and descriptions of alleged events appear in social work case files, it was as often the case that violent events went unreported or recorded, or if they were reported the judgement at the time was that no action was necessary by the authorities in relation to the adults involved. Referrals about the children were sometimes made by the police to social work. The importance of keeping the children at the forefront of consideration is discussed later in this report.

Training

22 Child Protection is much enhanced where management and practitioners work together. Team work needs team training – and yet in Child Protection, joint training spoken of by staff appeared to be restricted to specific skills sets. I recognise that the individual organisations have many other responsibilities in addition to child protection, but there is a clear need to ensure staff train together, not just on skills sets, but on the practice of child protection, so that there is a shared understanding as to how information is shared within organisations, how it is managed, what happens when a referral is made. Lord Laming identifies the importance of this matter in his recent report ‘which followed the death of Baby P. *‘Multi-agency training is important in helping professionals understand the respective roles and responsibilities and the procedures of each agency involved in child protection, in developing a joint understanding of assessment and decision making practices’¹*. The CYPPC has shared with me details of current interagency training, and while it is encouraging to see the existence of training programmes on working together, more needs to be done to ensure the attendance of operational staff and managers.

Observations

Procurator Fiscal Liaison

23 The District Procurator Fiscal is represented on the Dundee Children and Young Persons Protection Committee (CYPPC). However it does not preclude his office from acting independently, under direction from the Crown Office in matters of criminal investigation and the prosecution of cases.

24 During the Review it became apparent that some significant and practical issues emerged following the death of Brandon Muir, impacting on related matters of child protection, and in the management of staff who were later to be cited as witnesses in the trial at the High Court in Glasgow. There is already guidance in relation to the conduct of Significant Case Reviews where interdependencies around criminal investigations and court proceedings arise.² It would appear to an independent observer that it would be sensible to agree the structure of some form of ‘critical incident management group’ as a subsidiary of the CYPPC that might agree local guidance on areas such as critical incident debriefing, management of press releases, the conduct of pre-trial management reviews and other matters that emerge. The agreement as to when such a group should be established (i.e. in the immediate aftermath of any incident) would not impinge on the roles of individual organisations, but would be consistent with the partnership approach, and is likely to be beneficial to both management and staff alike. Having discussed this matter with the local Procurator Fiscal’s office and Crown Office representatives, I understand that discussions will take place to adopt such an approach with Child Protection Committees in all areas of Scotland.

Welfare Support for Joint Teams

25 It is clear that the tragic death of Brandon Muir has had an impact not only on his family and the community, but also on the professional staff involved, many of whom have been deeply affected by the case. In our enquiries it became apparent that notwithstanding the partnership approach to Child Protection, there was no shared approach to staff support. I am familiar with a well recognised approach to group critical incident debriefing which follows quickly after a significant event (often a fatal incident). This is not about determining what happened or how it happened, but is undertaken as an early form of staff support and often leads on to further support if necessary. In this case staff were dealt with differently in different organisations, and yet were expected to continue to work together thereafter. It would seem sensible for the CYPPC to agree a common approach to be adopted not only in cases of child death, but in other serious cases of child harm.

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Methodology

26 I was invited by the Chief Officer Group representing Dundee City Council, NHS Tayside, and Tayside Police to undertake a Review of the Brandon Muir case in the following terms:

To assist with and enhance the Significant Case Review procedure, initiated by Dundee Children and Young Persons Protection Committee, following the death of Brandon Muir and specifically:

- *Critically consider all information contained in the report by Mr J Hawthorn, give opinion on the extent to which that review has covered all necessary factors and issues, confirm recommendations you consider relevant and make additional recommendations as you deem necessary;*
- *Review the action plan prepared by Dundee Children and Young Persons Protection Committee on the basis of the recommendations made*
- *Provide critical comment on the proposed timescales within which recommendations may reasonably be completed taking account of factors including importance and complexity;*
- *Monitor progress towards achieving recommendations and provide public comment as considered necessary;*
- *Confirm publicly that all recommendations have been discharged or otherwise*

27 My work commenced following the conclusion of the High Court trial at which Cunningham was convicted of the culpable homicide of Brandon Muir.

My objectives in carrying out the Review were not only to ensure a rigorous examination of the circumstances, and the publication of an informed report from which an understanding could be had of the circumstances leading up to the death of Brandon with recommendations where appropriate, but also to ensure that the close family, the staff involved from the statutory authorities, and other stakeholders were kept informed. The maternal grandparents of Brandon, and frequently carers for him and his older sibling, were helpful when they set out their expectations for the review work – “to explain what happened, and if possible to prevent such a tragedy happening again”

28 I was conscious that the Significant Case Review (SCR) had been commissioned at a much earlier point, although progress had been delayed by the need for witnesses to give evidence in Court prior to speaking with the enquiry. In conjunction with Mr Hawthorn, who was carrying out the SCR, we agreed a method of working that provided professional support to his interviews of staff in each of the disciplines, and avoided duplication of enquiry. Where appropriate I was present at his interviews with staff and family members. Together with Mr Hawthorn we reconvened a meeting of the staff involved in the Initial Referral Discussion on 28th February 2008, which proved to be valuable in gaining their reflective and collective understanding of what was discussed at that meeting, and how (with the benefit of hindsight) a more informed meeting might have taken place. We also discussed how the follow up to that meeting might have been better planned and managed.

29 Another feature of my review was to establish whether anyone within the statutory authorities, but not known to be involved in the Brandon Muir case, or in the public at large, had a contribution to make to the Review. A description of my role and my contact details were circulated widely within the three authorities, and with the assistance of the local media, my contact details were repeatedly put into the public domain in association with relevant news coverage. As a result I was approached by two members of the public and one staff member who were not involved in the case, but who had a relevant contribution to make. I have spoken with each of them and their helpful contributions have been taken into account.

30 Mr Hawthorn and I have maintained close contact with the immediate family, and have interviewed relevant family members including Brandon’s parents. The family have been given advanced access to the Review findings.

31 Given the wider public interest in child protection matters, and the personal commitment given by Scottish Ministers, I have maintained contact with Government Departments and the relevant Inspectorates, namely the Social Work Inspection Agency (SWIA) and Her Majesty’s Inspectorate of Constabulary. While the Brandon Muir review, and the work of the joint inspection (HMIE) of child protection in Dundee which was published on 23rd June, were distinctly separate and independent areas of work, I have maintained appropriate contact with the HMIE team.

I hope that the Review findings will be capable of being managed in conjunction with the recently published Improvement Plan, although my continuing commission requires me to provide future comment on the response to the Review findings, and to monitor implementation of the resultant plan.

32 It is a sad fact that the death of Brandon Muir is neither the first, nor is it likely to be the last case where a child, known to the statutory authorities, suffers injury or death at the hands of those who have custody or care for them. Equally, the policies of the Dundee authorities do not stand in a vacuum. I have spent some time therefore considering the learning from other reviews of this sort, and in exploring the national policy environment on child protection. I have also taken account of practice elsewhere, and the work of some of the organisations that also play a supporting role such as the Drug and Alcohol Action Team, and external organisations that provide training.

33 Finally, Mr Hawthorn and I recognised from an early point, that having been separately commissioned by authorities in Dundee, it would be helpful to be able to demonstrate that our work had been tested against an objective framework. To that end we commissioned an external Senior Reference Group, comprising an executive director of Social Work from another authority, a chief constable, and recently retired chief nurse. Their purpose was to provide some scrutiny of our approach to information gathering, and to offer comment on the proportionality and relevance of our findings and recommendations. I am most grateful to them for their wise counsel.

Validation of Significant Case Review

34 In accordance with the primary requirement of my remit I can confirm that I believe the Significant Case Review has addressed all the relevant factors and issues relating to the circumstances leading up to the death of Brandon Muir. I support the recommendations made, and in this report I amplify some of those, and suggest some wider matters that ought to be considered by the Dundee Authorities or Scottish Ministers.

35 The sequence of events in this case is as set out in detail in the Significant Case Review. I have therefore not replicated the details here. It is worth emphasising the point however, that the critical period of this case is different from the majority of others, where the death of a child comes at the end of a long period of engagement between the statutory authorities and the family.

36 While the Inquiry has revealed a number of areas of policy, practice and approach, where improvements are required, the critical period in this case extended to only three weeks between the time when Brandon's mother began her relationship with Robert Cunningham and removed her children from the safety of her parents' home, and the time of Brandon's death. Up until the point where Robert Cunningham became involved with the family, neither the statutory authorities, nor the maternal grandparents would have suggested that any significant risk of harm existed for Brandon or his sibling.

37 Not only was this a very short timescale, but it was also peppered with a variety of contacts, scheduled and unscheduled, (including participative attendance by Brandon's mother with Brandon at the GP Practice), where experienced professionals made honest judgements on the basis of their belief that Brandon was not at risk of significant harm.

It is worth emphasising the supportive role which the grandparents played throughout Brandon's life, which in my view, negated the need for the statutory authorities to become more involved with a mother who would otherwise have had significant difficulties in managing an independent lifestyle with two young children. Her involvement in prostitution, and her drug taking were not known at this time.

Analysis

38 In this section I cover those elements of the Child Protection arrangements which have arisen during the Review. It is not an assessment of the overall provisions in Dundee, which was recently the subject of the HMIE led inspection, but there are parallels and overlaps within both findings.

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Independent Review for Chief Officers

Clarity of Leadership and Joint Working

39 The responsibility for Child Protection has to be a shared one at all levels. Policy statements at a local and national level in recent years have reinforced the message “It’s everyone’s job to make sure I’m alright”, and “Getting it Right for Every Child” (GIRFEC) are but two examples.

40 In Dundee the business of the Children and Young Persons Protection Committee (CYPPC), the work of the Drug and Alcohol Team, and the variety of reviews and studies commissioned to identify best practice and implement improvement provide good evidence that from a policy and practice perspective, management has been keen to do its best. However there is also evidence that difficulties existed in turning that commitment into meaningful cooperative effort.

41 In my experience, gained in youth justice, criminal justice boards and in community planning, inspiring leadership is needed in setting clear objectives and ensuring that teams work together and not separately. Everyone will tell you that such leadership is only effective if it comes from the top.

42 In Dundee, two of the key agencies, namely Tayside Police and NHS Tayside, cover three local authority areas, while Dundee City Council covers only its own authority area. Identifying the best model to bring the Chief Executives together is not straightforward, and I understand that a proposal to frame a strategic group for public safety issues across the three Tayside local councils with Health and Police is being considered. This discussion will also need to take account of the other contributors to child protection such as the Procurator Fiscal and the Children’s Reporter.

43 Until that wider issue is resolved however leadership in Dundee needs to be addressed. I was pleased to learn that the Improvement Plan published in response to the HMIE Inspection sets out arrangements for regular meetings of the Chief Officers Group. This Group needs to earn recognition amongst the staff of the different organisations that it is indeed a joined up and visible leadership group, not only a group meeting to review a plan.

44 I will be interested to see how the agendas for these meetings develop, as they will set the tone for the future. If Child Protection is going to be a team effort in Dundee, there needs to be a sharing of ideas and issues. Teams work together and not as a collection of individuals. For instance, the Police should be consulting with Social Work colleagues on categories of cases where referrals will be made, Health should seek support and cooperation in managing the pressures on health visiting resources, and Social Work should ensure the changes to their procedures involving the Access Team are understood by partner agencies. Partners should not be setting policies or changing procedures which impact on child protection in isolation from each other.

45 Communication is key to both external and internal audiences. The Chief Officers Group can ensure that the messages they send out are evidently ‘joined up’ and not separate for each organisation. As importantly, they can also ensure that they create shared opportunities to hear from the staff about the impact of the Improvement Plan, and the qualitative difference it is making. There seems to have been limited such opportunities in the past, and yet the experience and ideas within the practitioners can provide a valuable resource for continuous improvement.

Information Sharing and Assessment

46 A recurring finding of all reviews will be a reference or recommendation on information sharing. In these days of continually developing computer systems and increasing access to mobile data, the public expectation is that anybody should be able to receive a result as fast and as helpful as can be achieved through Google, so why do public services apparently fail? In truth they more frequently do not, but of course instances of successful information sharing, and informed decisions correctly made on the basis of disciplined work by professionals are rarely the subject of review or notoriety. And yet the good cases will outnumber the bad many times over. However, that is not a justification for complacency, and the Significant Case Review highlights to the Dundee authorities where improvements can still be made.

47 The death of Brandon Muir took place at a time when public authorities across Scotland were trying to find a solution to the problems resulting from an overburdening of referrals to the Reporter to the Children’s Panel (SCRA).

Indeed they still are. It could be argued that too much information is being 'shared', so that the dilemma lies in sorting out the categories of risk, and finding good mechanisms to counter or manage that risk. Referrals where compulsory measures of care need to be considered, still need to be made to the Children's Reporter, but it is in the many cases where that the threshold has not been so clearly reached, that the problem of managing volume critically lies.

48 The Scottish Government has been seeking to provide a solution through GIRFEC, which has been implemented and tested in the Highland Council area. Finding an effective model to meet the needs of children and young people whom the policy is designed to support and protect, also requires that the sustainability question is satisfied, and that inevitably raises the question of resources. While a series of interim reports, and briefing seminars have been conducted since the project was initiated in 2007, there is as yet no final report or evaluation, nor are there agreed national guidelines. As a result public authorities across Scotland have sought to pursue the principles of GIRFEC, while creating local solutions. In Dundee, the earlier interventions by partner organisations necessitate additional resource in that part of the process. These have not always been easy to agree to or provide.

49 However the volume of referrals continues to rise, and finding a solution in one area can create a problem elsewhere.

50 The legal authority to gather information from partner agencies and the responsibility to decide on further measures in relation to a child remains largely in the hands of the local Children's Reporter. Developing alternative local solutions relies on organisational co-operation rather than the clarity of regulation. The change in process away from referring cases to SCRA, but taking responsibility to manage cases within the other agencies, can and does create new challenges.

51 The Improvement Plan has formalised recent arrangements where Social Work and Health can discuss cases where referrals between organisations have proved problematic. This should provide a solution to the difficulties which exist where health and social work have differing definitions of thresholds of risk.

52 In August 2006, Tayside Police, in conjunction with the social work Child Protection Team at Seymour Lodge, including representation from health and education, introduced a weekly meeting at which they presented all the new child concern cases which had come to police attention in the previous seven days. Hitherto these cases may simply have been referred to SCRA. The weekly meeting allows a discussion on relevant family information to be brought forward by other agencies and a decision made on further action. This has been a very constructive step, as initially it was only the police who brought forward names. There is now a desire to extend this approach to other partners but the issues are complex. In developing an agreement on an extended model the Dundee authorities recognise that it is critical that all those involved have shared understanding of the purposes of what has been described as 'pre-referral screening'. This will prevent the children and their families becoming a subject of a process, rather than facilitating properly considered judgement, and deciding on action where necessary. It is also recognised that an extended process will bring additional volumes to the table, raising questions of available resources. This is a critical area, and the authorities in Dundee are actively considering this matter as part of the delivery of the Improvement Plan created following the HMIE inspection. The Chief Officers Group in Dundee will need to monitor these arrangements to ensure they are effective, and that the consequence is understood by all partners to the CYPPC.

It is important to stress that these problems are not specific to Dundee, and are facing all child protection authorities across Scotland, as local services continue to seek ways of supporting the apparently growing number of children and young people at risk through unstable family settings, domestic abuse, or substance misuse. The GIRFEC approach is recognised nationally as reinforcing a shared responsibility across agencies, and while positive signs are emerging from the Highland pilot, there is not as yet a consistent national approach. The Scottish Government needs to assist and support local authorities and their partners in finding solutions to these problems.

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53 In the Brandon Muir case, the Significant Case Review has identified gaps in the quality and completeness of information shared, and I have previously referred to the difference in risk threshold applied by different services. Such circumstances make it extremely difficult to assure the quality of informed decision making. This lies at what I call the information sharing deficit. In bringing information to the table, and in passing information between agencies there requires to be some assurance of quality, and account taken of other available information already in the system. In this case the experience has been that most referrals were treated in isolation and not in the context of previous events.

54 I have made some enquiry with those responsible for the development of the national E Care system, where more information will become accessible electronically, and in due course a linkage is envisaged with the Vulnerable Persons System which was first proposed in Lord Laming's original enquiry into the death of Victoria Climbié. For these systems to be a success, the data on which they rely has to be of a high quality, and I was pleased to learn that national interagency workshops are already taking place to create guidance on terminology, grading, and categorisation. This is a matter that also needs to be addressed locally, and given that implementation and integration of the new IT systems are likely to be some way off, the Dundee authorities would be well advised to create some interim standards of threshold of risk, so that as referrals are made between agencies, and less frequently direct to the Children's Reporter, staff are able to discern the level of risk assessed by the person making the referral. An example provided to me was that of the COPINE scale used to grade the nature of child abuse images, so that those dealing with the offenders or victims of such media do not have to have every detail of every image explained. This also avoids reliance on differing opinions or personal judgements. The police also use a grading system to categorise intelligence, so that a reader or analyst can understand its provenance, although not knowing the source. These models may provide a basis for finding an interim solution in a Child Protection environment.

Recommendation

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 informed as to the level of intervention required.

Initial Referral Discussion (IRD)

55 The SCR has identified the strengths and weaknesses of the IRD, called in relation to Brandon's mother and her children, and there is no need to repeat the findings here. The SCR has made specific recommendations in relation to the Dundee authorities.

56 While acknowledging that there are different circumstances upon which an IRD may be called, some with little information, and others prompted by an event, I am concerned that there are apparently no national guidelines in relation to the management of IRDs. It appears to me that the IRD is as an important a part of the process as a Case Conference or Review Case Conference, and that clear national guidance should exist which take into account training, chairing expertise, record keeping and timescales. I have seen examples of good practice in another local authority area, and examined the training documentation that is used at the Scottish Police College, so there is already material to build upon. I have met with representatives of Scottish Government responsible for developing the next set of Child Protection Guidelines (interim guidance last issued in 1998), and they have assured me that this matter will be considered within the guidance expected to be issued in early 2010. In the meantime, the local CYPPC needs to quickly create, and support, the implementation of new guidance on Initial Referral Discussions in Dundee.

Recommendation

The CYPPC clarifies guidance on the management of IRDs, pending the publication of national guidance, and provides training to those involved

Community Nursing

57 Health visitors are widely recognised as having a significant role in community nursing, particularly in relation to child protection. *The role of health visitors as a universal service seeing all children in their home environment with the potential to develop strong relationships with families is crucially important. A robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives.*³

At the time of Brandon Muir's death, NHS Tayside was involved in a new approach to community nursing being promoted by the Scottish Government which sought to improve the contribution made by Health Visitors through their wider role within public health nursing. While there was no connection between this change in approach and Brandon Muir's death, the SCR was presented with information from a variety of sources which identified concerns in the capacity of health visitors to deal effectively with the increasing work load. In accordance with my remit to address additional matters as necessary I have explored this matter in more detail.

58 The contribution made by health visitors to child protection has been described as problematic. *'The extent to which the role (health visitor) should focus on child protection issues and the way in which this fits into the broader public health and primary health care remit, can be the cause of some uncertainty on the part of both individual practitioners and on the part of those commissioning and managing the service.'*⁴

59 The new approach to public health nursing in Scotland was embraced by NHS Tayside who developed a style of skill mix involving a range of nursing skills, including the role of Health Visitor and School Nurse, as well as staff nurses who have been given additional training. Along with the intention to develop new working protocols, the intention has been to make the best use of nursing skills at different stages of child development. At the same time as the new policy was being implemented, a change of training was introduced which created a new qualification of Public Health Nurse, which in practice replaced the former Health Visitor course. I understand the underlying purpose of this development was to extend the skills of the health visitor role to encompass the health needs of the wider family. The impact of this change also had an impact on the school nurse role, the focus of which was to be extended beyond the child to the wider family environment.

60 NHS Tayside as one of four original implementation sites in Scotland for the new community nursing policy, embraced the approach, and has been developing a model which involves the expansion of Health Visitor 'teams' which includes Health Visitors, School Nurses and Staff Nurses. This mixture of skills is intended to ensure that the available resources are used to best effect.

61 As these changes were being introduced, Health Visitors were finding difficulty coping with an increasing case load which conflicted with management guidance, based on national policy, that they adjust their practices to fit with the new public health model. They felt there was not enough time allowed by their existing workload to make the change. Staff reported to the SCR that their concerns had been raised formally with management. In acknowledgement of their concerns management sought to provide support, through an increase in their skill mix resources, and by allocating cases out of the local area to other health visitors. It was as a consequence of this that the family with whom Cunningham had been living were allocated to a Health Visitor in another GP Practice, relocating the manual records, which later led to difficulties in pooling health information when Cunningham moved in with Brandon's mother.

62 While the changes to the Scottish policy on community nursing are clearly outwith the remit of the SCR, I feel that the important issues raised deserve some discussion. I was presented with a variety of pieces of evidence that there is both a continuing concern about health visiting capacity, and a professional disconnect between the views of the practitioners and their management. Within management too, I found a lack of clarity on resourcing between the views of the profession and the Community Health Partnership. The comments of Laming on resourcing, and Rouse on management understanding of the Health Visiting role, are both issues that the Chief Officers Group in Dundee need to take account of in discharging their responsibility for Child Protection

63 I need to make it clear that I do not have an opinion on the correctness or otherwise of the strategy in Dundee, or nationally. It is for local management to determine how to best utilise available resources to fulfil the objectives of community nursing. However, the evidence is that Dundee

Part 2

Independent Review for Chief Officers

CHP is having difficulty recruiting staff with a Health Visiting or Public Health Nurse qualification, and yet they have only trained two staff in the last four years. It was formerly the case that Health Boards funded staff to undertake the additional qualification, with the expectation that they continued to work for the Board.

64 The SCR identified that in addition to 'exporting' cases to colleagues in other Practices, under pressure Health Visitors in Dundee in 2007/2008 were being advised to prioritise their priorities, when the national guidance on intervention stipulated an approach governed by categorisation of each pre- school child as core, additional, or intensive, depending on standard indicators⁵.

Management has been working to address these known pressures, and the Improvement Plan published in response to HMIE describes the creation of four Zones, each with a child protection advisor (Advanced Nurse Practitioner) to support additionally resourced health visiting teams. However the question of adequacy of resource remains. Whilst the difficulty in recruitment continues, it seems inevitable that the specialist advisors can only be drawn from existing trained staff, which risks further depletion of the front line resource. It is an important point that the allocation of health visiting skills ought to be determined on the basis of need, and not simply on the basis of an equal spread of resources. While the Health Visiting teams can be built up through the addition of skill mix, NHS Tayside, and the CYPPC must remain vigilant that there is not a dilution of professional skill and expertise in the contribution which health visitors/public health nurses make to child protection.

65 I draw attention to three matters which highlight continuing concerns. The first describes the gap between staff and management in their perception of what is being done. There has been a lot of information presented on the training courses available, the communication arrangements, and the organisational changes planned to make a difference. However there is less evidence of the beneficial impact of these efforts. Instead, staff describe being called off training courses to staff clinics, of too many changes of management which undermine continuity of approach, and a lack of appreciation of the expected benefit.

While there is a risk of misinterpreting anecdotes, and of being misled by perception, the separation of understanding appears to be strong, and needs resolution. Management who are able to visibly demonstrate their engagement with front line staff will be able to gain a clearer sense of the perceived difficulties, and be better able to convey what they are trying to achieve.

66 The second reflects a potential indicator that resourcing issues are having a continuing impact on service provision in Dundee. Recently circulated Health Visiting Schedules describe the patterns and standards of engagement by staff in the health visiting teams. However in setting out these standards, it also advises that drop-in facilities which parents regularly access for information, advice and support are being suspended. While this may be a necessary short term consequence of the resourcing problem, it raises the question as to the impact of this loss of service to parents and children in Dundee. It is worth pointing out that these are local changes to meet the current circumstances. I was surprised to learn that there are no national quality standards for community nursing practice against which local policy changes can be compared.

67 The third and perhaps most significant issue arises through the attitude adopted to the realities of partnership working when dealing with the challenges of matching demand and resource in the child protection environment. In response to questions posed during the review, particularly concerning the level of awareness of staffing difficulties shared with the CYPPC, the response was that "staffing is an internal issue". It is critical that such an approach changes amongst 'ALL' partners. GIRFEC is by implication a team effort, and therefore children should have an expectation that the team works cooperatively. If there are weaknesses, the CYPPC must have an understanding of this, so that it can be in a position to address the problems. If it is not intended to fulfil such a role, then the effective delivery of child protection must be at risk.

68 I have tried to determine how NHS Tayside, and the Child Protection authorities might find objective advice from an external source to help them assess the impact of the changes to Community Nursing in Dundee. In England a number of informative reports are starting to emerge from the recently established Care Quality Commission on the role of the NHS in child protection. In Scotland HM Inspectorate of Constabulary offers advice on policing, the Social Work Inspection Agency fulfils a similar role in relation to Social Work, but there appears to be a gap in relation to the NHS and community nursing in particular.

The joint inspection programme on Child Protection headed by HMIE has created an innovative cross service approach to inspection, but thus far I do not see its role extending in depth into any of the professional disciplines. I have had helpful discussions with NHS Quality Improvement Scotland (QIS) which has a mission statement 'Raising Healthcare Standards'. Currently their involvement in children's health is focussed principally in the area of clinical standards. They recognise the limitations of the joint inspection model as discussed above and are to be encouraged in their efforts to resolve this in relation to health matters.

It remains in doubt however how Health Boards, child protection partners, or importantly the public, can assess the impact of these important changes in both the community nursing workforce, and in the valuable services they provide. Views vary as to whether assessments should be made by local management, the recently announced Modernisation Community Nursing Board, or bodies such as QIS, the Nursing and Midwifery Council, or the Royal College of Nursing. Another possibility may emerge from the reorganisation of regulatory bodies in the arena of community care, and the establishment of Health Improvement Scotland in 2011. Community nursing is not a high profile service, but it is critical to the lives of families across Scotland. Continuous improvement is essential, but so is a well understood reference point to measure progress against. It has been apparent from my enquiries that there is no shared view at a local or national level about what that reference point should be. This requires to be clarified.

Recommendation

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 Visitor skills are necessary, that they formulate a clear resourcing plan.

Recommendation

The Scottish Government clarifies the arrangements for developing and assessing local and national standards in community nursing.

Domestic Abuse

69 The impact of domestic abuse features in the narrative of the SCR in relation to both Brandon's family and in Cunningham's previous relationship, as captured in both police and social work records. The police acknowledge that there were opportunities missed in the interventions that should have taken place, particularly in the latter stages of the relationship between Cunningham and his previous partner

71 Having read the police incident reports, there is some doubt as to the roles played by the adult individuals in each of the particular events which have been categorised as domestic abuse. What seems much clearer however is that while decisions were taken on the basis of varying attitudes of the adults involved, inadequate consideration was given to the impact and interests of the children who were present. While referrals may have been made between the agencies involved there was a lack of appreciation as to the collective impact of these events on the children. This is notwithstanding that all the evidence of previous analysis of the domestic abuse issue, highlights the importance of giving attention to the needs of the child.

73 The HMIE report notes that Dundee has a significantly higher incidence of reported domestic abuse compared with other similar local authority areas, and the recent increase in organisational effort in this area must continue.

Part 2 Independent Review for Chief Officers

Training

74 If there is always a benefit to Reviews such as these, it is the opportunity provided to learn from the event, and to share that learning with staff. This case is no different, and it is clear much has been learned already. The family were anxious that the Review findings would provide some confidence that no other child would suffer in similar circumstances in the future.

75 In the Improvement Plan published by the Dundee authorities in response to the recent HMIE inspection, there are a number of changes proposed to policy, practice and organisation. The SCR recommendations identify a number of specific areas where attention is required, such as in relation to the participation and management of IRDs. The SCR specifically raises the point on information sharing “who else has information that I may need”, and “who do I need to share this information with?”

76 From my experience in building organisational partnerships, I know that it is simply not enough for organisations to share a common set of objectives, or combine in a shared action plan, if the staff in the separate organisations do not ‘understand’ how their partners operate, and how they will deal with information sharing. For the referring member of staff concerned about a child, the question “who do I need to share this with?” is insufficient. There needs to be added “and what will they do with that information?”. The simplest explanation of this point concerns capacity. If a member of staff who understood “who do I need to share this with” knew that once shared the information became part of a backlog, or through differing assessments of risk, the concern, was not accepted as a concern in a partner organisation, the likelihood is that the sharing of information or referral might be managed in a different way. In 2003, Health convened a discussion with colleagues in Social Work in Dundee to raise awareness on resourcing issues. More recently however the attitude to sharing information on similar organisational matters, has been more insular. In a partnership environment this cannot be the case. Teamwork requires cross organisational understanding.

77 In my enquiries I repeatedly asked the question about training, and the normal response was that training had been provided within the organisation, or occasionally joint training took place on specific skills such as ‘investigative interviewing’. At no point did I hear of training being provided which would permit those charged with Child Protection in Dundee to train together as a team. This point applies equally to management, as it does to practitioners.

However the CYPPC pointed out to me the range of training provided, which included not only joint training on skill sets but additionally partnership courses such as Introduction to Child Protection – Working Together (3 days) and Protecting Children and Young People – It’s Everyone’s job (1 day). I spoke with the provider of these courses, and she commented on their value, and that in her experience the Dundee CYPPC compared well with other authorities where she also provided training. The point was made however that not all partners in Dundee participate fully in the inter- agency training, management personnel were not visible in such training programmes.

Furthermore that in terms of team working, newly trained staff often returned to their work environment to find others with whom they were working less well informed, which reduced the impact and benefit of the training.

79 My recommendation is that the CYPPC, in delivering the changes demanded of the Improvement Plan, commissions an ongoing partnership training programme that allows those involved in child protection to understand cross organisational processes, including pressures and changes in organisational approach.

Recommendation

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.

Conclusion

I summarised my analysis of the key issues emerging from my review earlier in the report, and have highlighted some recommendations. I have also endeavoured to present an honest reflection of the current approach to child protection in Dundee based upon this particular case, and given a number of examples of the endeavours of all staff to do the best they can. All those to whom I have spoken in connection with the Review have demonstrated a strong sense of commitment. They are in no doubt about the importance of child protection, and their contribution to it, whether it be in policy formulation or face to face problem solving. What is missing is shared understanding – shared understanding between managers and staff about the challenges of turning policy into practice - shared understanding between organisations about thresholds, initiatives, and resource issues. Teams without shared understanding are not teams. Having engaged with senior staff and senior management on these issues I am confident that there is a commitment to build upon the significant improvements that have already been made since the death of Brandon Muir to achieve and demonstrate that improved understanding.

Professor Peter Wilson
August 2009

Recommendations

Recommendations

RECOMMENDATIONS

The recommendations listed within the two reports are re-presented below. While most are directed towards the authorities in Dundee, two are for the Scottish Government. Beyond these particular issues, included within the detail of the two reports are other matters which require to be taken account of by relevant authorities in Dundee, and at national level. It is the expectation that such matters will be given equal attention.

Significant Case Review

The Significant Case Review makes the particular point that the findings do not suggest any areas where wholesale changes are required. The recommendations are specifically targeted at strengthening identified gaps in practice or procedures that could leave children exposed to risks.

Recommendations have not been made where it is clear that the Dundee authorities have already addressed issues emerging within the Significant Case Review in the previously published improvement plan created in response to the findings of the HMIE-led joint inspection on Child Protection in Dundee.

Case Conferences

1. All agencies must ensure the most up to date information is available to the case conference.
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.
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.
4. All review case conferences should ensure consideration of key issues raised in the Core Group meetings.

Initial Referral Discussions (IRD)

5. Any revision of the inter agency guidance on IRDs needs to clearly state that the IRD is part of the critically important process of protecting children, and not a one off event.
6. An IRD should be considered where there is a cluster of concerns in relation to child care and domestic violence.
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.
8. Social work checks will also be made of other agencies, such as SCRA, housing, and substance misuse services.
9. Where a health representative is attending an IRD, they will be responsible for undertaking relevant health record checks.
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.

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 the children.
12. Social work must ensure that adults who cause concern are cross referenced with any known contacts and recorded on the social work database.
13. When social work staff are undertaking an assessment, they will carry out full system checks on adult members of the household.

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 referenced as appropriate.
15. Where a referral involves a pre school child, the social worker will always contact the health visitor as part of their response.

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.
17. Tayside Police should reinforce officers' awareness of the Force guidelines on Domestic Abuse.
18. Domestic abuse referrals should be graded and clearly specify where children were actually present in a house when an incident took place.

Health

19. NHS Tayside should ensure there is a system in place for tracking requests for reports from or referrals to SCRA.
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.
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

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.

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.

Independent Review for Chief Officers

The remit for the Independent Review for Chief Officers was inter alia to validate the findings of the Significant Case Review, and to make additional recommendations as necessary. The recommendations below supplement those emerging from the conclusions of the Significant Case Review.

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 informed as to the level of intervention required.

Initial Referral Discussions

2. The Children and Young Persons Protection Committee (CYPPC) clarifies guidance on the management of Initial Referral Discussions, and provides training to those involved, pending the publication of national guidance.

Community Nursing

3. NHS Tayside identifies 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 Visitor skills are necessary, that they formulate a clear resourcing plan.
4. The Scottish Government clarifies the arrangements for developing and assessing local and national standards in community nursing.

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.

Footnotes

Glossary

Abbreviations

Footnotes

Part 1

Significant Case Review

1. Getting it right for every child (GIRFEC) is a national programme seeking to shift culture, systems and practice to improve outcomes for children, young people and their families.
2. Social Care Institute for Excellence- 'Learning together to safeguard children: developing a multi- agency systems approach for case reviews'-December 2008)
3. NHS Tayside Family Needs Health Assessment Framework- mechanism for all public health nurses, health visiting and school nursing staff and midwives in Tayside to assess the needs of the children and families they work with and to help in the development of a Care Plan.
4. Dundee Social Work Department's Evidence Based Assessment Framework was introduced in February 2007. The Framework highlights the importance of assessment in identifying the needs of children, young people and their families and provides a structure for undertaking such an assessment. It embodies the GIRFEC principles.
5. Mellow parenting is a 14 week programme designed for families who are seen to be hard to reach, where support to parents and direct work on parenting are offered in parallel.
6. Analysing child deaths and serious injury through abuse and neglect: what can we learn? (Department for children, schools and families-2008)
7. The Protection of Children in England: A Progress Report (Lord Laming March 2009)
8. SWIA performance inspection of social work services in Dundee City Council in 2007.
9. Reder and Duncan, Lost Innocents: A Follow-Up Study of Fatal Child Abuse. (Quoted in biennial analysis of serious case reviews – Dept for children, schools and families 2008)
10. Evidence Based Assessment Framework- page 5
11. Haringey Local Safeguarding Children Board- Serious Case Review: Baby Peter. Executive summary February 2009.
12. Child Review report into The Life and Death of Carla Nicole Bone (07.04.01-13.05.02)-page 7
13. Chronic child abuse and domestic violence: children and families with long-term and complex needs- Dr John Devaney, July 2008

Footnotes

Part 2

Independent Review for Chief Officers

1. The Protection of Children in England: A Progress Report (Lord Laming March 2009)
2. 'Interim Guidance for Child Protection Committees for Conducting a Significant Case Review', Scottish Government 2007
3. The Protection of Children in England: A Progress Report (Lord Laming March 2009)
4. Rouse, 2000 - Health Visitors' role in protecting children
5. Health for All (Hall4)

Glossary and Abbreviations

A&E	Accident and Emergency Department at Ninewells Hospital, Dundee
CHP	Community Health Partnership
Chief Officers Group	Comprises the Chief Executive of Dundee City Council, Chief Executive of NHS Tayside, and the Assistant Chief Constable of Tayside Police
Core Group	Inter agency team responsible for carrying out the child protection plan
CYPPC	Children and Young Persons Protection Committee
Dundee Authorities	In this report taken to comprise those represented on the Children and Young Persons Protection Committee
DAO	Domestic Abuse Officer (of Tayside Police)
Evidence Based Assessment Framework	Social Work Department's comprehensive guidance to staff on assessment of vulnerable children and their families
FNHA	Family Needs Health Assessment: NHS Tayside framework provides comprehensive guidance to relevant staff on assessment of needs of children and families
FPU	Family Protection Unit (a unit of Tayside Police working in conjunction with Social Work and Health at Seymour Lodge)
FSC	Family Support Centre (run by the Social Work Department)
GIRFEC	Getting it Right for Every Child (is a national programme seeking to shift culture, systems and practice to improve outcomes for children, young people and their families.)
GP	General Practitioner
HMIE	Her Majesty's Inspectorate of Education
HV	Health Visitor
Improvement Plan	The response by the Dundee Authorities to the HMIE-led inspection on child protection in Dundee (2009)
IAR	Initial Assessment Report (completed by Social Work)
IRD	Initial Referral Discussion - A meeting of representatives of social work, health and police to discuss what is known about a child or family, and what further steps may be necessary
JAT	Joint Action Teams-Health service, social work and education personnel and other partners working together to assess children's needs to agree a single or inter agency response to identified need consistent with the GIRFEC principles.
MiDIS	NHS Tayside Computer system
MMR	Measles, Mumps and Rubella (immunisation offered to pre-school children)
NHS	National Health Service
PHN	Public Health Nurse
QIS	Quality Improvement Scotland, (an Agency of the NHS)
SAYF	Supported Accommodation for Young Families
SCR	Significant Case Review (a recognised process for reviewing case management)
SCRA	Scottish Children's Reporters Administration
SW	Social Work Department (of Dundee City Council)
SWAT	Social Work Access Team: First contact point for public and other agencies (for non child protection referrals). Provides a city wide referral screening and short term intervention and assessment service
SWIA	Social Work Inspection Agency

Notes



