DUNDEE CITY COUNCIL

REPORT TO: **POLICY AND RESOURCES COMMITTEE - 24TH AUGUST 2009**

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

REPORT BY: **CHIEF EXECUTIVE**

REPORT NO: **418 - 2009**

1.0 PURPOSE OF REPORT

1.1 To inform members of the Policy and Resources Committee of the outcome of the Significant Case Review (SCR) undertaken by Mr. J. Hawthorn and the Independent Report undertaken by Professor P. Wilson in respect of Brandon Muir.

2.0 RECOMMENDATIONS

It is recommended that the Policy and Resources Committee;

2.1 Note the content of the report;

2.2 Instruct the CYPPC to incorporate recommendations and actions from the SCR within the Improvement Plan prepared in response to the HMIe Joint Inspection of Services to Protect Children and Young People in the Dundee City Council Area.

2.3 Ask the Chief Officer Group of Dundee City Council, NHS Tayside and Tayside Police to monitor progress in respect of the implementation of the recommendations included in the report.

2.4 Ask the Best Value Review Group to include the recommendations from SCR within the Review Group's work programme.

2.5 Ask the Chief Executive to report back to the P & R Committee on progress in respect of the implementation of the SCR at the same time as reports are submitted in respect of the previously approved HMIe Joint Inspection of Child Protection Services.

3.0 FINANCIAL IMPLICATIONS

Committee Report 362-09 authorised additional expenditure of up to £500, 000 which has been identified from general fund balances to develop Child Protection Services.

4.0 MAIN TEXT

4.1 Brandon Muir was born on 2nd April 2006, and died on the 16th March 2008. He was killed by his mother's partner who was convicted of culpable homicide on 31st March 2009. Brandon's death was untimely and has had a significant impact on Brandon's family, agencies and the wider community. It is therefore the responsibility of agencies to ascertain the circumstances surrounding Brandon's death and the independent review should be understood as a "process for learning and improving services to children and as a means of recognising good practice" (SCR Report, Hawthorn, P.3)

4.2 In line with National Guidance a Significant Review Panel was established under the leadership of the then Chair of the CYPPC. This Panel appointed Mr J Hawthorn to undertake this SCR.

4.3 In general terms there is an expectation by the Scottish Government that each Children and Young Persons Protection Committee consider the need to undertake a Significant Case Review (SCR). The overarching objectives of a review are to:

- 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 - reviews should be understood as a process for learning and improving service as well as a means of recognising good practice;
- If and when appropriate, make recommendations for action (albeit that immediate action to improve service or professional shortcomings need not await the outcome of a formal review);
- Consider how any recommended actions will be implemented;
- Address the requirement to be accountable, both at the level of the agency/agencies and the occupational groups involved;
- Increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case about a child; and
- Identify national issues where appropriate including good practice.

4.4 To ensure that public confidence in child protection services was maintained, the Chief Officers of the Council, Tayside Police and Tayside Health Board appointed Peter Wilson, former Chief Constable of Fife. His appointment was as an independent assessor of experience and standing to consider all information that emerged for the SCR, and to confirm recommendations made, make any additional recommendations, and to oversee implementation of recommendations confirming progress publicly as required.

4.5 The outcome of the Significant Case Review was published as a report on 19th August and contains both P. Wilson and J Hawthorns' findings. The Executive summary covers both reports (Appendix 1).

4.6 Two of the main findings from the Executive Summary of the Significant Case Review concluded that;

- The violence of Robert Cunningham towards Brandon Muir could not have been predicted.

- That in a period of less than three weeks when Robert Cunningham became part of Brandon's family group, child protection staff quickly embarked on a process of assessment and information gathering which would have led to a Child Protection case conference scheduled for 18th March 2008

4.7 Mr Hawthorn's findings include:

- 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.
- There were no external reports or police intelligence that linked H to prostitution or drugs, and which made her less protective of her children.
- From 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.
- Areas which require wholesale changes have not been identified. The recommendations are specifically targeted at strengthening identified gaps in practice or procedures that could leave children exposed to risks.

4.8 Recommendations:

There are a number of recommendations highlighting key areas that should be considered. These include:

- Child Protection Case Conferences
- Initial Referral Discussions
- Adults who cause concern
- Monitoring changes
- Resources

There are also specific recommendations for the key agencies, as identified on pages 80, 81 of the report

Some of the key recommendations include:

- 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.

4.9 Professor Wilson's findings include:

- All those with whom Professor Wilson spoke 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.
- There is a need for a shared understanding between managers and staff about the challenges of turning policy into practice
- There is a need for a shared understanding between organisations about thresholds, initiatives, and resource issues.
- Professor Wilson indicated that he has confidence that significant improvements can be achieved provided that effort is made to achieve and demonstrate that improved understanding.

Recommendations:

- 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.
- The CYPPC clarifies guidance on the management of Initial Referral Discussions, pending the publication of national guidance, and provides training to those involved
- 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.
- The CYPPC institutes a continuing series of cross agency training events to ensure practitioners understand shared roles and responsibilities in Child Protection, inter-organisational processes and issues that affect the effectiveness of teams.

4.10 This Significant Case Review has highlighted many challenging areas for the Council and partner agencies, which the Children and Young Persons Protection Committee will progress on behalf of Chief Officers. It has reinforced the need to ensure continuous self evaluation takes place and that the need for multi agency training and development is crucial. This is a particular area being progressed by the Improvement Joint Inspection of Services to Protect Children and Young People in the Dundee City Council Area Improvement Plan. The recommendations from both Mr Hawthorn's and Mr Wilson's reports have been incorporated within the Improvement Plan (Appendix 2).

4.11 Staff directly involved from Social Work, Health and Police were provided with the findings on 18th August. Other staff from Social Work, Health and Police who have a role in children's services were provided with the opportunity to hear of the findings on the day of publication. Mr J. Hawthorn and Professor P Wilson delivered the findings along with Chief Officers.

The death of Brandon Muir has had a significant effect on front line staff and managers alike. Support continues to be offered to staff at all levels and in all agencies to help rebuild

their confidence so that they can continue to undertake the difficult day to day work in protecting children and young people in Dundee.

5.0 POLICY IMPLICATIONS

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

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

6.0 CONSULTATIONS

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

7.0 BACKGROUND PAPERS

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

APPENDIX 1

Introduction

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 restricted to the death of Brandon.

The two reports are published together. Part 1 relates to the Significant Case Review and was conducted by Mr 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.

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

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.

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.

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.

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 a chaotic household or lifestyle that suggested she had a dependence on substances.

Both health visiting and social work staff consistently stated that Heather and her children did not stand out as giving great cause for concern, 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.

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.

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.

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

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 raised include guidance on child protection procedures, 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.

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 the Boyd or Cunningham. The enquiry revealed gaps and inaccuracies, some caused by pre-existing systems, others by a lack of available resource.

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 R, could not have been predicted by the Dundee authorities.

Footnotes

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

19th August 2009

ALEX STEPHEN
CHIEF EXECUTIVE 07 AUGUST 2009
DUNDEE CITY COUNCIL

APPENDIX 2

Joint Inspection of Services to Protect Children and Young People in the Dundee City Council Area
June 2009

Hawthorn/Wilson Significant Case Review and Independent Review for Chief Officers
August 2009

Improvement Plan

As Chief Officers of Dundee City Council, NHS Tayside and Tayside Police we are committed to working together to make improvements to strengthen services to protect children and young people in the Dundee City Council area. In doing so we will take account of the findings of the HMIe Joint Inspection of Services to Protect Children and Young People in the Dundee City Council area, **and the recommendations contained in the reviews commissioned examining the case of Brandon Lee Muir**. This improvement plan specifically addresses the need to:

- improve the actions taken in immediate response to concerns about children;
- improve the processes of assessment of risks and needs and the system for jointly assessing the risks associated with parental substance misuse;
- improve the processes for joint planning to meet children's individual needs;
- review and update policies and procedures to guide staff in their work to protect children;
- improve the joint planning of integrated children's services to take full account of the needs of children at risk of harm, abuse and neglect;
- provide clear leadership and direction to the work of the CYPPC; and
- introduce a systematic approach to self-evaluation across services.

In putting together this improvement plan we, as Chief Officers, recognise our collective responsibilities in respect of the leadership of child protection services in the area. We have put in place structures and processes which will allow us to more effectively work together to lead service development, delivery, evaluation and monitoring.

We have adopted a joint vision for child protection services in the Dundee area and will take the lead in ensuring that this vision is collectively owned, communicated and achieved. Our vision states:
"Dundee's future lies with its children and young people. They deserve the best this city can give them. We will provide the protection they need, when they need it to keep them safe from harm."

In order to ensure the effective implementation of this improvement plan we have put in place a robust leadership, monitoring and reporting framework. We will meet together monthly as a Chief Officers' Group and will use these meetings to drive forward the plan for the city area. As well as the Chief Officers' Group, other key stakeholders will be involved in the development, delivery and reporting of this improvement plan. These include a Best Value Review Group, the Children and Young Persons Protection Committee, the Policy and Resources and Scrutiny Committees of Dundee City Council, and Board of NHS Tayside.

Getting it Right for Every Child

In Dundee, we are working to promote the principles and standards of GIRFEC. Although not a pathfinder authority, we have already made a number of changes and have a further planned programme for change which we intend to deliver via a strategic action plan.

As Chief Officers we recognise that our improvement plan contains a number of actions which will form part of a GIRFEC change programme. We thought it would be helpful to provide a brief overview of some of the actions we intend to take, particularly those around the needs of children affected by parental substance misuse and those affected by compromised parenting.

In line with GIRFEC principles we will work collectively to ensure we have a common, co-ordinated approach across all agencies that supports the delivery of appropriate, proportionate and timely help to all children and young people in need of protection when they need it.

Our first key action to ensure co-ordinated, timely and proportionate response will be to extend the scope and remit of existing, early intervention screening fora (Action 1). Weekly meetings will be held to which all agencies will be able to refer any child for whom there are care and protection concerns. We will work to ensure that this process is embedded in a multi-agency system from early intervention screening through to the provision of specialist joint police, health and social work child protection services. In order to improve the effectiveness of our screening and assessment processes, we plan to fully implement a framework for integrated assessment activity. This framework, which has a single agency assessment activity as its starting point, is about to be piloted by the New Beginnings Service, with the intention to roll out during 2010. This framework will have integrated core and comprehensive assessments. A parenting capacity tool is to be piloted in Children 1st with Addaction, the Lilywalker Centre, Criminal Justice, Learning Disability and Mental Health Services (Action 10). Plans are already in place to pilot the introduction of the Child's Plan in multi-agency locality services in one area of the city from August 2009.

We believe that the work on the early intervention screening fora and the integrated assessment framework, combined with staff development activity, will enable us to improve the quality of information recorded and ensure that decisions made about sharing information are based on identifying and meeting needs and promoting the welfare of the child. This will include the development of CP Messaging and future work on electronic integrated assessment (Action 11). We intend to review all agency and inter-agency staff development in relation to assessment. We will use the findings of this review to inform the future content of staff development activity in relation to assessment. We plan to deliver the majority of training in a multi-disciplinary basis (Action 14).

We recognise the need to ensure that children receive timely, as well as proportionate responses, and intend to take a range of actions to enable ease of access to services and a more co-ordinated model of service delivery. We intend to conduct a multi-agency Rapid Improvement Event to re-design the pathway and access to substance misuse services (Action 13). We will also appoint a waiting list coordinator for the substance misusers team (Action 12).

We plan to use the combined strategic leadership of the Chief Officers' Group, CYPPC and the recently reformed Alcohol and Drug Partnership to set a joint strategic direction for the development and delivery of services to children affected by parental substance misuse, domestic abuse and other forms of compromised parenting. This work will lead to improved service design and delivery models (Action 24). We recognise that to achieve this we will have to review the range and effectiveness of current delivery models of services to children and young people affected substance misuse, mental health, learning disability and domestic abuse who experience compromised parenting (Action 26).

In relation to children in their early years we intend to develop and implement a model of joint team working, which could include the co-location of health and local authority services in relation to compromised parenting of pre-school children from unborn babies to children in their pre-school year. We will explore a service delivery model which will involve the co-location of health visiting and midwifery staff, drug problem workers, social workers and family support staff, community psychiatric services and adult services (Action 25).

Multi-agency Staff Development Plan

We recognise that with major cultural and developmental change, a robust staff development regime will be required to ensure that change is achieved and sustained.

There are some very specific actions already detailed in the improvement plan in relation to staff development (e.g. Actions 8, 9 and 14). However, we recognise that to achieve the culture change required by GIRFEC and to impact on a number of the other actions (Actions 10, 11, 15) there will be a need to develop a very clear multi-agency workforce development plan supported by a change management plan. This will set out the organisational development and service improvement work which will be commissioned by the agencies to underpin change and encourage a greater degree of joint agency working. There will be a continuing need for single agencies to assess and address the staff development needs of their individual workforces, but this activity should flow from the jointly agreed strategic plan.

Child Protection: Improvement Plan

Outcome Required		Actions	Timeframe	Responsibility	Progress
Actions taken in immediate response to concerns meet the needs of the child or young person	1	Audit of 174 case files of children • currently on the child protection register in which household characteristics included parental substance misuse • currently looked after in which referral reasons included concern re parental substance misuse • currently receiving support under s. 56(2) C(S)A '95 in which referral reasons included concern re parental substance misuse • new referrals received between 01.03.09 and 31.05.09 in which referral reasons included concern re parental substance misuse To be completed	22nd June 2009	SWD	
	2	Extend current scope of existing early intervention screening fora (held weekly) to ensure that all agencies can refer any child for whom there are care and protection concerns and these concerns can be considered before they escalate and the child circumstances become more concerning. Ensure that this process becomes part of a multi-agency system from early intervention screening through to specialist services based at Seymour Lodge. Agree multi-agency protocol Implement protocol	August 2009 Sept 2009	Tayside Police DCC Dundee CHP	
	3	Any failure to identify an emergency placement OOHS is notified immediately by Out of Hours Service to social work head of Children's Services.		SWD	Complete
	4	Increase the capacity of the social work access team by adding 2 social workers		SWD	Complete
	5	Increase the capacity of the specialist social work child protection team by adding 2 social workers		SWD	Complete
	6	Increase skill mix within community nursing and move to locality Zone model. Further review workforce capacity.	August 2009	Dundee CHP	
	7	Increase the Capacity to support Health Visiting staff by putting 4 Advanced Practitioner posts (Children and Vulnerable families) 1 to each of the four zones (doubling current capacity).	August 2009	Dundee CHP	
	8	Establish panel to include Head of Social Work Children's Services, Nurse Consultant for Child Protection and Vulnerable Families, Lead Nurse Dundee CHP, and SWD Service Manager to meet monthly to	Dates set	SWD Dundee CHP	

Outcome Required		Actions	Timeframe	Responsibility	Progress
		discuss specific cases to illustrate issues to be clarified and fed back to CYPPC			
	9	Train a further 14 practitioners as child protection case supervisors to support frontline staff across NHS Tayside.	Sept 2009	NHS Tayside	
	10	Provide supervision, staff development and support to all professionals to ensure that staff: • have a shared understanding of the factors that give cause for concern • understand what they should do in response to those concerns, including when to involve other agencies Implement multi-agency staff development programme	 Sept 2009	 CYPPC Member Agencies	
Processes and practice for assessment, particularly joint assessment of children and young people who may be affected by parental substance misuse, result in appropriate, proportionate and timely intervention that improves circumstances.	11	Fully implement a framework for integrated assessment that has single initial agency assessment activity as its starting point, in accordance with GIRFEC principles. An initial assessment tool, which forms part of the integrated assessment framework is about to be piloted in the New Beginnings Service. A parenting capacity tool is to be piloted in Children 1st with Addaction, the Lily Walker Centre, Criminal Justice, Learning Disability and Mental Health Services. Complete current pilots Full roll-out	 Dec 2009 Dec 2010	 DCC Dundee CHP Vol Sector Partners	
	12	Improve the quality of information recorded where this is necessary, to capture significant events in the life and experiences of each child as well as agency activity and analysis. Ensure that decisions made about sharing information are based solely on identifying and meeting the needs and promoting the welfare of the child. Monitor improvement through case file / recording auditing and 6-monthly reporting to CYPPC. First report due -	 October 2009	 Dundee CHP Educ Dept	
	12(a)	**Ensure that:** • **Assessment reports for case conferences consider all adults in the household, whether or not resident at that address, and those with significant contact with the child. (H3)**	**October 2009**	**CYPPC member agencies**	

Outcome Required		Actions	Timeframe	Responsibility	Progress

		• **Where any agency becomes aware of an adult causing concern who moves to a household with children, information is shared across all relevant agencies involved with the children. (H11)**
		• **Adults who cause concern are cross referenced with any known contacts and recorded on the social work database, (H12)**
		• **When social work staff are undertaking an assessment, they carry out full system checks on adult members of the household. (H13)**
		• **On receiving any referral, access team social work staff 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. (H14)**
		• **Full consideration of the impact of domestic abuse and substance misuse on children, is given, when the implementation of the Family Needs Heath Assessment Framework is reviewed. (H20 - NHS Tayside)**
		• **The re launch of the Family Needs Health Assessment emphasises:**
		  • **the importance of assessment and care planning for health visiting teams, and**
		  • **the need for more objective record keeping (H21**)
		• **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. (W1)**
		
		These actions will also be addressed in the review of the content of the Child Protection Procedures (see 21a).
			October 2009
			
			December 2009
			
			March 2010
			
			December 2009
				Social Work Department
				
				NHS Tayside
				
				NHS Tayside
				
				CYPPC member agencies	

	13	Appoint a waiting list Coordinator for the Substance Misusers Team	August 2009	NHS Tayside	
	14	Conduct a multi-agency Rapid Improvement Event (RIE) to redesign the pathway and access to Substance Misuse services.	Sept 2009	DCC and NHS Tayside	

Outcome Required		Actions	Timeframe	Responsibility	Progress
	15	Review all agency and inter-agency staff development activity in relation to assessment. Develop as required. Complete review Implement required development	 Sept 2009 Dec 2009	CYPPC Members Agencies	
The process and practice of joint planning produces robust inter-agency plans, the impact of which is carefully monitored and the implementation of which results in improvements for children and young people	16	Ensure that existing policies and procedures are consistently applied so that children, young people and their families are given every encouragement and support to fully participate in decision-making processes that affect them. Monitor the effectiveness via supervision, management and case evaluation activities Report 6-monthly on participation activity to CYPPC and Chief Officers Group. First report due -	October 2009	CYPPC Member Agencies / Chief Officers	
	17	Establish and implement standards for attendance and submission of reports by professionals at Review Child Protection Case Conferences. Review current attendance levels and provide, as necessary, updated direction and guidance to all staff Implement standards Monitor effectiveness through quarterly performance reports to Chief Officers Group	 July 2009 October 2009	Chief Officers / CYPPC	
	18	Review and develop as necessary, procedures and practice by managers to ensure consistently high quality child protection plans are in place when required, that decisions are ratified and that monitoring and implementation of plans is carried out in accordance with procedures. Ensure that self-evaluation and auditing tools capture the necessary information to monitor effectiveness. Provide 6-monthly reports to CYPPC. First report due -	October 2009	CYPPC Member Agencies	
Children and Young People will have their needs met through the consistent application of appropriate policies and procedures	19	Establish and implement a system and process for ongoing joint review, updating and evaluation of impact of all multi and single agency procedures and guidance that are concerned with the provision of services to children in need, ensuring that they promote best practice. Implement system	August 2009		

Outcome Required		Actions	Timeframe	Responsibility	Progress
		Include evaluation of impact of multi and single-agency procedures and guidance in annual reports to Chief Officers Group and CYPPC			
	20	Review existing systems in Health to follow up Medical appointment defaults to be reviewed. New protocol to be produced and 'Joining up the Dots' to be expanded.	August 2009	NHS Tayside	
	21	Develop a range of methods which support staff understanding and application of procedures that demonstrates best practice; e.g. mentoring, peer review, action learning.	December 2009	CYPPC Member Agencies	
	21(a)	**Produce updated multi-agency and single-agency Child Protection Guidance to reflect the requirement of the H and W Reports by ensuring that:** • **All agencies ensure the most up to date information is available to the case conference (H1)** • **The initial case conference minute lists risk and protective factors for the child, and these are updated at subsequent review case conferences and identify any risks or protection that they present to the children (H2)** • **All review case conferences ensure consideration of key issues raised in the Core Group meetings.(H4)** • **Any revision of the inter agency guidance on IRDs clearly states that the IRD is part of the critically important process of protecting children, and not a one off event. (H5)** • **An IRD should be considered where there is a cluster of concerns in relation to child care and domestic violence, (H6)** • **Where internal social work checks indicate that other colleagues have relevant information to share, they are invited to the IRD, or if unavailable their views sought. (H7)** • **Social work checks will also be made of other agencies, such as housing, and substance misuse services. (H8)** • **Where a health representative is attending an IRD, they will be responsible for undertaking relevant health record checks. (H9)** • **The IRD identifies actions, with timescales, to be taken to**	**September 2009 interim guidance**	**CYPPC member agencies**	

Outcome Required		Actions	Timeframe	Responsibility	Progress
		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. (H10) • **Where a referral involves a pre school child, the social worker automatically contacts the health visitor as part of their response.(H15)** • **Domestic abuse referrals should be graded and clearly specify where children were actually present in a house when an incident took place (H18)** • **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. (W2).** ***Interim revised CP guidance will be issued immediately and details incorporated in subsequent reviews.***	**Revised multi-agency guidance by March 2010.**		
The arrangements for the delivery of integrated children's services will be driven by the sole aim of meeting the needs of children	22	Review the role, responsibilities and membership of the CYPPC Complete review	October 2009	Chief Officers	
	23	Review the role, function and membership of the SPG/IMG and the relationship with the CYPPC, the Alcohol and Drug Partnership and Dundee Violence Against Women Partnership Complete review	October 2009	Chief Officers	
The collective leadership provides	24	Jointly set, communicate and keep under review the vision, aims and values for child protection services	August 2009	Chief Officers	

Outcome Required		Actions	Timeframe	Responsibility	Progress
clear direction to effectively protect children	25	Further develop joint working by creating a new child protection unit based at Kings Cross Hospital where specialists in child protection from all of the agencies will work together to share information on each and every case	October 2010	Chief Officers	
	26	Further develop joint strategies in respect of children affected by parental substance misuse and domestic abuse which lead to improved service design and delivery models	October 2009	Chief Officers / Community Planning Partners	
	26(a)	**Reinforce the need for Family Protection Unit staff to produce up to date and accurate information to case conferences and IRDs. (H16)** **Reinforce officers' awareness of the Force guidelines on Domestic Abuse. (H17)**	**October 2009**	**Tayside Police**	
	27	Develop and implement proposals for improved joint team working arrangements, including co-location, of health and local authority services in relation to compromised parenting to enable more effective assessment, planning and intervention with those who have care of children, including those affected by substance misuse. Develop proposals Implement from ...	 August 2009 March 2010	 DCC NHS Tayside	
	27(a)	**Ensure there is a system in place for tracking requests for reports from or referrals to SCRA. (H19)**	**October 2009**	**NHS Tayside**	
	28	Review the range, effectiveness and, where appropriate, delivery models of services to children and young people affected by substance misuse, mental health, learning disability and domestic abuse, who experience compromised parenting.	March 2010	DCC, NHS Tayside and Voluntary Sector Partners	
	29	Monitor the impact of the implementation of the phased investment plan and improvement programme for Child and Adolescent Mental Health Services (CAMHS) 6-monthly review to CYPPC. First 6-monthly review report to CYPPC ...	 October 2009	 NHS Tayside	First two phases of additional investment in place.
	30	Review and update communication strategy re how agencies communicate effectively with their staff and how they are helped understand the relevance of and how to influence and contribute to the content of strategic planning processes	August 2009	Children's Services Strategic Planning Group	

Outcome Required		Actions	Timeframe	Responsibility	Progress
	31	Establish and implement a framework for the way in which all children, parents and carers are involved in the development of children's services through integrated children's services planning. Child, parental and carer involvement to be monitored through annual reporting processes Establish framework Implement	 October 2009 March 2010	 Chief Officers	
	32	Review all child protection provisions as part of the ongoing commitment to implementing GIRFEC	December 2010	Chief Officers	
	32(a)	**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 re-sourcing plan. (W3)**	**October 2009** **March 2010**	**NHS Tayside**	
	32(b)	**Promote 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. (W5)**	**December 2009**	**CYPPC member agencies**	
A systematic and robust approach to self evaluation across services and agencies will inform agencies of the quality of services, identify good practice and how that can be further developed, and any areas in need of improvement	33	Fully agree the content of and implement the Performance Management framework	October 2009	Chief Officers	
	34	Create and embed a culture, via awareness raising and staff development, across service sectors in which all staff embrace self-evaluation as a positive means to improve outcomes for children and young people. And establish processes that ensure findings are gathered and collated and inform continuous improvement Establish a front-line practitioners action learning set to act as a primary change agent to embed self-evaluation and influence cultural change. Implement self-evaluation framework Implement processes to gather, collate and analyse findings	 October 2009 Dec 2009 March 2010	 CYPPC Members Agencies	

Outcome Required		Actions	Timeframe	Responsibility	Progress
		Report on self-evaluation information via the performance management framework in annual reports to the CYPPC and COG.	March 2010		
	34(a)	**Ensure that self evaluation and auditing tools collect the relevant information to monitor their effectiveness in keeping children safe. (H22)**	**December 2009**	**CYPPC member agencies**	