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Board Nurse Director

<u>NHS Greater Glasgow & Clyde Position With Regard to the Conclusions and Recommendations from Two National Inquiries into Child Fatalities: Baby P and Brandon Lee Muir</u>

1. Recommendations

The Board is asked to note the current position and actions in NHSGG&C with regard to the conclusions and recommendations from two national inquiries into child fatalities: Baby P and Brandon Lee Muir.

2. Introduction

This paper reports on the current position and action in NHSGG&C with regard to the conclusions and recommendations from two national inquiries into child fatalities: Baby P and Brandon Muir.

- Review of the Involvement and Action taken by Health Bodies in Relation to the Care of Baby P, Care Quality Commission, May 2009
- Significant Case Review: Brandon Lee Muir, Part 1: Significant Case Review for Dundee CYPPC, Jimmy Hawthorn, Social Work Consultant and Part 2: Independent Review for Chief Officers Group, Peter Wilson, Professor, Scottish Institute for Policing Research, August 2009.

3. Background to Baby P Case

On 3 August 2007 at 11.30 am, the mother of a 17-month old boy. Baby P, called the London Ambulance Service. On arrival, the paramedics took Baby P to North Middlesex University Hospital. He was pronounced dead at 12.10 pm. A post mortem was completed and gave a provisional cause of death as a fracture/dislocation of the thoraco-lumbar spine. From 22 December 3006, Baby P had been living the subject of a multi-agency child protection plan involving social services, health services and the police.

4. Current position and actions in NHSGG&C with regard to the recommendations in the Baby P case

4.1 Clear communication and working arrangements with relevant social services departments must be established to ensure that there is no delay in establishing contact between agencies once a safeguarding referral has been made to social services

CHCP's have working arrangements in place that facilitate speedy communication between social work and health practitioners. In some areas there are particularly strong interface arrangement between health and social work addictions staff. There are various local arrangements in place whereby health and social work staff routinely discuss vulnerable families.

A single telephone number for health staff providing direct access to the Emergency Social Work Stand by Service was introduced in July 2008. This was positively evaluated in February 2009.

In 2007 NHSGG&C introduced the shared referral form, which health staff completes after making a telephone call to social work regarding concerns about a child. This form ensures that relevant information is communicated and recorded. The use of the form is monitored via a quarterly statistical report that is produced by CPU and scrutinized by local managers. A first – stage audit on the use of the form indicated that while the vast majority of staff who responded knew about the Shared Referral Form and where to access it. Future action should concentrate on:

- Targeted communication on the form
- Improving the frequency of feedback from Social Work to Health
- Completing the second stage of the audit.

4.2 Staff must be aware of child protection procedures and adhere to these procedures

NHSGG&C have a folder that contains a wide range of child protection procedures for all key areas in health services. When a procedure is introduced managers are briefed by CPU staff and the briefing is cascaded. The folders are located in all key premises in health services and can also be accessed on the CPU website. A timetable is in place to evaluate awareness, compliance and effectiveness of each procedure and review its content every three years. Recent HMIe inspections indicated that policy and procedure was an area of strength across agencies. Future actions should concentrate on ensuring that the timetable for evaluation and review is implemented. In particular the following procedures require review within the next year:

- Procedure for the Tracking of Missing Families/Children
- Standard Operating Procedures

- Guideline for Emergency Departments and Receiving Units where a child or young person presents under the influence of alcohol and/or drugs.

4.3 Medical staff should receive safeguarding training to a level that is appropriate to their role, as set out by the Royal College of Paediatrics and Child Health

A system is in place for all doctors in RHSC to complete child protection training via Doctors online training system (DOTS). All FY1 and FY2 grade paediatric and emergency medicine doctors receive safeguarding training to the level appropriate to their role, as set out by the Royal College of Paediatrics and Child Health. CPU provides consultant delivered Tier 3 child protection training to all Consultant staff within the Women and Children's Directorate and to Consultants in Emergency Medicine Board – wide.

From April 2009 – February 2010 48 doctors completed child protection induction on line, 28 doctors completed the Safeguarding Course and 228 doctors completed Tier2/3 training. 160 GP's were trained from April – March 2010. A further safeguarding course has been arranged for 31st March and 16 doctors will attend.

Future actions should concentrate on expanding access to DOTS and maintaining current training capacity.

4.4 Recruitment practices must ensure adequate hospital staff - this includes consultants, nurses and administrative staff. There must be a sufficient number of appropriately qualified paediatric staff available when required, in line with established guidelines. There must be adequate consultant cover in hospitals.

Child protection is part of the core function of all general and community paediatricians. In addition dedicated child protection sessions are included within the job plans of appropriate medical staff.

CPU is the central referral point for access to forensic and paediatric assessment. A redesign of child protection paediatric services is currently being implemented in the hospital settings. In addition NHSGG&C provide a child protection specialist paediatric service 24/7 and comprehensive medical assessment clinics are currently being rolled out across NHHSGGC that will provide medical assessment for neglected children. Archway provide medical intervention for adolescents that have experienced acute sexual assault and arrangements are in place for child examiners to provide medical examination on health premises for adolescents that have experienced physical assault.

4.5 Appropriate arrangements must be in place to enable safeguarding supervision

A supervision policy for health visitors and school nurses has recently been introduced and training is currently underway. A tool for the supervision of child protection cases for supervisors has been devised. Consultation by CPU on complex cases is in the process of being introduced across NHSGGC. It is recognised that these arrangement have only recently been put in place so future action should concentrate on embedding the arrangements and auditing effectiveness.

It is ensured via the current Consultant appraisal process that all consultant staff within the Women and Children's Directorate have had Tier 3 child protection training. Peer review is in place for doctors that aims to ensure that they maintain a high level of skill. This was identified as an area of strength in an evaluation of the medical service conducted by the University of Strathclyde in March 2008.

A telephone advice line that is staffed by Nurse Advisors is in place during daytime hours, which offers support to all practitioners, but is particularly useful to inexperienced staff. Future action should concentrate on auditing the effectiveness of this service.

Skilled paediatricians are available 24 hours to give medical advice where required. Future efforts should concentrate on maintaining this service.

4.6 Appropriate arrangements must be in place for staff to attend multi-agency child protection case conferences

NHSGG&C introduced a policy for staff attendance at case conference in September 2005, which made it clear that staff must attend and provide a report. An audit of staff attendance was completed in November 2008. Key recommendations were:

- Monitor invitations and attendance
- Ensure agencies are given full information about the health staff involved at the earliest possible time
- Update guidelines for staff around attendance at case conferences and report writing
- Targeted training for staff to ensure that there is a focus on the health needs of the child

The policy was reviewed in May 2009 and The Head of CPU has written to all Directors of Social Work emphasising the need for social work to ensure that they invite all key staff and that contact should be made with CPU for advice where there is uncertainty about whom to invite. Future actions should concentrate on ensuring that the audit is repeated in 2010 to continually monitor staff attendance and provision of reports.

4.7 Arrangements must be in place for appropriate training to be undertaken

Child Protection training is provided by CPU on a calendar and bespoke basis. Attendance is monitored via a quarterly management information reports. 22,2771 staff were trained by CPU from 2007 – 2009. The training material is quality assured and an evaluation in December 2008 evidenced that the training positively impacted practice. Future actions should concentrate on the review of the strategic training plan and longer term evaluation of impact of training on practice.

4.8 Appropriate arrangements must be in place for quality assurance and governance

Performance on actions arising for audits, inspections and significant case reviews is reported to the Child Protection Forum and action is taken when required to accelerate progress. There are a range of local child protection meetings that address performance and child protection is a standard agenda item on all Clinical Governance Groups.

NHSGG&C quality assures and governs child protection services via the NHSGG&C Child Protection Forum. The membership of this Forum consists of NHSGG&C Acute and CHCP Directors. Two Child Protection Operational Groups (Acute) and (Partnerships) implement policy and report to the Child Protection Forum on performance. A timetable was recently introduced for Directorates and Partnerships to report on performance to the Child Protection Forum at each bi monthly meeting.

Future action should concentrate on embedding the Directorate and Partnership performance reporting system.

5. Background to Brandon Lee Muir Case

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 who was convicted of culpable homicide and given a prison sentence of 10 years. Charges against Brandon's mother were withdrawn on grounds of insufficient evidence. This case is unusual in that sustained involvement was confirmed to the three week period leading up to Brandon's death; an extremely short timescale.

6. Current position and actions in NHSGG&C with regard to the conclusions and recommendations in the Brandon Muir case

6.1 There must be appropriate arrangement for the evaluation and the sharing of information

An early sharing of information system provided by CPU Facilitates communication between health and social work promptly by sharing information with social work at the investigation stage in order to assist

effective decision making. Future action should concentrate in expanding this service to the earlier gathering of information stage and expanding electronic access to systems to speed up response times.

An information sharing protocol has been developed for health staff. Future action should concentrate on ensuring a robust launch and implementation of this policy, with an inbuilt timescale for early audit of compliance.

Work is in progress between NHSGGC, CPU, LMC and the Medical Defence Union Chief Executives to improve information sharing and ensure appropriate contact with CPU by General Practitioners for advice on child protection cases. Future action should concentrate on progressing current efforts to ensure that CPU is contacted first and foremost for advice on individual child protection cases.

6.2 Full background checks must be carried out on all household members

An early sharing and collation of information system provided by CPU provides social work with health information for background checks. Addictions teams have assessment tools in place that incorporates a parental assessment to identify adults that may present a risk to children. A similar tool is being developed in mental health services. Future action should concentrate on expanding CPU electronic access to adult systems to improve the information provided.

6.3 Arrangements must be in place for continual assessment and care planning

Integrated Assessment Frameworks are being introduced across the local authority areas covered by NHSGG&C that aim to ensure robust assessment and care planning. The Family Health Record has been introduced for Health Visitor caseload that ensures full gathering and recording of information. Future action should concentrate on embedding IAF into practice and evaluating the effectiveness of the family health record.

6.4 Arrangements must be in place for initial referral discussions and organizations must assure themselves that they are conducted effectively

An IRD/Tripartite discussion protocol is either in place or is being developed in all local authority areas covered by NHSGG&C. Future action should concentrate on agencies embedding the protocols and monitoring their effectiveness. CPU provides an Early Sharing of Information system to support the IRD/Tripartite discussion process and will evaluate the impact of this service in May 2010.

6.5 Staff must be aware of the impact of domestic abuse and substance misuse on children

Training on the impact of domestic abuse and substance misuse on children is provided by CPU. 131 staff were trained in domestic abuse and 116 in substance misuse by CPU from 2007 – 09.

Child protection and domestic abuse guidance for health staff was reviewed and circulated in April 2009. All Child Protection Committees have introduced specific substance misuse protocols and assessment tools have been introduced by addictions services across NHSGG&C that assess the impact of the substance misuse on the child. A protocol for intoxicated adolescents that present at Emergency Departments has recently been introduced.

The following are examples of specific services for substance misuse and domestic abuse:

- Community Addiction Teams

- Specialist midwifery services for vulnerable women across NHSGG&C to identify high risk women in the early stages of pregnancy

- Child and Adolescent Substance Misuse Liaison Nurses to improve awareness and provide assessment of intoxicated adolescents prior to discharge (planned)

- Three gender based violence nurses that provide specialist support to staff

Future action should concentrate on ensuring that pregnancy protocols for vulnerable women are embedded across NHSGG&C.

6.6 There must be clear multi-agency ownership and leadership of child protection

There are clear lines of accountability in place in NHSGGC via the Child Protection Forum and Operational Groups. NHSGG&C is represented on all Child Protection Committee Chief Officers Groups. Recent HMIe inspection reports have identified leadership as an area of strength. Future action should concentrate on maintaining this.

6.7 Child protection teams must be adequately resourced to cope with capacity

There are very few school nurse vacancies across NHSGGC. East Renfrewshire, Inverclyde and Renfrewshire have a small number of health visitor vacancies but there are active plans to recruit for these. A recruitment action plan is also being implemented to address Glasgow City's health visiting vacancies. Ongoing analysis of vacancies will be kept under review.

6.8 Community nursing resources must have capacity and resilience

The recruitment action plan that is being implemented to address Glasgow city's health visiting vacancies will develop capacity, as will the action being taken by other areas to fill a relatively small number of existing vacancies.

Resilience within the workforce will be strengthened via the newly introduced Clinical Supervision Policy and KSF and PDP's are in place for all staff

7. Conclusion

This paper provides an overview of the actions that have been implemented across NHSGGC in relation to lessons learned from:

- The Review of the involvement and action taken by health bodies in relation to the care of Baby P, Care Quality Commission, May 2009

  and

- Significant Case Review: Brandon Lee Muir