NHS Greater Glasgow and Clyde
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Board Nurse Director

NHS Greater Glasgow & Clyde
Key messages for Health from two national inquiries into child fatalities: Baby P and Brandon Lee Muir

1. Recommendations

Board members are asked to note the key messages for NHSGGC arising from two national inquiries into child fatalities: Baby P and Brandon Lee Muir.

2. Introduction

This paper summarizes the messages for Health in the following reports:

- 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.

The mother of Baby P, her partner and the lodger living at the household were charged with causing or allowing the death of a child. On 11 November 2008 at the Old Bailey, the two men were found guilty. The mother had previously pleaded guilty to this charge.

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.

The Healthcare Commission reviewed Baby P's care in relation to the involvement and action taken by health professionals.

4. Summary of overall lessons learned from Baby P report

Systemic failings in a number of areas leading up to the death of Baby P were indicated:

- Poor communication between health professionals and between agencies, leading to a lack of urgent action with regard to child protection arrangements, and no effective escalation of concerns
- Lack of awareness among some staff about child protection procedures, and a lack of adherence, by some staff, to these procedures
- Poor recruitment practices combined with lack of specific training in child protection, leading to the risk of some staff being inexperienced in the arrangements to protect the safety of children
- Shortages of staff at St Ann's Hospital, leading to delays in seeing children - this includes shortages in consultants, nurses and administrative staff
- Failings in governance in the Trusts concerned, excluding the Whittington Hospital NHS Trust.

The Trusts had improved the arrangements in place to safeguard children who attend health services. However, there were some important improvements that still needed to be made. Five specific recommendations were addressed to the four Trusts:

- All four Trusts should ensure that their staff are clear about child protection procedures and have received safeguarding training to a level that is appropriate to their role, as set out by the Royal College of Paediatrics and Child Health

- Haringey Teaching Primary Care Trust and North Middlesex University Hospital NHS Trust must work with Great Ormond Street Hospital for Children NHS Trust to ensure that their staffing arrangements have a sufficient number of appropriately qualified paediatric staff available when required, in line with established guidelines

- Great Ormond Street Hospital must review the adequacy of consultant cover at St Ann's Hospital

- All four Trusts need to establish clear communication and working arrangements with relevant social services departments and, in particular, ensure that there is no delay in establishing contact between agencies once a safeguarding referral has been made to social services

- The boards of all four Trusts must assure themselves on the adequacy of the system as a whole. Specifically, the trusts must ensure that appropriate arrangements are in place to enable:
    - Safeguarding supervision.
    - Staff to attend multi-agency child protection case conferences
    - Appropriate training to be undertaken
    - Signing off the Trusts' own declarations against core standards, assuring themselves that they can do so and do so adequately.

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.

Following the death of Brandon Muir, two separate reviews were commissioned into this case: a significant case review in line with national guidance and an independent review to ensure validation of the significant case review and to address wider issues which may emerge.

6. Summary of overall lessons learned from Brandon Lee Muir reports

The two reviews on the death of Brandon lee Muir identified a number of important issues including:

- Evaluating and the sharing of information
- Need for full background checks on all household members
- Need for continual assessment and care planning
- Conduct of initial referral discussions
- Impact of domestic abuse and substance misuse on children
- Need for clear multi-agency ownerships and leadership of child protection
- Capacity of resources in the child protection team
- Capacity and resilience of community nursing resources.

National issues include:

- Guidance on child protection
- Recognition of the problem of the volume of child referral discussions
- Assessment of the impact of changes to community nursing.

The SCR concluded that there was little opportunity to prevent the fatal assault on Brandon. It also concluded that Brandon's death could not have been predicted by the Dundee authorities.

7. Conclusion

These reports have been examined by the NHSGGC Child Protection Forum. NHSGGC Child Protection Operational Groups (Acute) and (Partnerships) are currently considering the main messages from these reports with a view to ensuring that adequate arrangements are in place in all areas identified. A further report to the Board will indicate the position in NHSGG and C with regard to the conclusions and recommendations and any action which is required.