

# THE HIGHLAND COUNCIL

3 September 2009

Report by Director of Social Work

Agenda Item	
Report No	

## DUNDEE CHILD PROTECTION COMMITTEE SIGNIFICANT CASE REVIEW – BRANDON LEE MUIR

### 1. SUMMARY

The purpose of the report is to inform Members of the significant case review findings into the circumstances surrounding the death of Brandon Lee Muir; to note the response of the Scottish Government; and to request that the Highland Child Protection Committee considers the report's findings and ensure any relevant lessons are applied locally to further promote the protection and well being of Highland's children.

### 2. INTRODUCTION

- 2.1 Brandon Muir died on 16 March 2008, following a violent assault by his mother's new partner, Robert Cunningham. The child when examined was found to have a ruptured intestine and in excess of 30 injuries, including cracked ribs and cuts. Both he and the mother, Heather Boyd, who has learning difficulties, misused drugs.
- 2.2 Concerns about Brandon's welfare in the care of his mother and Robert Cunningham were raised by relatives. Consequently, health and social work staff were in contact with the family, and had arranged to hold a case conference for 18 March.
- 2.3 Following Robert Cunningham's conviction and sentence of 10 years imprisonment, Dundee Child Protection Committee commissioned a significant case review to be undertaken by an independent consultant, Jimmy Hawthorn. Furthermore, Peter Wilson (previously Chief Constable of Fife Constabulary) was asked to prepare an independent review for chief officers.
- 2.4 Both reports were published on 20 August. What follows are the main points in the reports.

### 3. MAIN FINDINGS

#### 3.1 The Report

- The violent attack Robert Cunningham carried out on Brandon Muir could not have been predicted.
- Robert Cunningham had only been living with Brandon and his mother, Heather Boyd, for less than three weeks prior to the boy's death, but the process of assessment had already started.
- Brandon's mother had learning difficulties, and a history involving drugs, alcohol and offending behaviour.

- Social workers had been in contact with Heather Boyd over concerns about her care of Brandon and her other child, but whilst there were ongoing concerns, these never reached a level which prompted consideration of more formal intervention until shortly before Brandon's death.
- Ms Boyd's parents had contacted social workers with concerns about her parenting skills and relationship with Robert Cunningham, who they had seen be violent to another partner.
- Contact with Heather Boyd had revealed no evidence of Ms Boyd's prostitution or drug use.
- Robert Cunningham was known to police, social work services and the Children's Reporter following reports of violence towards a previous partner.
- Social Workers had discussed the concerns about the previous reports of Robert Cunningham's violence towards a partner; however, Ms Boyd did not appear to take their concerns seriously
- When social workers visited the family home they found Brandon did not have any blankets on his bed and that he was wet and needing changed.
- Health visitors identified concerns about the way Brandon was walking. They also noticed a scab on his eye which they accepted had been caused accidentally, though they did consider whether it might have been a cigarette burn. They also noticed the way he craved attention.
- Some information was not made known to the statutory agencies, and some opportunities were not taken for the necessary sharing of information between agencies. In particular, the lack of any substantive information about Cunningham and his history was particularly telling. If the full information had been made available, this may have led to more proactive involvement of agencies with the children.

3.2 The Significant Case Review emphasises the importance of the effective organisation and deployment of staff within both health and social work services. It notes that the workload of the health visiting team and the social work team were very high throughout this period, and that both faced staffing pressures.

3.3 The Case Review stresses the need to have effective engagement between agencies, and illustrates some occasions when this was not achieved with regard to Brandon. It makes clear that inter-agency activity should follow the principles of 'Getting it Right for Every Child', and fulfil the core components that are set out in the national guidance published as part of the Highland pathfinder.

3.4 The Case Review contains a number of recommendations aimed at tightening up procedures and practice in Dundee, and some of which are of wider national interest. These relate to:

- 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 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.
- 3.5 The Independent Review, undertaken by Peter Wilson for the Chief Officers in Dundee, adds to the analysis of the significant case review by endorsing the 'Getting it Right for Every Child' pathfinder in Highland. Furthermore he makes recommendations in relation to:
- Securing clarity of leadership and joint working
  - Improving information sharing and assessment
  - Improving interagency training
  - Community Nursing
  - Domestic Abuse
- 3.6 Whilst these recommendations relate to the circumstances in Dundee, the Minister, Adam Ingram, has asked that the report be made available to all Child Protection Committees to enable wider dissemination and application of any lessons.

#### **4. RECOMMENDATIONS**

Members are asked to note the positive endorsement and support of the 'Getting it Right for Every Child' approach, which has been the focus of the Highland Pathfinder and to ask the Chief Executive to ensure the report and its findings are considered by the Highland Child Protection Committee.

**Signature** -----

**Designation** Director of Social Work

**Date** 25 August 2009

**Background Papers:**

**Author/Reference** Harriet L Dempster