Angus Child Protection Committee

Significant Case Review

"Isabelle"

EXECUTIVE SUMMARY

Published August 2020

Foreword from the Independent Chair of Angus Child Protection Committee

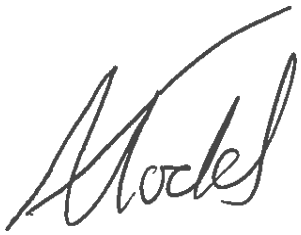
It is with sadness that I publish this Executive Summary of Findings in respect of Isabelle, a young person who tragically lost her life at a young age. My thoughts and sympathies are with Isabelle's family, who have been fully involved in the review. I am confident that the experience of Isabelle and her family are at the heart of this report and that it provides a real opportunity to learn and improve.

The purpose of the Child Protection Committee is to ensure that children and families receive excellent services when they need them and that all children and young people are protected and safe. This review was commissioned to ensure that opportunities to learn and improve in pursuit of this goal are maximised.

We must be confident that, where necessary, appropriate changes are made that impact positively on culture, systems and practice. We work within a complex system and complex external environment. We recognise that this is very challenging work and remain absolutely committed to do our best.

Progress has already been made in many areas and we will continue to review these Findings to ensure that the intended impact and improvement is achieved. Our commitment is to review our work regularly to ensure we do all we can to avoid similar tragedies happening in future.

I would like to sincerely thank Bridget Rothwell, the Independent Reviewer, and all the staff who took part in this review. I know it was a difficult process but also know that the learning throughout the review process was deep and meaningful. My thanks also go to the family of Isabelle who were integral to the findings and recommendations.



Alison Todd

Independent Chair

Angus Child Protection Committee

4th March 2020

Introduction

This Executive Summary presents the main Findings of the Significant Case Review (SCR) in respect of Isabelle.

All names have been changed to protect the identity and confidentiality of the family.

This Executive Summary is produced with the approval of the Independent Reviewer, Bridget Rothwell, and reports on the findings from the Significant Case Review, together with an appraisal from Angus Child Protection Committee on how the Committee will use the findings and the subsequent questions to influence improvement planning for services to children and young people.

The findings of this review have relevance both locally and nationally. We would encourage the findings of this SCR to be used widely as they offer a view on a complex system from the perspective of a young woman, her family and those who supported her.

Why this case was chosen to be reviewed

A request for an Initial Case Review in respect of young person 'Isabelle' was made by Angus Council Children and Families Service to Angus Child Protection Committee on 6th October 2017. Angus Child Protection Committee (ACPC) gathered initial reports from a range of agencies involved with the young person. A mandated sub-group of ACPC was formed and remitted to make a recommendation to the Angus Chief Officers Group on the need for an SCR. The group unanimously recommended that the circumstances surrounding the death of Isabelle would meet the threshold for an SCR on the basis that Isabelle was looked after at the time of death and her death was by apparent suicide (This had not been formally confirmed at this time). The information provided highlighted areas requiring further scrutiny and consideration of service provision in the years before death, including mental health assessment, support and intervention and transition planning at key points including times of crisis. Initial indications were that there were areas of good practice to be highlighted as well as areas for improvement.

Methodology

National guidance gives Child Protection Committees discretion to consider and agree a review methodology and explicitly advocates two evidence-based approaches, the Social Care Institute for Excellence (SCIE) Learning Together model and Root Cause Analysis.

The SCR Panel agreed that SCIE's Learning Together[1] methodology should be used for the multi-agency SCR and that this should be informed through structured conversations held with staff who had been involved with the family and who would comprise the 'case group'.

Research Questions

Learning Together (LT) reviews take their focus from what a Child Protection Committee (CPC) wants to learn more about, using a review of a particular case as the vehicle. LT reviews therefore have research questions rather than fixed "terms of reference".

The research questions build on the learning from the Initial Case Review and were agreed as:

1. What can we learn about how well services in Angus help vulnerable young people make the transition to adulthood?
2. How well do services in Angus provide the right service at the right time and in the right way, to vulnerable young people?
3. To what extent do professionals in Angus understand each other's roles, responsibilities and rationales for decision making in respect of vulnerable young people?

The research questions identify the key lines of enquiry for the review and are framed in such a way that make them applicable to casework more generally.

Reviewing expertise and independence

The SCR has been led by Bridget Rothwell, who is independent of the case under review and is accredited by SCIE. She has been supported by Beth Smith, independent consultant, who is also an accredited SCIE reviewer and has acted as a critical friend to the process; and by Niki McNamee, Lead Officer of Angus Child Protection Committee, who has provided valuable perspectives from her position in relation to the multi-agency system.

Bridget Rothwell has received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

[1] Fish, S; Munro E and Bairstow (2008) *Learning Together to safeguard children: developing a multi-agency systems approach for case reviews* London: Social Care Institute for Excellence

The Review Team

The Review Team are senior managers representing the agencies involved in the case.

The Case Group

The Case Group comprised of 19 **front-line professionals and managers** who were identified as having had a significant role at some stage during or nearby at least one of the Key Practice Episodes (KPEs), or others who could represent them if they were not available. They provided a detailed picture of what happened in the case and why. They also brought their wider experience of working within local systems over a period of time and with a range of cases. All case group members were invited to a two-hour briefing event to orient them to the process and its methodology. They subsequently participated in individual or group conversations about their involvement.

THE FINDINGS

The overarching theme in this case is that there was significant inconsistency in the extent to which the implications of Isabelle's diagnosis of Autism was understood (sometimes because it was not fully accepted). This compromised the coherence of planning and delivery of care in the period between January 2015 and October 2016. When Isabelle moved to a home where the starting point for planning was 'to get to know what Isabelle being autistic meant', the focus and rhythms of her caring environment enabled her to make significant progress.

The question of her future living arrangements and support needs were being explored when Isabelle took her own life in 2017, but it is not possible to conclude that this was the reason why she did so. It was the intention of the review, nevertheless, to reflect on processes for supporting young people to transition to adulthood and the period in which Isabelle's skills for independence were 'tested' in late 2017 form part of what was considered.

The period of review is from January 2015 to Isabelle's death in late 2017 but this period is contextualised by a longer history of contact with services by Isabelle and her mother, Jane, in relation to concerns about her wellbeing.

It is important, however, to note that the 'direction of travel' was to a large extent set in the years preceding the review period. The identification of January 2015 as the starting point underlines this point in that it was the most obviously missed opportunity for professionals to revise understanding of both Isabelle (past, present and future) and the relationship that both she and professionals had with her mother, Jane. This is not to say that there are no other issues in the period before January 2015 that may merit further attention. This is acknowledged as an issue that remains unresolved for both Jane and some of the professionals involved with Isabelle.

January 2015: Dissemination of information and ongoing support

The focus of the review in this period was the planning and decision-making following Isabelle's diagnosis with Autism Spectrum Disorder (ASD or 'autism') in November 2014. Up to this point, Isabelle was understood by mental health practitioners through the conceptual frameworks relating to attachment - mostly in relation to her mother Jane: and trauma - particularly in relation to her attempted suicide. The diagnosis of ASD was shared with Jane and Isabelle in December 2014 and, in January 2015 a 'final network meeting' involving two Child and Adolescent Mental Health Service (CAMHS) staff, the Social Worker, Looked After Children Nurse, and Educational Psychologist, who were all working with Isabelle was held to explore the details and implications of the diagnosis for her care. Other difficulties that were noted at that time were Isabelle's 'identity and changes in care provision'. Isabelle had moved from Secure Care to the current residential resource in October 2014.

Of those attending the network meeting, only the Social Worker was in direct contact with Isabelle at this point. The CAMHS professionals withdrew not long after this, partly because Isabelle said she no longer wished contact and partly because there was considered to be no locus for the service since ASD does not require medical 'treatment'. There was a suggestion that some training would be offered by CAMHS to residential staff caring directly for Isabelle.

There is evidence that the Social Worker made good use of the knowledge gained from this meeting and possibly other sources, to advise and guide care staff. There were significant limitations however, to the dissemination of this key information. It would arguably have served Isabelle better for the meeting to have taken place in the home she was living in, where her immediate carers could have been directly involved in more meaningful discussion about how to implement the strategies suggested in the SMARTS profile that resulted from the diagnostic process. Further, some continuity in consultancy and advice could have been effected, either through clear and active handover to CAMHS staff local to the resource, or to Autism specialists, or by the Tayside team. ***The issue of continuity in out of area placements is addressed in Finding 5.***

January 2015 – August 2015: planning and decision making for placement move

Review meetings that took place during this period paid insufficient attention to the implications of the ASD diagnosis, both in terms of the conduct and content of the reviews (which remained unchanged in format and process) and in terms of the overall frameworks through which both Isabelle herself and her relationship with Jane were understood. In particular, this information should have informed planning for her future and the emerging consideration of a move back to the locality. There is some indication that the Social Worker attempted to prompt some of this thinking when they queried the move in supervision, but this was understood in the context of a current Corporate Parenting Board commitment to scrutinise the number of moves accommodated children were subject to and did not appear to impact further.

Both Isabelle and Jane were vocal in their opposition to the move in placement and there were mixed messages about their contribution to and locus in decision-making and neither were included at the critical meeting in July when it was finalised. Both were reported to be 'coming round' to the idea. While this was clearly a challenging decision to make, due to a number of competing variables and influences, the Lead Reviewer considers there to have been insufficient transparency of process and an impression of inevitability about the move which contributed to the failure to accurately anticipate significant difficulties of adjustment. This is not to say that the decision itself was made lightly or was 'wrong', but that it was grounded on unsafe assumptions and therefore the risks were misunderstood. What was needed at this time was a fundamental revision of how Isabelle had been understood in the past and present and how her ASD would impact on both her transitions and her future care. Autism cannot be 'factored in' as an 'additional' challenge - it is the frame for understanding all aspects of her experience and behaviour.

The long-term consequences of the missed opportunity to appropriately 're-set the direction of travel' were reinforced by the habitual use in Review meetings of the SHANARRI indicator 'list' as a means of allocating agency responsibility for individual domains.

This period particularly exemplifies ***FINDINGS 1 - 4 relating to the relative priority given to reviewing over planning processes, the lack of reflective opportunity and the capabilities of the multi-agency system in relation to Autism and to meeting complex needs***.

It should be acknowledged that Isabelle being in an 'out of area' placement at the time of her diagnosis contributed to communication difficulties and that barriers to the provision of educational and health services in particular clearly contributed to overall failings in this placement. ***FINDING 5 raises questions about the priority given to ensuring continuity for young people, particularly when they are cared for out of their own locality.*** The Lead Reviewer would like to note that considerable effort to work around and beyond the restrictions was made by a number of individual practitioners.

August 2015

When Isabelle returned to the locality, she experienced a complete change in her caring team and environment and was allocated a Newly Qualified Social Worker whose responsibilities were those of Lead Professional in the co-ordination of her multi-agency plan. Given Isabelle's known history and the apparent difficulties and instability in her previous placements the Lead Reviewer questions the appropriateness of this allocation and the ***understanding, oversight and support of Lead Professionals is a question raised in FINDING 6.*** It is important to stress that this is not a question about the commitment or capability of the individual Social Worker who, within the context of their professional experience and length of service at that time, is considered by many colleagues and the Lead Reviewer to have exceeded reasonable expectations in the course of their work with Isabelle and to have had noticeable impact on the relationship Jane had with professionals.

Child Protection Investigations August/September 2015

Two Child Protection Investigations were conducted in August and September 2015, prompted by information Isabelle shared with her Barnardo's practitioner about her involvement in drug use and sexual activity. The conduct of both of these episodes raises serious questions about the conceptualisation of young people's experiences and the extent to which their 'culpability' rather than their vulnerability is emphasised. While the process was influenced by the inappropriate normalisation of 'teenage behaviour' without sufficient account being taken of Isabelle's history and her diagnosis, there is also a wider issue of the need to reconsider these episodes for all young people as an issue of potential exploitation.

There are wider concerns about the multi-agency process. The reduction of the issue to one of needing to establish whether there was a prosecutable offence diverted attention from the need to devise more comprehensive and collaborative plans to protect Isabelle while other agencies 'waited' for a 'result'. There is a sense in which this process was thereby reduced to a model of single agency (Police) responsibility for 'safety' and this is an echo of the issue discussed in ***FINDING 2 about making holistic use of the concept of wellbeing.***

In addition, pursuing evidence relied solely on Isabelle as a source of information and thus the means to safety was considered to lie in her own hands, rather than being the responsibility of the professionals around her. She 'chose' not to reveal information or to surrender her mobile and when she did the assumption that it would reveal vital information was discovered to be untrue and no further action was taken. ***This relates to the focus of FINDING 7, which explores how young people's views are sought and used to 'inform' decision making.***

The Lead Reviewer is aware that there have been improvements in the wider system with regard to police liaison with staff caring for young people and the adoption of more appropriate assessment and response to situations of sexual exploitation. There is a need to continue to actively support practice in this area.

Access to CAMHS August 2015 to September 2016

In the context of the Child Protection concerns, Isabelle's caring team were alarmed about her distress and concerned for her safety. In an attempt to meet her needs and understand what underlay her obvious distress, they wondered if she was suffering from a mental illness or disorder and referred her to CAMHS for assessment. The ensuing processes of short term and event-specific assessment and re-assessment did not result in a diagnosis of mental illness or mood disorder and other professionals experienced invitations from CAMHS to 're-refer if needed' or to 'seek help via the GP' as unhelpful and blocking. For their part, CAMHS professionals defined their role in these (sometimes emergency) circumstances as primarily to 'rule out' mental illness and so did not understand what was being sought of them beyond this response. An assessment in relation to ADHD was commenced.

It is not clear that there was any reference to, or reiteration, of guidance from previous periods of CAMHS input and the advice to "change her environment" was insufficiently specific and/or based on assumptions about shared insight into both diagnosis and history. The Lead Reviewer considers that the lack of shared understanding and eventual conflict, between agencies at this time was the result of a number of systemic issues discussed in ***FINDINGS 1, 6 and 8 relating to opportunities to reach mutual understanding of each other's' thinking and services, and to the role of the Lead Professional as well as the difficulties experienced because of the unreliable transfer of written information.*** This includes the interface between CAMHS and services to support those with Autism.

Secure Care October 2015 – March 2016

A consensus was reached among Isabelle's caring team that she represented an immediate and significant risk to herself and she was transferred by Director's Order to Secure Care in October 2015. In order to establish some breathing space and safety for her a three-month order was sought and granted. Isabelle almost entirely withdrew from interaction except under her own inflexible terms and could not be persuaded by the regime to 'fit in' or 'play by the (incentivised) rules'. Accordingly, at the end of three months, no further insight into the causes of her behaviour or distress were gleaned.

It is significant that, at this point, Isabelle's Who Cares Scotland Advocate helped her construct some written information which was shared with Children's Hearing and in which she conveyed her belief that her Autism was not being accounted for in her care. This appears to have impacted on care in the subsequent period.

A further three-month order was granted and adaptations to 'the usual programmes' were made, and these had positive impact on Isabelle's willingness to participate in ways that she found manageable. Although the assessment of ADHD was considered to remain incomplete and Isabelle having refused to participate in screening for medication, Secure Care staff at this time did not experience her as requiring medication.

While the adoption of autism-informed care led to an improved experience for Isabelle, it also prompted a need to change her placement, given that she would no longer meet the criteria for secure care and was experiencing it as a 'punishment for being autistic'. The onus to identify an alternative placement seems largely to have fallen to the Social Worker individually and they were not apparently able to access a database of information to assist this process and a suitable placement could not be identified. In this context Isabelle told her Advocate that she wanted to go home to Jane's house. ***Aspects of practice here are addressed across a number of FINDINGS as detailed above.*** In the ensuing period of decision making it appears that Isabelle's autism was once again inconsistently used to inform process, particularly the question of her return home.

Frustrations with her (often forceful) oscillations raise the issue of the extent to which the question of permanence became inappropriately her 'responsibility' in the context of seeking to 'respect her wishes'. ***This issue is addressed further in FINDING 7.***

'Open' Care April – June 2016

Plans to transfer Isabelle alerted professionals to the 'incomplete' ADHD assessment. Isabelle transferred to a less 'secure' environment, with a new set of carers and peers, in April and soon after expressed doubt about her move home. By the end of May 2016 there were significant concerns about her use of social media and sexual activity with 'older males' with whom she had 'reconnected'. There is no indication that this was considered through the contextual framework of sexual exploitation which the Lead Reviewer considers would have been appropriate.

Concurrently her ADHD assessment was being completed and, with the approach of her 16th birthday, Isabelle was informed that standard practice was that if she was no longer enrolled in education, once the regime for her medication was agreed, she would be discharged from CAMHS. ***This raises questions about the appropriateness of transitional arrangements for young people and this is discussed in FINDING 10.***

Her future living arrangements were unclear and Isabelle's Social Worker continued to try to identify an appropriate resource.

Isabelle's presentation became more distressed over the next few weeks. An alarming episode of self-harm prompted another referral for assessment to CAMHS and a request for this to be carried out on an inpatient basis. The judgment of the CAMHS consultant was that it was not in her best interests to be admitted to in-patient care. Advice was given about how Isabelle's needs might be met within the setting she was in. This episode resulted in open conflict between CAMHS and Social Work agencies and Isabelle was fully aware of these difficulties and the struggle to identify somewhere for her to be cared for. The deterioration in her functioning led to a further Director's Order being invoked and she moved back to Secure Care for a third period in July.

July – September 2016

The CAMHS consultant's judgment was tested and agreed by a second opinion and further advice was given to other professionals about how to help Isabelle through strategies for self-soothing and the management of her environment. Her stay in Secure Care was reviewed on a three-weekly rolling basis and there was a clear professional consensus that Secure Care was an inappropriate long-term environment for Isabelle. This meant that uncertainty remained dominant. The allocated CAMHS nurse engaged in a high level of liaison and was given leave to visit Isabelle and her carers on site. The Lead Reviewer considers this level of liaison and contact would have been appropriate earlier in the inter-professional relationship since it effectively enhanced communication between the agencies and allowed some level of mutual

understanding to emerge, even in the context of disagreement. It also enabled those who were in a position to offer care tailored to Isabelle's needs to do so, making better use of existing capabilities. ***These issues are further discussed in FINDING 4.***

September 2016 – August 2017

Predominantly through the efforts of the Social Worker and Advocate, a resource was identified for Isabelle in a neighbouring local authority, run by Aberlour (a third sector organisation). The orientation of the home is informed by a core model of care drawing on the principles of attachment-informed care and the centrality of relationship. They began their assessment of Isabelle while she was in Secure Care and took care to prepare for her move, ensuring that a coherent plan could be constructed with her when she moved. Their 'starting point' was provided by Isabelle who told them it was important for them to know that she was autistic. In the opinion of the Social Worker, Isabelle was cared for in this home in a way that she had not been cared for before. Isabelle's care was not straightforward or without difficulties, some of them significant. However, the Lead Reviewer has been repeatedly impressed by the orientation of the staff she has spoken to and the written planning conveys coherence: the resource is able to enact its principles without becoming rule bound and demonstrates child-centred practice both in terms of its own provision and the effective networking to seek further protection for Isabelle when needed. There was a period of relative stability and containment which was mirrored in the functioning of the professional group. ***The effectiveness of this placement is the subject of FINDING 9.***

August 2017 – October 2017

Isabelle's self-care, use of cannabis, contacts on social media and relationship with her boyfriend caused periodic concern and in August 2017 these had become more noticeable. She was not in education or working and had little structure to her day, using her home 'like a hotel'. She was 17. Her Social Worker told staff at Aberlour that they were aware of 'drivers' within their agency to 'evidence' that the placement should continue, given Isabelle's age and the observation that she was not 'engaging in the resource'. A review meeting concluded that some demonstration of her capacity in relation to independent living skills was needed and a two-week programme of assessment was agreed. This began in early September. After a week Isabelle was confronted with the prospect of not receiving any money for the following week and objected forcefully to the solution proposed by those managing her assessment period. She left the home and remained missing. She was found a week later, having completed suicide. It is not possible to draw clear conclusions about some of the issues raised by this episode, but they do ***raise questions about the philosophy and practice of supporting young people to transition to more autonomous lives and this addressed in FINDING 10.***

IN WHAT WAYS DOES THIS CASE PROVIDE A USEFUL WINDOW ON SYSTEMS?

All young people are unique and can only be properly understood within their particular characteristics, histories and circumstances and this case demonstrates the extent to which their very uniqueness creates a particular demand on the multi-agency system as it currently operates. Agencies design their services on the basis of an assumption that there is some predictability about what will be demanded of them. Case group members recognise that this young person, while unique in her particular needs, is also representative of other young people, whose needs are equally, but differently, unique and who come with a 'spectrum' of complexity. They also recognise that those needs are noticeably difficult to meet with the current operating procedures and assumptions (based on knowledge and experience) in the multi-agency care system. The recurring characteristic then, is complex uniqueness (the demand) and the need to respond in individually crafted and sometimes novel ways (the response). To some extent, this has always been true, and an aspiration of the system is to meet individual young people's needs rather than fit them to the system. However, there is some indication that the complexity of the needs of young people who become accommodated is increasing and that there is a need to orient the system to that reality. The particular shift in thinking that professionals need to make when planning care for a young person with ASD epitomises our hopes for all young people – that they might be offered sufficiently customised (i.e. child-centred) responses, regardless of the terms used to describe their combination of characteristics. It is not the label itself that matters, but that it alerts us to the need to examine professional and system assumptions about how we should understand and respond to them.

The Findings describe practitioners' familiar and recurring habits of thinking and doing, which are reinforced by custom, practice and system design, in order to illuminate the ways in which they combine to create vulnerabilities in the system. The intention is not to seek a quick fix or suggest that there is a ready solution, but to help the system to mindfully evolve further to better meet the needs of the young people it serves. Sometimes this might be achieved by some 'rebalancing' of processes or attending to questions about the extent to which the implementation of national and local policy intentions has been enabled.

FINDING 1

There is an over-reliance on procedurally driven review and crisis meetings to bring professionals together, which is undermining the quality of multi-agency assessment and care planning for individual children and young people who have complex needs.

SUMMARY

The two related processes of assessment/planning and reviewing the care of a young person need to be maintained in balance for an effective service to be reliably designed and delivered. The consequences of imbalance towards review are that practice becomes increasingly bureaucratic and proceduralised. Paradoxically, such a system can convince itself that it is active (i.e. busy) and achieving what the assembled professionals are expected to.

Alternatively, as here, the system may become 'stuck' and unable to make progress because it becomes focused on holding professionals to account for their (pre=conceived and not necessarily accurate) contribution to achieving the target. The focus of concern moves to the functioning of the system and does not centre on the young person. The 'rhythm' of pursuit and the need to make progress can become an end in itself.

'Updating' does not incorporate new aspects of a young person's life and the assessment becomes increasingly irrelevant but continues to be the reference point that 'informs' the reviewing process. One consequence of this is that practice becomes increasingly problem-focused and the probability of conflict increases as simplified 'fixes' are sought to resolve those problems. This is mirrored in the narrative about the young person.

QUESTIONS FOR THE COMMITTEE

1. Does the Committee recognise these issues?
2. What is the Committee's role in seeking to manage or reduce the risks of imbalance in the system?
3. What is the Committee's role in enabling reflective assessment and planning practice in joint work?
4. What is the Committee's role in supporting the development of person-centred outcomes for young people?
5. How might the Committee assure itself that the issues highlighted by this Finding are being effectively addressed for all young people?

FINDING 2
The way reviews are conducted prioritises the process of allocation/achievement over joint reflection on meaning, reducing holistic assessment to a list of indicators.

SUMMARY

The wellbeing wheel was designed as a tool which enabled a holistic assessment of young people's needs to be constructed and the means by which different perspectives on elements of their wellbeing could be shared. The 'SHANARRI' acronym can lead to the use of the elements in list form (often to meet the requirements of the electronic recording and storage system), enhancing a tendency in the system to allocate individual agency responsibility to each element and an assumption that others do not need to/cannot contribute to meeting the needs identified under headings not allocated to them.

This both limits the collaborative capabilities of the group and results in blocks when an element cannot be 'allocated' successfully, or the agency allocated to does not fulfil others' expectations. Both the tool and the young person become reduced to a collection of discrete (and problematised) parts, rather than being understood in the round, with the consequence that the young person is objectified and 'done to' rather than effectively included. The introduction of recent changes in both process and recording appear promising and need to be further sustained.

QUESTIONS FOR THE COMMITTEE

1. What is the role of the Committee in supporting an effective and holistic use of the wellbeing framework in Review processes?
2. How does the Committee plan to enable more nuanced collaborative practice among all relevant professionals?
3. How will the Committee measure the degree to which the changes to process that are currently being made are effective the necessary changes to practice?

Angus Child Protection Committee Commentary on Finding 1 and 2

Angus Child Protection Committee recognise Findings 1 and 2 and the need to ensure that there is greater emphasis on the relationship between assessment, planning and review so that plans are made with families to address current need, are adaptive and based on multi-agency assessment. Our systems are established to reflect national practice guidance and this SCR has enabled us to step back and recognise the over-emphasis on the 'review' part of our system and to consider improvements.

Work has taken place between partners to ensure that all children who are looked after, or subject to child protection processes, have a child's plan that is informed by an updated multi-agency assessment. In practice this means the lead professional is responsible for the coordination of an updated assessment, which is inclusive of the views and wishes of the young person and is shared with the young person's network to inform the revision of the child's plan. This is a change in practice from when Isabelle experienced review meetings when the emphasis was on 'updates' against key actions.

Whilst we believe this is a positive change in practice, our efforts are focused on ensuring the professionals involved are supported to deliver assessments that are of a high standard and analytical, rather than descriptive, and we recognise that this is an area that requires improvement. The unique professional expertise of each person involved in a child's network is required to achieve a full and informed understanding of the individual child or young person within their wider world.

The Review Team have revised how child's planning meetings are structured and recorded. We have ceased to use 'SHANARRI' to structure and order the discussion and minutes of a child's review meeting and we place greater focus on the outcomes we are working to achieve. There is further work needed to consider how we promote the 'collaborative capacity' of the network and avoid over-reliance on allocation of task and accountability. Angus CPC will use the findings of this review to further revise our approach to assessment and decision-making for our children and young people and welcome the analysis from the lead reviewer to challenge our current thinking.

We further acknowledge the experience of the family in feeling excluded from decisions, particularly around the use of professional workers meetings and this perspective will influence our future work in reviewing the systems in place to support good decision making.

Through our 'Getting It Right' partnership we have reviewed the previous 'Staged Intervention' pathway to re-focus on a 'Continuum of Need'. The aim is to ensure that we consider children and young people in respect of their identified needs and not based on access to resources. This work supports a programme of multi-agency training which encourages a culture of collaboration and work across boundaries to meet need at an early stage.

Angus CPC and Angus Corporate Parenting Board are involved in testing approaches to improve how we support children and young people and build on a strengths-based practice model. For example, 'Circle of Adults' approach is being tested across our Residential Housing provision and is an approach to promote secure based care. It places the voice of the child, and relationships with that child, at the centre. Angus CPC is also leading a pilot on a strengths-based approach to child protection planning and decision-making - PREpare and will report the findings of this pilot in August 2020.

Aberlour's positive approach to flexible support for young people is discussed in Finding 9. Aberlour have taken steps to ensure staff are supported by engaging an Independent Clinical Psychologist to provide case consultancy and have also restructured their approach to therapies for children and young people. They have implemented a system whereby each child/young person has an individual fund that allows the commissioning of individual therapies based on need.

Aberlour have revised their approach to the planning of children's care to ensure that this is far more developmentally informed. New training in child development for residential staff has been introduced and changes are being driven in recording practice to reflect these approaches.

FINDING 3

Resources are not currently designed to meet the needs of some young people with complex needs, including Autism, running the risk that the care they receive is inappropriate.

SUMMARY

Resources for young people have largely been designed with an assumption that their needs can largely be 'classified' in a limited number of ways and that both generalist and specialist services can be aligned with those needs. Further, staged intervention and tiered services assume that young people's needs can be understood on a scale of 'severity' and that only where an 'earlier' level of intervention has failed to meet the need should more specialised services be accessed.

These assumptions, which are also grounded in a 'least intervention' principle, are useful when the need (and its further development) is well understood and there are theoretical frameworks which guide the design of services and access to them. In this way, many children's needs do get met and they are, furthermore, diverted from full-time public care. It is likely, then, that those who become looked after and accommodated are those young people whose needs are more complex.

However, emerging spectrum disorders such as ASD (which are themselves complex) as well as complex contexts for young people's lives, including greater exposure to risks outside the family and immediate community, challenge a system designed in these ways. Recent studies demonstrate that the impact of early experiences does not impact in a uniform way on individual children. As a consequence, "we must privilege **individual** rather than **generic** accounts of children's wellbeing" (Woolgar, 2013)[2] and create flexibility in services to meet their needs.

QUESTIONS FOR THE COMMITTEE

1. What is the role of the Committee in assessing the capacity of the system to work with young people whose needs and presentations are complex?
2. What is the role of the Committee in supporting the development of a system flexible enough to meet the needs of individual young people?
3. What is the role of the Committee in supporting practitioners to tolerate and work effectively with complexity?
4. If this is a national challenge, what is the role of Committee in further informing and prompting wider change?

[2] in Bazalgette et al (2014)

Angus Child Protection Committee Commentary on Finding 3

Angus CPC recognise that in some situations, secure care is used to safely care for young people who have a number of complex and presenting needs including mental health. There are a number of examples across the Partnership where young people, and in particular young women, experience secure care in response to risk and to preserve safety and wellbeing. There is a lack of appropriate alternative resources where young people can receive intensive intervention and support and remain safe.

"When it became an issue of immediate safety, there were no identifiable alternatives to secure care and this was a recurring situation. Although her initial admission to secure care was felt by all involved to be appropriate as an intervention, she was also felt to have remained there too long (an issue related to 'orientation' of the service and discussed in Finding 4). Her re-admission to secure care was widely felt to be the result of a lack of alternative resources and during this period there were repeated assessments related to the question of the appropriateness of her admission to hospital. Isabelle herself said she felt she was being punished for being autistic and was very aware of the difficulties being experienced in finding someone to care for her".

Angus CPC recognise this as a local and national issue to which there needs to be further consideration under the Scottish Mental Health Strategy as to the use of secure care in relation to the noted area of development of the inpatient needs of young people with an autism spectrum disorder.

There are significant challenges in sourcing appropriate resources for children with ASD and even nationally approved resources can struggle to meet such young people's needs, with concerns emerging regarding the use of restraint and management of extreme behaviours. There are limited opportunities for a joint approach between services to secure suitable resources that meet all the needs of the individual young person.

Angus CPC are also engaging in work across the Tayside Regional Improvement Collaborative in developing a Tayside Mental Health Strategy for children.

FINDING 4

For some children, the current understanding of the interface between attachment, trauma and neurodevelopmental conditions is not sufficiently well-established, which creates a risk of responding inappropriately to some children and their parents/carers and the inefficient use of available resources

SUMMARY

Children with neurodevelopmental conditions form the largest group of children with a disability and estimates of prevalence appear to have risen, possibly at least in part because of increased recognition[3]. Autism is a lifelong spectrum condition, meaning that for some autistic people sufficient environmental adjustment can enable them to fulfil their potential, both as children and into adulthood.

Autism is a pervasive condition which impacts on all aspects of the person's life and fundamentally influences their interactions with other people and their understanding of social situations. Many people with autism are adept at 'camouflage', but this requires effort and energy and may lead to sudden expression of the stress caused by constant adaptation and masking. Terms such as 'high functioning' can mislead professionals to believe that the condition has limited impact and this may result in inappropriate demands being made of the young person with ASD in terms of, for example, their capacity for self-determination and self-care.

QUESTIONS FOR THE COMMITTEE

1. What is the role of the Committee in enabling an increase in awareness of autism across the range of professionals who need it?
2. What is the role of the Committee in enabling the identification of and access to sources of additional information and consultancy when professionals need it?
3. What is the role of the Committee in relation to the inconsistency across agencies in relation to the transitions in the helping system?
4. How might the Committee be assured that practice in relation to autism is improving across all member agencies?

Angus Child Protection Committee Commentary on Finding 4

Angus CPC accepts that there needs to be a greater awareness for staff working with young people who have experienced both trauma, disrupted attachments and who have a diagnosis of neurodevelopmental conditions. There is a higher degree of confidence where staff are supporting children and young people who have autism and have access to specialist advice, guidance and autism-informed services. Isabelle was involved with services for a number of years preceding her diagnosis and the SCR notes that the diagnosis of autism was somewhat lost in the ongoing

[3] Blackburn C et al (2012) *Children with Neurodevelopmental Disabilities* Chapter 9 in Our Children Deserve Better, the Annual Report of the Chief Medical Officer (England)

assessment, planning and review. As is reported above, this was compounded by the focus on review. Angus CPC will consider how we can work with our integrated children's services partnership to ensure that staff working with children and young people have access to specialist consultation to enable them to understand and support young people in the context of complex diagnosis.

NHS Tayside have been considering how systems can be enabled to meet the needs of young people such as Isabelle. All referrals to CAMHS, with the exception of emergency referrals, are now assessed by a Referral Management Group comprising of CAMHS Nursing and Psychology staff. The Group meets twice per week and utilises information from a range of sources including the child/young person's Emis Web health record (e.g. 27 to 30-month developmental review) to inform the assessment process. If a child/young person has co-morbidities, they can move across neuro-developmental pathways as required and do not need to join a new waiting list for different pathways.

Finding 5
Some agencies do not support practitioners to provide care to young people who are placed out of area, resulting in unnecessary disruption and discontinuity for the young people.

SUMMARY
There are good practice reasons - for example, the wish to maintain family ties – why placements outside local authority boundaries are relatively exceptional, but the distribution of specialist resources means that, at times, it is appropriate to access 'out of area' placements in order to best meet young people's needs. Where this happens, it is incumbent on professionals to enable and expedite access to relevant services in the area of the placement. To do so effectively requires a common understanding and willingness to act quickly and in good faith, in order to support and sustain the placement and so maximise the chances of stability and continuity.

A dependable, mutually agreed set of principles in relation to the provision of services for these vulnerable young people is needed to ensure that gaps and delays in provision of key services, such as health care and education, do not undermine other aspects of the young person's life and care. Furthermore, for some young people the issue of continuity of personnel is particularly key and supports clear communication of needs and history, meaning that the young person is less likely to have to repeatedly tell their own story. Where changes are unavoidable particular attention should be paid to transition; signposting is often not enough.

QUESTIONS FOR THE COMMITTEE

1. How can the Committee support continuity in the care of young people, particularly when they are looked after and accommodated?
2. How can the Committee enable greater understanding of the specific roles and responsibilities of practitioners and agencies so that 'exceptional' services are clearly identified as such?

Angus Child Protection Committee Commentary on Finding 5

During the course of this Review, members of Angus CPC have worked to ensure that policies are in place to support both continuity of practice and, where required, planned transitions to local services.

Social workers routinely support children placed out-with Angus although our priority is to keep 'out of authority' placements to a minimum. At times, availability and suitability of resource dictates the location of the placement and this can present logistical difficulties in terms of monitoring, support and family contact.

There is effective shared practice in terms of Educational Psychology input across Tayside in relation to children and young people placed out-with area, with similarly aligned processes. Nationally, the need to be more efficient in finding placements for children and young people out-with area has been recognised and is being explored.

Within NHS Tayside, when a vulnerable child or young person moves out of NHS Tayside Health Board area to another Health Board area, there is guidance in place to support the transfer of health care to the area the child young person will be residing in. Adherence to this guidance ensures that a child/young person has access to local health facilities and that their health needs continue to be assessed during their time out of area, ensuring continuity of care and provision of service.

FINDING 6

The role of Lead Professional in the context of accommodated young people is not sufficiently understood and supported across the multi-agency network, which can undermine its effectiveness.

SUMMARY

The role of Lead Professional (LP) in integrated work is straightforward in theory ("co-ordinating") and more complex in practice. As a professional with a locus in one of the represented agencies, the LP must attend to their own core functions and have an accurate knowledge of the network of other services and the role of other professionals. They are accountable to their own agency but responsible at some level for the functioning of the 'package' and need to be able to assess, *on the basis of practice experience*, what is a reasonable and accurately focused demand of others and when it is that they fall short of requirements.

To do this successfully requires both that the LP authorises themselves (on the basis of sound confidence in their own capabilities) in role and that others in the 'team' around a particular young person authorise them to fulfil their additional functions on the basis of accurate understanding of the extent of their power and the nature of the professional group's task. While this seems well established in the context of 'Child Protection' work, it is less reliable in other contexts. There appears to be an over-reliance on the individual practitioner's skill in this role, leading to variation in its successful operation. One of the contextual changes which may be helpful in this regard is the formalised introduction of the principles and processes of Corporate Parenting.

QUESTIONS FOR THE COMMITTEE

1. How can the Committee support and enhance understanding of both the capacities and limitations the Lead Professional role and the role's relationship to others in the 'team' around a child?
2. How can the Committee support further understanding and active commitment to Corporate Parenting responsibilities?

Angus Child Protection Committee Commentary on Finding 6

Angus CPC will further consider Finding 6 to ensure that professionals across services have a mutual and shared understanding of the role of the Lead Professional. In Angus, it is agreed that for all children subject to a Compulsory Supervision Order, the Social Worker will be the Lead Professional. In all other cases, except children on the child protection register, it will be the person best placed to co-ordinate the plan.

This guidance is contained in our Continuum of Need framework and core to our Roles and Responsibility training. However, we need to consider how we further enable shared understanding, and this will be a focus of our improvement work. Staff engaged in this SCR process expressed the view that professional roles and responsibilities in respect of child protection work are much more clearly established and understood, and we will further explore how to embed these strengths in the looked after children and young people system. This will be undertaken along with

supporting workers across all levels of our organisations to acknowledge, understand and champion their role as corporate parents.

FINDING 7

Sometimes the understanding of children and young people's views is restricted to what is verbalised and not fully understood in the context of their lived experiences which creates risks that children and young people's needs and wishes may be misinterpreted or ignored.

SUMMARY

The requirement to seek and include young people's views is a principle sewn into practice, policy and legislation. While the 'instruction' is straightforward, the achievement of it is not. For practitioners dilemmas will arise as they try to reach an appropriate balance between what children and young people say (or otherwise communicate their wants) and what may be in their best interests. Where time is short and the process of 'seeking views' becomes reduced to a technical exchange (in person or via various technologies and tools), the negotiation between young person and adult is absent or truncated and the young person can be either taken too literally, ignored, or both, depending on the situation.

Understanding other people's views is sometimes not easy; understanding the views of those whose lives have been complex and who experience conflicts of loyalty and anxiety about their futures is even more difficult. Appreciating the 'view' from where they are and their route to that place can lead to the resolution of apparent contradictions in their wishes. This is a process that requires time and the capacity to be 'led' by the young person themselves. The locality has demonstrated some strengths in consultation at board and strategic levels and a commitment to enhancing the voice of young people through Advocacy and these are commendable. However, sometimes practitioners feel less enabled to hear young people's voices and respond authentically from their position as informed professionals. A willingness to negotiate and a focus on person-centred outcomes (rather than actions) is needed, alongside the provision of contexts in which young people can meaningfully participate in the discussion.

QUESTIONS FOR THE COMMITTEE

1. How can the Committee support practitioners to practice more consistently and effectively in this respect?
2. How can the Committee support professional systems to enhance the experiences of young people in having their perspectives understood and made use of to inform their individual planning and care experiences?

Angus Child Protection Committee Commentary on Finding 7

Angus CPC accepts that 'seeking the views of children and young people' can be overly proceduralised and seen as a task that should be completed instead of being a fundamental part of relationship-based practice. We have evaluated some of our systems to understand where systems have actively prohibited relationship-based practice. An example of this is within Social Work Services where services have been restructured to promote consistent and sustainable relationships between children and young people and their workers by reducing points of transfer between teams and services. Based on the views of children and young people, we have designed a digital 'App' to support communication between young people and key professionals involved with them to provide an additional communication channel.

Advocacy for Isabelle was clearly very important to her. We acknowledge the need to enhance our advocacy provision to ensure more young people have access to independent advocacy. Angus Council has invested to further develop this area.

As detailed above, we are testing an approach to engaging children, young people and families (PREpare) in child protection processes. This strengths-based approach places the voice and experience of the child or young person in the centre of decision making, using independent advocacy. We envisage using the learning from this 'pilot' to ensure all of our systems are established with the voice of the child at the centre.

This SCR together with the recently published Care Review will form the basis for joint work between Angus CPC and Angus Corporate Parenting Board to ensure we have a culture that listens to the voice of the child and values the voice of the child in all that we do.

The SCR has highlighted a need to consider how we recognise and respond to Child Sexual Exploitation (CSE) and a need to investigate beyond what young people are willing to tell us directly, or share their view in a way we would prefer to receive it (i.e. in an interview situation). Since 2015/16, the ability of Police Scotland and partners to recognise Child Sexual Exploitation (CSE) has progressed significantly and practice around Interagency Referral Discussions has also changed. We have focused on prevention and disruption of CSE through a programme of awareness raising and learning and will continue this focus through our improvement plans. In addition to the aforementioned changes in processes, Police have led a number of successful operations across Tayside, taking a proactive approach to CSE by targeting and disrupting perpetrators in conjunction with Public Protection partners. These operations have targeted perpetrators rather than relying on victim evidence as the sole trigger for enforcement action.

Tayside, along with the North/East Division, were the first in Scotland to enter into a Partnership with Barnardo's using the RISE Project to embed a CSE Advisor within the Policing Division. This Advisor has been instrumental in driving forward changes in practice and understanding of CSE and the project has been recognised at Scottish Government level.

The Tayside Regional Improvement Collaborative has been created, allowing for a sharing of experiences across the Local Authorities. The Priority Group responsible for child protection has identified child protection processes as a priority and Interagency Referral Discussions have been refreshed across the region, ensuring CSE is considered at all times. The experience of each Tayside Authority around CSE has been shared and a strategic approach to CSE is being developed across the region, recognising that these issues do not respect geographical boundaries.

All Child Protection Officers within Police Scotland are now offered enhanced child protection training and all Detective Officers in Angus have undergone bespoke CSE training sessions. A programme of awareness raising has been underway for some time with all probationary Police Officers, first line managers within the Child Protection system and Chief Officers, raising awareness of CSE and the links to Human Trafficking.

Police, along with partners, are engaging with schools and young people's advisory groups to improve their response to CSE. Events for parents have been held in Angus and Perth and these will be extended across the region under the guise of the Tayside Collaborative. Police and partners have used social media to raise public awareness, with Police Scotland hosting two Facebook events of keeping children safe reaching over 26,000 people.

FINDING 8

The quality of written information and its transfer among professionals and agencies may not always be reliable, which creates a risk of misunderstanding young people's needs and may contribute to a negative impact on their participation.

SUMMARY

Client records are a powerful tool that convey a written version of a young person's story. The full record may catalogue a series of constructed understandings and their associated consequences over a considerable period of time and these are often summarised – in minutes of meetings, or formalised assessments, for example – and/or 'absorbed' in implicit ways in later records. Thus a narrative and a preferred way of understanding a situation is constructed and reinforced over time. This may be useful in some circumstances. However, where a record does not include sufficiently prominent notification of significant changes and events, which indicate that the narrative needs to accommodate new understanding or revision, practice and decision making continues to be grounded in assumptions and understandings that are no longer pertinent.

The complexity of some young people's experiences and the difficulties inherent in capturing multiple perspectives make accurate recording a challenging task. Where more than one agency keeps records about a young person from within their own professional perspective and language, this challenge is even greater. Each step in the effective selection and communication of key information requires skill and knowledge and written documentation is one strand of this process, which helps a group of diverse and sometimes changing professionals establish and retain

or revise understanding of a young person. Where a young person is (over)relied upon to correct information it is likely to lead to conflict and/or withdrawal.

QUESTIONS FOR THE COMMITTEE

1. How can the Committee support practitioners to produce and make effective use of written records, particularly in multi-agency contexts?
2. How can the Committee support practitioners to provide appropriately accessible information at the right time?
3. How can the Committee support recent developments in the use of integrated chronologies?
4. How can the Committee be assured that improvements are being achieved and sustained over time?

Angus Child Protection Committee Commentary on Finding 8

The quality of written records is highly important to ensure a true narrative of the child's history and an evidence basis for assessment and planning for support. As is the case in most, if not all, areas in Scotland, there are no shared information systems in use in Angus and each agency has its own stand-alone system. Angus CPC will undertake work with member agencies to support them to ensure improvement and streamlining of written records. Agencies have programmes of quality assurance in place and we will use the findings of this review to influence our quality assurance and improvement work. This will include work already being undertaken on chronologies as an assessment tool and relates to Finding 1 and 2 about the whole system and support to enable dynamic assessment, analysis, planning and review.

Aberlour has completed some work to improve practice in residential care. Aberlour has refined and improved their referral impact assessment and this revised approach sets out an expectation that staff will meet with referring teams at points of enquiry to allow them to better understand a child's history and ultimately better match children into houses if the assessment is that Aberlour services can meet the child's needs.

FINDING 9

Aberlour's coherent, relationship-based and theoretically informed model is effective in caring for individual young people.

SUMMARY

The resource which provided care for Isabelle latterly demonstrates that a coherent model of care which is both attachment and trauma-informed can have a substantial impact on the young person themselves, and also creates a more contained environment for both family and professional relationships. Much of what was provided at this resource is consistent with national guidance and is informed by currently available research evidence. In particular, it is consistent with a person-centred philosophy which recognises the uniqueness of each young person. In contrast, the models of care offered in other placements appeared to struggle to adapt their care to Isabelle, who was expected to learn to conform, largely through behavioural management.

This meant that the *function* of her non-normative and risky behaviours was often misunderstood, not because staff were not potentially able and willing to offer appropriate care, but because limited and limiting frameworks for understanding were employed. The complexity of needs brought to caring environments by young people makes them challenging to care for well, and even those environments that are more successful, require inter-professional support. The challenge for the multi-agency system is to (re)orient resources to care that is fundamentally designed from an understanding of what vulnerable young people need from carers rather than the other way round.

QUESTIONS FOR THE COMMITTEE

1. How does the Committee understand the challenges of group care settings?
2. What role does the Committee have in enabling wider learning from 'specialist' resources?
3. What role does the Committee have in enabling and supporting the development of systems to support practitioners to adopt a person-centred and relationship-based model of group care?

Angus Child Protection Committee Commentary on Finding 9

Angus CPC recognise the good practice identified from this SCR. Aberlour are recognised as a provider of good quality care for children and young people and we continue to commission their services for some of our young people.

We aspire to deliver consistently high standards of care and partners in the local authority are working to ensure all care offered to children and young people, whether in residential, foster or kinship, is underpinned by a secure base parenting model and that carers have all the support and resources to deliver relationship based care.

FINDING 10

Child and Adult Services are not designed to support seamless transition for vulnerable young people which creates unnecessary anxiety for them and in some cases exacerbates their vulnerability and increases risk.

SUMMARY

The negative impact of insufficiently supported transitional process for young people leaving care is well-evidenced. There have been documented improvements more recently. Over the past decade increasing attention has been paid to defining the fundamental re-orientations required to ensure that young people who are cared for away from home are supported in a way that mirrors what 'we' would want for all 'our children'. In this context, 'we' are those individuals defined as Corporate Parents and 'our children' are those for whom there is a collective responsibility, because it has not been possible for them to live in their birth families. The responsibilities towards these young people have been substantially extended through legislation and there is detailed guidance on implementation. The shifts that require to be made, however, are cultural, and thereby extend beyond process changes in individual agencies – although these will help. What is more urgently needed is meaningful adoption of a new philosophy of 'staying put' rather than 'moving on' and systemic and systematic shifts from the co-ordination of services to collaboration as Corporate Parents. While there has been substantial strategic work in the area, this does not appear to have impacted consistently at practice level raising questions about (support for) implementation.

QUESTIONS FOR THE COMMITTEE

1. Do the Committee recognise this issue?
2. How can the Committee be assured that practitioners are being provided with the opportunity to re-orient to the philosophy of Staying Put and that this is being supported by appropriate decision making?

Angus Child Protection Committee Commentary on Finding 10

Angus CPC accept that we need to work across boundaries to improve transition for young people within and between services, across both geographical and service boundaries. We have been working jointly with Angus Adult Protection Committee to deliver improvements in consistent care pathways for vulnerable young people and at the time of publication of this SCR, continue with this work.

A Complex and Co-existing Needs Group has been developed within Angus Health and Social Care Partnership (AHSCP) as a process for ensuring individuals with complex needs are having those needs met by the most appropriate resource. A Transitions Group, with representation from AHSCP and Children, Families and Justice amongst others, is undertaking work to consider the transition process for vulnerable young people into Adult Services.

Continuing Care is the preferred option for young people, enabling them to stay in long-term stable placements and we continue to promote this option for care experienced young people in Angus.

Summary response from Angus CPC

We would again reiterate our thanks to Bridget Rothwell for this very detailed and analytical SCR which gives us the foundations to consider whole system change. We have not delivered an action plan in response to this SCR, rather we have highlighted where we have made some change already and areas where we will take more of a focus to ensure improvement is not only achieved, but sustained, to lead to better experiences and outcomes for children, young people and families. This SCR forms part of our evidence base for change in child protection and we want to express how strongly we have heard Isabelle's voice during this process of reflection and analysis. We commit to continue to listen to Isabelle's experiences in order to improve our services for children and young people in Angus.

APPENDIX

ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder	
ASD ASC	Autism Spectrum Disorder/Condition	
CPC	Child Protection Committee	
GIRFEC	Getting it Right for Every Child	
KPE	Key Practice Episode	These are brief periods within the longer time frame, selected for more intense scrutiny.
LAC	Looked After Children	
SCIE	Social Care Institute for Excellence	
SCRA	Scottish Children's Reporter Administration	