SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 201707281, The Moray Council

Sector: Local Authority

Subject: Social Work / Child services and family support

Summary

Ms C complained on behalf of Mrs A, about Moray Council (the Council) Children and Families social work department. Mrs A's two children, Child Y and Child Z, were removed from Mrs A's care in September 2016 as a result of a Child Protection Order (an emergency legal order granted by a Sheriff which allows the local authority to remove a child from their parent's care). Ms C complained that the Council unreasonably failed to gather and take into account relevant information when making decisions regarding the children's care and education, both before and after the children were removed from Mrs A's care and placed into accommodation.

During our investigation, we took independent advice from a social worker (the Adviser). We identified the following failings:

- Prior to the children being accommodated:
    i. little or no evidence of exploring parenting style, family or other supports; or questioning and challenging what was observed;
    ii. little or no evidence of clear assessments of risk and need;
    iii. little evidence of the Getting It Right For Every Child practice model (GIRFEC; the Scottish Government's approach to supporting children and young people) being utilised, including a robust, multi-agency assessment; and
    iv. failure to make attempts to engage the family in supporting the prevention of a breakdown in the family or to provide kinship care as a means of preventing statutory care.
- Following the children being accommodated:
    i. failure to consider and arrange independent advocacy for the children in a timely manner;

ii. in the absence of independent advocacy, failure to explore ways of communicating with the children to elicit their views and feelings;

iii. failure to include the views and feelings of the children in many reports;

iv. failure to facilitate Child Y attending their hearings when Child Y voiced their wish to attend;

v. when Child Y changed their story about allegations made, it appeared that the allegations were given less weight and there was not enough understanding of the way in which children and young people may retract their stories. Rehabilitation with the children's father (Mr A) went ahead without this being resolved or there being more clarity on the risks and safeguards in place;

vi. failure to reasonably consider and assess potential kinship placements and follow national guidance and legislation in relation to kinship care assessments;

vii. failure to communicate in a reasonable and timely way with extended family in relation to kinship care;

viii. no evidence that Child Z's views were obtained in relation to moving school; or that Child Z or the new school were prepared for the transition;

ix. failure to promote or encourage extended family relationships;

x. failure to inform Mr & Mrs A of Child Z's admission to hospital shortly after they were accommodated; and

xi. failure to complete a number of Looked After Child forms which should have been completed at the point of the children being accommodated, in a timely manner.

Given these numerous and significant failings, we upheld the complaint and made a number of recommendations to address these failings.

Ms C also complained that the Council failed to handle complaints raised by herself and Mrs A in a reasonable and timely manner. We acknowledged that the complaint was complex, involved correspondence from a number of different people, some of which had overlapping issues, and that there were concurrent information requests. The Council had taken some action to address their complaint handling failings. However, we considered that it remained that much of the handling of Ms C and

Mrs A's complaints was unreasonable and we did not consider the action previously taken by the Council to address all of the complaint handling failings. We therefore upheld this aspect of Ms C's complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Council to do for Ms C and Mrs A:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint (a) we found that the Council unreasonably failed to gather and take into account relevant information when making decisions regarding the children's care and education. (The individual failings are listed below.) Under complaint (b) we found that the Council failed to deal with complaints raised by Mrs A and Ms C in a reasonable and timeous manner	Apologise to Mrs A, Child Y and Child Z for the failure to reasonably gather and take into account relevant information when making decisions regarding the children's care and education. Apologise to Mrs A and Ms C for the failure to reasonably and timeously respond to their complaints The apologies should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/informationleaflets	Copy or record of the apologies. By: 16 September 2020

We are asking the Council **to improve the way they do things:**

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint (a) we found that there was no clear use of the Getting It Right For Every Child practice model being applied (including appropriate multi-agency and risk assessments) when recording the concerns highlighted in the months prior to the children's admission to care; which would have assisted practitioners to identify the cumulative concerns and collated information from other agencies	The Council's child protection function should be delivered within the context of supporting families and meeting children's needs through the Getting It Right For Every Child practice model as stated in the National Guidance for Child Protection In Scotland and the Children and Young People (Scotland) Act 2014	Evidence that the findings of this investigation have been fed back to relevant staff in a supportive manner that encourages learning. Evidence that the Council have considered any training needs for social work staff in relation to the Getting It Right For Every Child practice model and child protection. The Council may wish to consider using this case as a training tool. Evidence that the Council have reviewed their Child Protection guidance to ensure it takes into account the Getting It Right For Every Child practice model and the relevant legislation in relation to supporting families and meeting children's needs. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint (a) we found that there was a failure to engage the extended family in supporting the prevention of a breakdown in the family or to provide kinship care as a means of preventing statutory care	In line with the Children (Scotland) Act 1995, the Council should promote the upbringing of children by their families and the possibility of kinship care placements should be considered at the earliest opportunity and if this is not possible, the reasons should be recorded	Evidence that the findings of this investigation have been fed back to relevant staff in a supportive manner that encourages learning. Evidence that there is appropriate policy and guidance in place to ensure that the possibility of kinship care placements are considered at the earliest opportunity. By: 9 December 2020
4.	Under complaint (a) we found that there was both an absence and delay in properly seeking the views of the children, including by use of independent advocacy, and including these views in the relevant plans and paperwork	The views of children should be sought in line with the Getting It Right For Every Child Framework and as laid down in the Children (Scotland) Act 1995 and the Children and Young People (Scotland) Act 2014. The views of children should be listened to, considered and recorded; and independent advocacy should be considered for children in a timely manner	Evidence that social workers have been reminded of the importance of recording children's views appropriately and considering the use of independent advocacy. Evidence that the Council have considered any training needs for social work staff in relation to seeking and including children's views. Evidence of an audit being carried out of Looked After Child and Child

Rec. number	What we found	Outcome needed	What we need to see
			Protection paperwork, and Child's Plans, to ensure that children's views are being sought and included appropriately. By: 9 December 2020
5.	Under complaint (a) we found that there was a failure to facilitate Child Y attending their hearings when Child Y voiced their wish to attend	If a child expresses a wish to attend their Children's Hearing, they should be facilitated to attend, regardless of whether they have previously been excused; in line with national guidance	Evidence that social workers have been reminded of a child's absolute right to attend their hearings; and of their responsibility to facilitate this if a child has expressed a wish to attend. Evidence that the Council have considered any training needs for staff in relation to their responsibilities to facilitate children to attend their hearings. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
6.	Under complaint (a) we found that the timescales to complete the kinship care assessments were considerably outwith the recommended timescales laid down by the statutory guidance	Timescales for kinship care assessments should be in line with the Looked After Children (Scotland) Regulations 2009 and the Adoption (Scotland) Act 2007 - Part 9 Kinship Care unless the reasons as to why this is not possible are specifically recorded	Evidence that the Council's policy and procedures on kinship care assessments are in line with the timescales in statutory guidance. Evidence that social work staff at the Council have been reminded of the guidance in relation to kinship care assessments. Evidence that there is a system in place to monitor timescales for kinship care assessment and management action taken to address when timescales are not being adhered to. By: 9 December 2020
7.	Under complaint (a) we found that communication with the extended family regarding consideration and assessment of kinship care placements was delayed, unclear, and not proactive	Communication with extended family in relation to potential kinship care placements should be proactive, clear, and timely	Evidence that the findings of this investigation in relation to communication with extended family members have been fed back to relevant staff in a supportive manner that encourages learning. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
8.	Under complaint (a) we found that Child Z moved school without any proper sharing of information and preparation and the decision was made outwith a Looked After Child review and prior to a Children's Hearing, without reasonable evidence that this was warranted	Prior to any decision that brings about a change to the child's plan, or before a decision to seek a Children's Hearing for a child whose supervision order they think should be varied or terminated, a Looked After Child review should be held	Evidence that social workers have been reminded that significant decisions concerning a child should not be made outwith a formal review. Evidence of an audit to ensure Looked After Child reviews are being held appropriately. By: 9 December 2020
9.	Under complaint (a) we found that when Child Z moved school, the new school were not notified of the background and did not learn of the involvement of other agencies until they received the child's educational file some time later	When a child who has social work involvement moves school, the new school should be informed of this in a timely manner in line with the Getting It Right For Every Child national framework principles of working collaboratively with the child at the centre	Evidence that the findings of this investigation in relation to the Getting It Right For Every Child national framework principles of working collaboratively with the child at the centre have been fed back to the relevant staff in a supportive manner which encourages learning. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
10.	Under complaint (a) we found that the records evidence that the attitude of social work was at times judgemental and based on pejorative personal opinions	Social workers should avoid making statements based on assumptions and pejorative personal opinion	Evidence that the findings of this investigation in relation to record-keeping and attitude towards families have been fed back to relevant staff in a supportive manner that encourages learning. By: 9 December 2020
11.	Under complaint (a) we found that the parents were not notified that their child was admitted to hospital despite still having parental responsibilities and rights	Parents with parental rights and responsibilities should, as far as possible, be consulted prior to medical treatment or in cases of an emergency admission be notified as soon as possible, in line with the Children (Scotland) Act 1995	Evidence that social workers have been reminded of and understand their legal obligations in respect of children and parents. By: 9 December 2020
12.	Under complaint (a) we found that although Child Z moved to a new local authority area, a letter to the authority informing them that Child Z was living there and requesting a transfer Child Protection Case Conference was not sent until three weeks after they moved. This was outwith guidance and also caused the receiving local authority to be	The Council should adhere to the National Guidance for Child Protection in Scotland in relation to notifying the receiving local authority immediately when children and/or their family move	Evidence that social workers have been reminded of their obligations under the National Guidance for Child Protection in Scotland. Evidence that the Council's procedures and guidelines meet the National Guidance for Child Protection in Scotland standards.

Rec. number	What we found	Outcome needed	What we need to see
	outwith the timeframe for holding the Child Protection Case Conference		By: 9 December 2020
13.	Under complaint (a) we found that Looked After Child forms, including a general medical consent form, were not completed at the point of admission to care and there was a delay of almost four weeks following accommodation	The relevant Looked After Child forms, including general medical consent, should be completed at the point of a child being admitted to the care of the local authority, or in cases of emergency, as soon as is practicably possible after the child is placed; in line with The Looked After Children (Scotland) Regulations 2009	Evidence of an audit to ensure that Looked After Child forms are completed prior to or at the point of a child being accommodated. By: 9 December 2020
14.	Under complaint (a) we found that there were numerous and significant failings in relation to gathering and taking into account relevant information when making decisions regarding the children's care and education	When making decisions regarding the care and education of children, the Council should appropriately gather and take into account relevant information	Evidence that the findings of this investigation have been reviewed in full by a senior member of staff at the Council and that they are satisfied that all failings have been addressed by the recommendations above or actions already taken by the Council. If they are not, an action plan should be devised to ensure that all issues are addressed appropriately and fully. By: 9 December 2020

We are asking the Council to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
15.	Under complaint (b) we found that there were serious and significant failures in relation to complaints handling	Complaints should be handled in line with the relevant complaint handling procedure	Evidence that the Council have carried out a review into the handling of this complaint, identified where improvement action (such as training) is required, and developed an action plan to improve complaint handling. By: 9 December 2020

Feedback

Points to note

The Adviser noted that there was a regular programme of supervised contact with both parents, but commented that, in their view, the timetable of contact placed a heavy burden on the children as on occasion they were having two contact visits a day, one with each parent and some that included extended family. The Adviser acknowledged that it is always a difficult balance to ensure there is sufficient contact but also that it is relaxed and comfortable to promote a good experience and build relationships. However, they considered the contact plan, while demonstrating a regular arrangement, was a demanding one for everyone, not least the children. The Council may wish to reflect on this matter.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to my office on behalf of Mrs A, about Moray Council (the Council) Children and Families social work department. Mrs A's two children (Child Y and Child Z) were removed from Mrs A's care in September 2016 as a result of a Child Protection Order (CPO) (an explanation of terms used throughout this report is in Appendix 1) granted by the Sheriff Court. Ms C complained that the Council failed to follow national regulation and guidance, both before and after the children were removed from Mrs A's care.

2. The complaints from Ms C I have investigated are that:

(a) The Council unreasonably failed to gather and take into account relevant information when making decisions regarding the children's care and education (*upheld*); and

(b) The Council failed to deal with complaints raised by Mrs A and Ms C in a reasonable and timeous manner (*upheld*).

Investigation

3. In order to investigate Ms C's complaint, my complaints reviewer and I obtained the relevant social work records from the Council, and independent, professional advice from a social work adviser (the Adviser). In this case, I have decided to issue a public report on Ms C's complaint because of the significant personal injustice to Mrs A and her family arising from the failures identified; including significant local complaint procedure failings. I also consider there may be wider learning from the issues addressed in this report for other social work authorities.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer and I have reviewed all of the information provided during the course of the investigation. Ms C and the Council were given an opportunity to comment on a draft of this report.

Background

5. Mrs A originally contacted social work around March 2016 detailing concerns about Child Y's behaviour, which was impacting on Child Z. Mrs A made a referral for support and this was responded to by social work who visited the family at home to establish what support was required. By April 2016, Child Y had a working diagnosis of Autism Spectrum Disorder (ASD). (This diagnosis was confirmed by the Child and Adolescent Mental Health Service (CAMHS) in February 2017).

6. Following social work's involvement an Initial Child Protection Case Conference (CPCC) was convened and both children's names were placed on the Child

Protection Committee Register. A Child Protection Plan was put in place to support Mrs A and the children's father (Mr A) and this included working with Action for Children (a third sector organisation who work with local authorities to provide support to children and families) on parenting skills and support.

7. Social work made a request to the Children's Reporter to consider whether there were grounds of referral for a Children's Hearing to be convened.

8. Before a Children's Hearing was organised, concerns of a child protection nature took over and the children were made subject to a CPO which resulted in the children being removed from parental care and accommodated in a Residential Home for Child Y and a foster placement for Child Z. The CPO was granted by a Sheriff on 16 September 2016 and this was then reviewed by the Children's Hearing who made a decision that the risk was such that the placements should continue. The grounds of referral were put to Mr & Mrs A. Mrs A denied the grounds and they were referred to the Sheriff to prove. (Mr A later accepted the grounds as amended in April 2017).

9. This was a lengthy process and the grounds were not proven until 23 June 2017. In the intervening period, several Interim Compulsory Supervision Orders (ICSO) were made until the grounds were established. The Sheriff referred the grounds back to the Children's Hearing to make a decision on whether there was a requirement for a Compulsory Supervision Order to be put in place, which they did at a Children's Hearing in July 2017.

10. Kinship care planning was considered, as multiple family members wished to provide alternative care for the children. In-between time, and as a result of the length of time that the grounds took to be proven, Child Z was placed with Mr A. Following transfer to another social work service, Child Y was returned to Mrs A's care.

(a) The Council unreasonably failed to gather and take into account relevant information when making decisions regarding the children's care and education

Concerns raised by Ms C

11. Ms C raised the following main concerns about the Council in relation to their social work practice:

- Failure to carry out multi-disciplinary assessment of the children's needs;
- Failure to carry out a parenting assessment before or after removal of the children;

- Failure to obtain corroboration of assertions regarding Mrs A's mental health;
- Failure to involve educational psychology service in decisions regarding moving the children to different schools;
- Failure to involve the children and parents in decision-making;
- Failure to involve extended family in assessment and planning;
- Failure to bring the children to Children's Hearings and Looked After Children reviews despite their wishes to attend;
- Failure to consider placing children in kinship care placements; and
- Failure to promote family relationships.

The Council's response

12. In their initial response to Ms C and Mrs A's complaints (sent around 19 June 2018), the Council responded to only some issues, stating that the outstanding matters would be responded to by an 'independent enquiry officer'. I have considered complaints handling further under complaint (b). Of the aspects that were considered in the initial response, the Council identified only one failing: that they had wrongly advised that Mrs A could not bring Ms C to a meeting for support.

13. On 9 August 2019, the Council sent Mrs A a further complaint response addressing the outstanding issues. They upheld the following points:

- A Looked After Child (LAC) Review held on 25 October 2017 did not meet the professional standards that the Council aspires to, in that it did not appropriately include everyone.
- They considered that they could have been more robust in their engagement with family and their commitment to assessing and supporting a range of contacts with family members and alternative care options. The Council said that from this, they have built into practice the need to rigorously consider family options, and are developing 'Family Group Decision Making' as a primary intervention.
- The Council acknowledged that they could have provided Mrs A with a dedicated worker to ensure that she was fully contributing to planning around the children's care during this difficult time, and allowed the opportunity to go through and reflect on reports and statements being presented. They said that the learning from this had enabled them to reflect upon practice and consider the separate needs of parents in a more meaningful way.

Relevant policies, procedures, legislation, etc.

14. The Adviser considered the following legislation, policies and guidance when providing their advice:

- Children (Scotland) Act 1995
- Children and Young People (Scotland) Act 2014
- Children's Hearing (Scotland) Act 2011
- Looked After Children (Scotland) Regulations 2009
- Getting it Right for Every Child (GIRFEC)
- National Guidance for Child Protection in Scotland
- National Risk Framework to Support the Assessment of Children and Young People

Advice

15. The Adviser was first asked to comment on the Council's social work input prior to the children being removed from Mrs A's care in September 2016.

16. The Adviser noted the following background from the social work records:

17. The family moved into the Council area in February 2016 and the first contact with social work was when Mrs A contacted them on 2 March 2016 about Child Y's behaviour and the impact this was having on Child Z. Social work contacted the children's school to gather some initial information. Between March and September 2016 there were a number of concerns documented by social work including Child Y's behaviour, serious allegations made against Mr A, and Mrs A's behaviour and mood.

18. In July 2016, the Children's Reporter requested a social background report and Mrs A's lawyer requested that additional information be considered prior to the report being sent, as the family had commissioned a report from a specialist in autism. Following the submission of the report, social work received several emails from extended family members who were extremely unhappy about not having been consulted prior to the report being submitted.

19. Due to an accumulation of concerns over the summer months, social work sought advice from the Council's legal department on 12 September 2016. The legal department advised that although the situation was distressing it did not give rise to seeking a CPO. However, on 15 September 2016, when carrying out a home visit a social worker documented that Mrs A was not answering her door[1], and when she did they were very concerned about the way Mrs A was acting around Child Z and the

[1] In commenting on a draft version of this report, Ms C and Mrs A disputed that this was the case.

behaviour of Child Y. The situation was deemed to have escalated and a CPO was applied for and granted on 16 September 2016.

20. The Adviser's view was that the situation as it unfolded over the months revealed a family who were clearly struggling with a variety of issues, were not coping well and Mr A left the family home during this time. The Adviser noted that there were real concerns regarding Child Z who was showing obvious signs of struggling with Child Y's behaviour towards them, and their parent's inability to prevent this; serious allegations were made; and social workers felt that Mrs A was not engaging with the support being offered.

21. The Adviser said that although extended family lived in another part of the country it was evident that they wished to provide support and it was not clear why there was not more involvement of them by social work at an earlier stage in supporting the family; this is covered in more detail later in this report.

22. The Adviser said that with regard to Child Y, there were attempts to engage with CAMHS to determine a proper diagnosis of their condition in order to be able to support them in a way that met their needs, but Child Y appeared to be reluctant about formal testing or going to meet a psychiatrist. Therefore, formal diagnosis took much longer and indeed was not made until almost a year later in February 2017, when they had been in statutory care for almost five months.[2]

23. The Adviser said that while it can be evidenced that there was regular visiting to the house including responding to different crises, they did not consider there was enough questioning by social work of what was observed both in the home situation and of the family dynamics. The Adviser's view was that there did not seem to be any challenge to the conflicting accounts being given of what was happening. The record depicted descriptions of what was found rather than how these issues were addressed with the family. Neither was there an understanding of why it was important to do so in respect of how the children were presenting and behaving, notwithstanding that Child Y had a working diagnosis of ASD.

24. The Adviser said that there was little or no evidence of exploring with the parents their style of parenting or what support from extended family or other sources was available. For example, in the record the social worker writes, following a home visit on 20 April 2016, *"I noticed pinned on the fridge is a hand written note from dad to [Child Y] saying that he promises not to hurt [them], mummy or [Child Z] anymore love dada"*. The Adviser said that there was nothing to suggest this was discussed with the parents as to its meaning or the implications that may arise from that for the children or the family unit.

[2] In commenting on a draft version of this report, Ms C noted that at one point Child Y's case had been closed by CAMHS as they were under the impression that the family were moving to a different area, and this contributed to the delay in reaching formal diagnosis.

25. The Adviser further noted that on 25 April 2016 social work was contacted by Mrs A informing them that Mr A had been taken to the police station; and on visiting, the social worker recorded that the family were in crisis. However, the Adviser said that there is no record to suggest that this was taken as an opportunity to delve a bit deeper into what was going on. Despite the recognition that there was a lot happening within the family and a great deal that was unknown, there was no real evidence of this being investigated or explored more thoroughly to enable a clear assessment of risk and need.

26. The Adviser said it was hard to get a sense from the records of what aspects of care social work were focussing on and what was expected to change within the family to diminish the perceived risk to the children. The Adviser noted that the National Risk Framework states in its introduction "*Risk is a difficult and complex notion that can create understandable anxiety for many. It is, however, also a core consideration of any intervention that is undertaken with children and families".*

27. The Adviser said that this was a family where from early on, there were signs and indicators that highlighted the complexity of family relationships and the concerns arising from this, and the necessity to have a clear risk assessment. However, the Adviser said that this never seemed to be achieved.

28. The Adviser went on to comment that GIRFEC principles are woven into the National Risk Framework to support the assessment of children and young people and enables workers to ask the GIRFEC key questions:

- What is getting in the way of this child or young person's well-being?
- Do I have all the information I need to help this child or young person?
- What can I do now to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?

29. They noted that it is also important to consider the source of the risk and the capacity of the parent to effect the necessary changes. The Adviser said that they could not see evidence of this methodology having been taken which would have enabled a more rigorous approach and may have prevented the circumstances from reaching the point where emergency intervention was required. The Adviser did not believe that enough was done to obtain a robust multi-agency assessment.

30. The Adviser said that irrespective of whether much more could have been done to prevent the situation escalating, at the point that an emergency CPO was sought, the balance of risk had reached a point whereby it was assessed the children could not remain at home. However, the Adviser said it was unclear why approaches were not made to the extended family at the point of considering the taking of a CPO in order to have minimised the trauma for both children and prevent them being

received into the care system. It was recorded that an attempt was made to contact the family and no one had got back to them. However, the Adviser said that from the record it did not appear to have been a very robust attempt to contact the family.

31. Overall, the Adviser was of the view that the absence of a multi-agency risk assessment and plan from the point that it was clear that this was a family in crisis (around April 2016) hampered ongoing involvement of social work; which appeared to be reactive rather than proactive in its approach, leading to distrust and a lack of confidence from the family, and thereby creating a situation that was perceived as non-engagement by Mrs A. The Adviser said that in their opinion this created an impasse from which it was difficult to move on.

32. The Adviser was asked whether or not they considered social work to have reasonably taken into account Child Y's working diagnosis of ASD during their assessment of the family prior to the CPO being sought and granted. The Adviser noted that Child Y was referred to CAMHS in February 2016 but was reluctant to engage in the formal testing and it took some time to build Child Y's trust. It was not until February 2017 that a formal diagnosis was made. The Adviser said that it appeared that all professionals took the view early on that there was a working diagnosis of ASD and there does not appear to have been any disagreement that Child Y had ASD. However, as above the Adviser did not see evidence of a risk assessment taking account of the key GIRFEC questions to establish how much of what was going on was related to Child Y's ASD and whether more could have been done in supporting this aspect of their care or whether any of the behaviour was related to what was going on within the family.

33. The Adviser noted that it is important that there is a multi-agency effort when meeting the needs of a child with complex needs, and although all agencies were contributing to the child's plan there was not a sense of this being a team approach in terms of day-to-day working to develop an appropriate plan.

34. The Adviser was asked whether they considered there to have been an unreasonable failure to carry out parenting and mental health assessments for Mrs A prior to the children being removed from her care. The Adviser said that it was evident that the relationship between Mrs A and social work was poor and Mrs A did not find the approaches being taken helpful to her or her children. They noted that there were recordings which voiced concern regarding Mrs A's mental health but attempts to refer her for a forensic mental health assessment did not come until after the children were removed, and at the family meeting held a few days after the children were accommodated the social worker raised the need for a mental health assessment. The Adviser noted that the involvement of Action for Children, in May 2016, was to provide parenting support and advice but from the outset Mrs A did not like their approach and this made progression of this difficult.

35. The Adviser also commented that in relation to a mental health assessment, Mrs A would need to have agreed to such an assessment and this would generally be arranged by a GP referral. The Adviser said that there is no record of this being discussed fully with her or with the involvement of her GP. The Adviser was of the view that if the concerns about her mental health had been so great that her mental health placed the children at risk, they would expect contact with the GP to have been made.

36. The Adviser considered that there should have been more collaborative and focussed work carried out prior to the situation reaching the point of the CPO being sought, and this may have prevented the need for such a step. However, they explained that the circumstances around the point of the CPO being taken made whether a parenting assessment or a mental health assessment had been completed secondary to the immediate risk thought to be present.

37. The Adviser was asked to comment as to whether or not they considered the Council to have made reasonable attempts to involve wider family when making plans for the children; taken into account their views; and considered whether kinship care as opposed to foster/residential care was a possibility. The Adviser noted that there was plenty of evidence that many of the wider family and some friends were keen to be involved to help prevent the need for the children to be accommodated.

38. As far back as August 2016, family members were indicating that they were keen to be involved and were flexible in the range of support they could provide. The Adviser said that whilst the department recorded these notes of interest, there was little evidence that they did anything with them prior to the children being accommodated. The Adviser also noted that the family wrote conveying their distress at not having been involved prior to the report for the Children's Reporter being submitted in the summer of 2016 and indicated that they were assured they would be involved prior to its submission. The Adviser said that while the numbers of family keen to be involved, and the distances involved, were challenging, this did not justify the lack of involvement or consideration being given to them caring for the children to prevent them having to be accommodated.

39. The Adviser was of the view that there was no evidence that any real attempt was made to engage the family in supporting the prevention of a breakdown in the family or to provide kinship care as a means of preventing statutory care. They noted that there was a family meeting held with social work on 20 September 2016, four days after the children had been accommodated, to ascertain what support from family may be appropriate for the future planning for both children. However, the Adviser said that it was not clear what happened immediately thereafter. They noted that there was an undated kinship care plan, devised by the maternal family, using the GIRFEC principles of Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included ('SHANARRI'), which showed a great deal of thought had been given to the support needed for each child and how the family would work

together to support them. The Adviser was not clear when this was written or if it was ever used by social work.

40. The Adviser said that they could see no evidence that there was any real attempt to consider kinship care prior to the removal of the children, even after the Council sought legal advice on 12 September 2016, when involvement of the extended family would have been important in supporting what social workers considered to be an increasingly concerning situation, and one that they could have anticipated would continue to get worse. The Adviser's view was that it should have been at this point, following the family meeting, that the kinship care assessment should have begun. However, it did not commence properly until April 2017, seven months later.

41. The Adviser said that a key principle of the 1995 Act is

> *So far as is consistent with safeguarding and promoting the child's welfare, the public authority should promote the upbringing of children by their families.*

42. The Adviser said that there was obviously an intention at the outset that the extended family may be an alternative to care as the following internal email on 4 August 2016 would suggest:

> *"If you are wanting to place in kinship care it's best to use a planned method and do the assessment first – this gets checks done, home seen and a carers profile ready for the Children's Hearing.*
>
> *If it has to be an emergency placement you (as lead professional) need local police checks, health check on proposed carer – usually a call to GP or health visitor – and local authority checks – call [authority], living arrangements seen and a signed carer agreement – found on the day to day placement agreement form"*

43. However, the Adviser said that there is nothing in the record to show why this was not followed through; and they considered this to be an unreasonable omission. They said that even if there were reasons why the extended family who were keen to be involved were deemed not suitable, this should have been recorded and reasons given.

44. The Adviser was then asked to comment on social work involvement following the children being accommodated. First, they were asked whether they considered the children's views to have been appropriately sought and reflected in reports, etc., by social work, or not. The Adviser said that in much of the LAC and Child Protection paperwork from both before and after their admission to care, there is considerable evidence of the children's views not being recorded and that they had not contributed to the plans.

45. The Adviser said that there was little sense of how the children were helped to understand what was happening and why. There does not appear to have been any consideration of a Children's Rights Worker being involved or an independent advocacy organisation such as 'Who Cares? Scotland' (a third sector organisation working with care experienced young people) until July 2017, almost a year after the children had been accommodated. The Adviser noted that there was an example of Who Cares? Scotland talking with Child Y prior to an LAC review and Child Y expressed that they did not want their views shared. Child Z met with a Who Cares? Scotland worker in August 2017 and their views were emailed to social work, however, these views were not included in the LAC review which was held two days later.

46. The Adviser noted an internal email on 20 September 2016 from the out-of-hours service who contacted Child Y's unit to be able to give Mr A an update on Child Y, and was told that Child Y had been anxious and disappointed that they did not get to attend the hearing or see their parents.

47. The Adviser said that given the circumstances, the involvement of a children's advocate much earlier on, and provided regularly, would have facilitated better communication for the children and allowed their voice to be heard.

48. The Adviser said that amongst the key principles of the 1995 Act is

i. *Each child has a right to be treated as an individual*

ii. *Each child who can form a view on matters affecting him or her has the right to express those views if he or she so wishes*

49. They also said that the National Guidance for Child Protection in Scotland stresses the importance of this when working with young people who may be at risk:

> *The reactions, perceptions, wishes and feelings of the child must also be considered, with account taken of their age and level of understanding. This will depend on effective communication, including with those children and young people who find communication difficult because of their age, impairment or particular psychological or social situation. It is important to observe what children do as well as what they say, and to bear in mind that children may experience a strong desire to be loyal to their parents/carers (who may also hold some power over the child). Steps should be taken to ensure that any accounts of adverse experiences given by children are accurate and complete, and that they are recorded fully.*

50. And the Government's guidance Working Together to Safeguard Children highlights:

"… the effective protection of children is founded on practitioners developing lasting and trusting relationships with children and their families."

51. The Adviser acknowledged that communicating with children involves building a relationship with them, and that this is not always possible in the initial stages when involved in a Child Protection investigation where there has been no prior involvement. However, the Adviser was of the view that there was little evidence of the above principles being applied while the children were at home, or immediately after they were accommodated. The Adviser noted that there are a lot of helpful tools in working with children and communicating with them to elicit their views, particularly when a situation is complex. Independent advocates for children are trained to do this but there are also online websites which have helpful resources that can be used to facilitate this. The Adviser said that they could find no evidence, in the absence of involvement of independent advocacy, of any attempt to explore more helpful ways of communicating with the children by the social worker to elicit their views and feelings and in many reports there was no recording of their views. The Adviser said that this is not reasonable.

52. The Adviser also commented on whether the children were appropriately aided by social work to give their views, attend Children's Hearings and LAC reviews. The Adviser did not consider that this was done well. Although they noted that some reports recorded the children's views, they were not offered independent advocacy for a considerable time after they were received into care. The Adviser noted that a meeting requested by Child Y with residential staff, held on 3 March 2017, illustrates their frustration and unhappiness about this. The Adviser said that it appeared that Child Y voiced quite articulately how they were feeling about the failure to organise independent advocacy in time for the review. The Adviser added that if a child expressly wishes to attend a hearing, even if social work believe they should be excused, the child has the right to attend. The Adviser said that given Child Y had voiced their wish to attend the hearing, this should have been facilitated for them and the Adviser said that the Council had not acted appropriately or reasonably in denying this.

53. The Adviser said that there is a record of Child Z not wanting to be in the hearing in July 2017 and arrangements being made for them to meet with panel members outwith the formal hearing. The Adviser said that whilst this appears to have been Child Z's choice, the involvement of independent advocacy or recording of Child Z's views were absent both prior to being removed from home, and much later in the process. The Adviser also said that it is not clear that Child Z's views were sought about changing schools, but that it seemed unlikely from the records.

54. The Adviser also said that they considered that generally there appeared to be selective listening of what Child Y had to say, and most notably in relation to the

allegations and retractions they made regarding their father, Mr A.[3] Though the Adviser noted that there was a police investigation at the outset, they raised concern that because Child Y changed their story frequently it was given less weight.

55. The Adviser said that there is a lot of research available with regard to children making allegations and then retracting them. It is a complex matter that needs to be carefully handled and not dismissed. The Adviser did not consider that there was evidence that the allegations were taken seriously (following the initial police investigation) due to Child Y changing their story/retracting the allegations, and said that it appeared there was a lack of understanding of the way in which children and young people can retract or change their stories but this does not mean that the events did not occur. The Adviser said that there did not appear to have been any significant exploration of the issues with either parent or attempt to gain a better understanding of the dynamic within the house by challenging some of what was alleged to be happening. The Adviser noted that Child Z's rehabilitation with Mr A was agreed without any clear outcome emerging from the allegations.

56. The Adviser was next asked whether or not they considered potential kinship placements to have been appropriately considered and assessed. In addition to the response given above, the Adviser said that there was a lot of evidence in the record to demonstrate that potential kinship placements were not appropriately considered or assessed and that the national guidance and legislation were not followed.

57. The Adviser acknowledged that there was a considerable distance to travel, and the potential kinship carers lived in different authorities. However, they said that this did not justify the delays that were evident in contacting and maintaining the momentum of securing family care for the children when they could not live with their parents. The Adviser said that it was clear that the both the paternal and maternal family were keen to be considered, but in particular there was persistent communication from the maternal family to move things along and to maintain contact with the children while this was happening. Their interest and desire to be involved was evident prior to the children being accommodated as evidenced by an email from a relative dated 10 August 2016 '*pleading'* to be considered to provide support rather than the children being accommodated.

58. Following the children being accommodated, the Adviser noted that there was an internal email dated 28 November 2016 from the social worker to their managers requesting a meeting to discuss the children, as at a review the decision had been made for parallel planning and a few family members and a friend were requesting to be considered as kinship carers. The Adviser explained that parallel planning allows for two sets of plans to run side by side: one plan is for the child's return home and, in the event this is not possible, there is a second plan for the child to be placed

[3] In commenting on a draft version of this report, the Council highlighted that there were also allegations made against other parties.

elsewhere on a permanent basis. The Adviser said that in this instance the alternative to the children being able to be at home was kinship care and a variety of family members had indicated their willingness to be kinship carers. However, the Adviser said that it was not until 24 January 2017 before social work met with relatives, and it was several months before any commencement of the assessment took place.

59. The Adviser said that the minute of the meeting of 24 January 2017 does not include a list of who attended, or indicate their relationship to the children and did not include any timescales against the list of tasks agreed. The Adviser said that whilst the minute suggests the meeting gave a good account of the legal position for the family, they considered that given the complexity of the situation and the number of people involved it would have been helpful to have been clearer about the expectations with regard to paperwork; what and by whom had to be completed; and clearer guidance regarding timescales for taking things forward. The Adviser said that it became evident from later correspondence that this caused confusion and miscommunication that added to the continual delays. The Adviser also considered the delay of three weeks before sending out the minute of this meeting compounded this further. The Adviser was of the view that none of this was reasonable practice.

60. The Adviser noted that an email from a family member dated 13 February 2017 indicated that they had sent back the completed disclosure forms but they had still not heard anything back from social work. The following day there was a response to this email stating that the forms had been received but there was no identification documents included and indicating what identification should be forwarded. The Adviser said that this information should have been made clear at the outset and indeed the meeting of 24 January 2017 could have been used to take copies of everyone's identification to prevent such delays. However, the Adviser said that it was their view that when the forms had been received by social work, without identification attached, they should have contacted them immediately to advise the identification was missing. This created yet further unnecessary and frustrating delays for the family.

61. The Adviser noted that at an LAC review in March 2017, the minute recorded the Reviewing Officer as saying in response to progressing the requests from family to be kinship carers, *"[the reviewing officer] reminded all that it is still very early days"*. The Adviser said that this was concerning as the children had been in care for almost six months at that point. The Adviser considered this to be another indication that the kinship care assessments were not being treated with any urgency or importance.

62. The Adviser went on to note that an email communication from a relative dated 8 March 2017 stated they were '*dismayed'* to learn that the family had been described at the recent LAC review as being '*non-engaging*" as they believed they had been doing everything to be '*fully cooperative'.* The Council's response to this explained

this was due to the fact that not all family members agreed with the child protection concerns that had been identified.

63. The Adviser noted that the minute also indicated that the family "*disputed the understanding of some events and stated they felt some things were taken out of context."* The Adviser said that this does not necessarily mean that the family were not accepting of the concerns, but that there needed to be more dialogue with them, and indeed for social work to gather some of the intelligence that the family may have to inform their assessment. The Adviser was of the view that consideration does not appear to have been given to the fact that for many of the family members this would have been the first time that they had dealings with social work and hearing of the concerns; and they said that it is reasonable to allow people some opportunity to discuss and digest the information before responding. The Adviser could see no indication that these concerns were discussed with family members in order to establish if their understanding of the issues of concern had progressed, or any consideration given on how to help them gain a better understanding of why these concerns were held by social work. The Adviser said that there was no obvious proactive engagement by social work towards the extended family; and it was the family who were trying to progress things and keep the lines of communication open.

64. The Adviser noted the following extracts from the National Guidance for Child Protection in Scotland, which they considered are also pertinent to the extended family who are being considered as kinship carers:

- *In cases of familial abuse, practitioners should ensure the non-abusing parent or carer is involved as much as possible. Practitioners need to be wary of making judgements on parents and carers who are likely to be in a state of shock and experiencing great anxiety. While the priority should always be the protection and welfare of the child, practitioners should attempt to engage with the non-abusing parent/carer and determine what supports are necessary to help them care for the child…*

- *Parents / carers should be treated with respect and, where possible and appropriate, given as much information as possible about the processes and outcomes of any investigation. Parents / carers should feel confident that staff are being open and honest with them and in turn, feel confident about providing vital information about the child, themselves and their circumstances. Working in partnership with one or more family members is likely to have long-term beneficial outcomes for the child and staff must take account of a family's strengths as well as its weaknesses.*

65. The Adviser said that they did not see evidence of this approach being taken with the extended family.

66. The Adviser's view was that the ongoing communication between social work and the extended family was not reasonable, as evidenced in the delays in responding to emails from the family and information not being passed on timeously. The Adviser said that at times miscommunication was evident, which caused distress to the family.

67. The Adviser considered it clear that the Council were not following the guidance in respect of kinship care assessments (Looked After Children (Scotland) Regulations 2009 and the Adoption (Scotland) Act 2007 - Part 9 Kinship Care), which state that emergency placement assessments should be carried out within 12 weeks; and that planned placement assessments should also be carried out within this timescale *'unless there are identified reasons for requiring a longer period. In such situations, a realistic timescale should be agreed and adhered to in order to ensure that decisions are made within a child centred period.'*

68. The Adviser said that the failure to meet these timescales was poor practice. They noted that the children's grandmother signed the paperwork on 28 January 2017 and the first visit for the assessment did not take place until 20 April 2017. The Adviser said that this was far in excess of the Looked After Children Guidance timescales to complete the assessment. As noted above it was their view that the assessment should have begun in September 2016; the guidance is clear that these timescales should be met "*unless there are identified reasons for requiring a longer period".* The Adviser said that there were no identified reasons recorded. Though they noted that around 13 June 2017 there were internal emails suggesting that the social workers wanted to wait until the children's 'legal status' had been decided and there was a clear statement as to whether the grounds (for referral to the Children's Hearing) had been met, the Adviser did not consider this to be an appropriate reason to further delay coming to a decision on kinship assessments. They said that the idea of parallel planning is to have a viable alternative plan in place. Waiting to undertake the assessments, given the length of time that had already passed, built in further undue delay to the planning for the children and ensuring they had a secure permanent base. The Adviser also noted that internal emails suggested that the service manager was of this view, stating that *'we cannot assume anything re the legal process and we certainly cannot wait until after the children's hearing… I would be worried resources were influencing this decision rather than the child/family rights … I am also concerned we are denying this maternal family… the option of being fully assessed as kinship carers.'*

69. The Adviser pointed to an internal email of 14 June 2017 which stated *'the assessment is part way through and is currently on 'hold' although the family have not been notified of this, given the length of time since our last contact which was about mid-April. Do you want us just to sit tight?'* The Adviser said that this was another indication that communication with the family was extremely poor and far

from transparent, and that there was a significant lack of clarity internally as to what should be happening.

70. The Adviser noted that despite the above, a letter was not sent to the maternal grandmother until 12 July 2017, advising that the kinship care assessment was not going ahead. The Adviser said that the letter was very formal and in their view the tone was brusque. The Adviser considered that although it was an accurate account of the decisions, it could have been conveyed differently and they believed that good practice would dictate it should have been communicated face-to-face given the length of time the grandmother had been trying to offer this care, along with the delays in the assessment process. The Adviser added that not only would it have been best practice, but also more courteous and respectful, which are key social work principles.

71. In addition, the Adviser noted that the family were keen to maintain contact with the children and for their cousins to meet up with them over Easter. There was evidence within the chronology of various emails from the family between 16 March and 5 April 2017 attempting to organise this; however they did not receive a full response until 12 April 2017. The Adviser said that this seems unreasonable and another example of poor communication.

72. Overall, the Adviser considered the practice in respect of the kinship care assessments to be unreasonable and outwith statutory guidance.

73. The Adviser was then asked to comment as to whether they considered there to have been appropriate involvement of educational psychology or other professionals when the decision was made to move Child Z to a different school. The Adviser noted that the reason given for moving Child Z to a different school was that Child Y had raised a serious allegation against their father, and there was concern that this would reach Child Z and cause them distress. The Adviser noted that it appeared that Mr A had been involved in this decision, as had staff from the school and social work, but no one else appears to have been involved in the discussion and Mrs A was not made aware of the discussion around Child Z moving school until this had already occurred.

74. The Adviser noted that the decision was not made within an LAC review, which would have been normal practice; and following Child Z moving schools a referral was made for the ICSO on Child Z to be amended in order to ensure that Child Z remained at their new school. The Adviser noted that regulation 45, Section 5 of the Looked After Children (Scotland) Regulations 2009 outlines the purpose and requirements of an LAC review, which include taking the child's views into consideration; considering the child's educational needs and whether those needs are being met; revising the child's plan to take account of the outcome of the review; and that a review should also be held when seeking to change or vary a Supervision

Order. The Adviser considered that there was not reasonable evidence that making the decision to move Child Z to another school in this manner was warranted.

75. The Adviser also noted that whilst the concern may have been real, Child Y had made these allegations almost ten months previously and had repeated them several times; therefore the Adviser said that it was difficult to see what made the holding of this information more unmanageable at this time that it resulted in what could only be described as an emergency move and one which was not discussed at an LAC review which would have involved a wider group of professionals, as well as both parents and the child. The Adviser considered it concerning that given all of the changes that Child Z had experienced, they were abruptly removed from their school and moved to another within five days. It was not clear what, if any, preparation was made to ease the transition for Child Z, what explanation they were given or how the new school was made aware of the situation and were prepared for any issues or concerns that may arise.

76. The Adviser noted that when Child Z later moved to another school when they moved to live with Mr A, there did not appear to have been any contact made with the school in preparation for them going. The Adviser referred to an email from the new head teacher on 24 August 2018 indicating that they were totally unaware of any social work involvement at the time of enrolment and only learned of it when the files were transferred from Child Z's previous school. This email also noted that the head teacher had tried to make contact with the named social worker to gather more information but calls had not been returned. The Adviser said that this is not reasonable practice and does not adhere to the GIRFEC principles of working collaboratively with the child at the centre.

77. The Adviser also noted in relation to Child Y that at the LAC review on 2 March 2017 the plan was for a foster placement to be found for Child Y as it was recognised that "*a residential unit for a [ ] year old was not ideal"* but there was difficulty in finding a suitable placement. The plan was that Child Y would move schools following this. In the report written in June 2017 for review on 4 July 2017 the school reported an improvement in the quality of Child Y's work and that they were more sociable; Child Y was described as establishing new friendships in the local community. However, the Adviser said that the recommendation of the review appeared to contradict this description as it was decided that, as the parents had moved outwith the area, an appropriate therapeutic residential placement be sought. The adviser could not find the reasoning or explanation for this recommendation or an educational assessment recommending this.

78. The Adviser was then asked whether or not, after the children were accommodated, there were reasonable attempts to promote and encourage family relationships through contact. The Adviser noted that there was a regular programme of supervised contact with both parents. They commented, however, that in their view, the timetable of contact placed a heavy burden on the children as

on occasion they were having two contact visits a day, one with each parent and some that included extended family. The Adviser acknowledged that contact is always a difficult balance to ensure there is sufficient contact but also that it is relaxed and comfortable to promote a good experience and build relationships; however they considered the contact plan, while demonstrating a regular arrangement, was a demanding one for everyone, not least the children.

79. The Adviser also commented that they did not believe there was a great deal of evidence to suggest that a reasonable attempt was made to promote or encourage extended family relationships as highlighted earlier in this report. The Adviser noted that in April 2017 an internal email from the social worker indicates that Child Y did not want contact with the extended family[4] and the decision was made that it was not in Child Z's best interests to have contact as they had experienced so many changes. The Adviser said that it was unclear why this was thought to be the case for Child Z, as it was known they had had good relationships with their cousins and it could be suggested that it would have been positive for Child Z given they were living away from home. The Adviser said that the main point is that it did not seem to have been discussed with Child Z and views sought, but rather followed on from Child Y's decision.

80. The Adviser was asked whether or not, overall, they considered that the children and parents were appropriately involved in decision-making. The Adviser noted that there was evidence that the parents were invited to attend meetings and to participate. However, they said that there was also a great deal of evidence highlighting the strain in the relationships that made this difficult in reality. The Adviser noted that Mrs A made the decision in some meetings not to participate and at other times was given advice by her lawyer that that communication should be via them. The Adviser considered that it was unfortunate that fairly early on the differences in terms of the concerns that existed and what supports were needed meant that, with Mrs A in particular, there was never a relationship built on confidence and trust.

81. The Adviser was of the view that the attitude by social work was at times judgemental and based on personal opinion, such as shown in an internal email from the social worker to their manager stating *"I met with mum and dad, I think she has autism, she would not have eye contact at all and she said 'I am not meeting your eye because I am too emotional'"*. The Adviser said that there was no basis for making this assumption and it was a pejorative personal opinion based on the social worker not liking or approving of Mrs A's response, rather than any medical diagnosis or fact. The Adviser said that while it was reasonable to describe the behaviour and

[4] In commenting on a draft version of this report, Ms C disputed that Child Y did not want contact with the extended family.

assess the impact of this behaviour, it was not reasonable to make assumptions based on a personal view.

82. The Adviser also noted that Child Z was admitted to hospital for a vomiting bug and was dehydrated on 19 September 2016, within days of being admitted to care. The Adviser noted that Child Z was kept in overnight and a decision was made not to inform the parents as the condition was not life threatening. This was despite the fact that the parents were concerned and had been enquiring how the children were as they both had had a temperature prior to being admitted to care. The Adviser said that this was not acceptable practice, as notwithstanding the CPO, the Council did not have parental rights and the parents should have been notified. The Adviser said that this poor practice was compounded by an internal email from the out-of-hours social work service on the evening of 19 September 2016 stating, *"On the earlier advice from [social worker], I could not comment on [Child Z]'s situation, so I chose to advise [Mr A] that I had tried calling the other placement but could not get through…"* The Adviser said that this is poor practice that was recognised by the Head of Service in an email the next day.

83. The Adviser said that the involvement of the children in the decision-making was inconsistent as highlighted above.

84. Overall, the Adviser's view was that the approach by social work was reactive, rather than proactive and responsive. The Adviser explained that by this, they meant that while social work responded to individual incidents and particular circumstances, there was little evidence of building a relationship that would have enabled a more conducive discussion and exploring more openly with both parents the concerns that were held. The Adviser said that there was little evidence of challenging the contradictions that emerged regarding what was observed and witnessed by social work or other professionals, and what the parents or children stated was happening. The Adviser was also concerned that the understanding of what had happened in relation to the serious allegations made was left very unclear and the rehabilitation with Mr A went ahead without this being resolved or there being more clarity on the risks and safeguards in place.

85. The Adviser noted that the Child's Plan for the review on 4 July 2017 notes under the risk factors, "*[Child Y] has been exposed to inappropriate [ ] behaviour, the full details of how are not known consequently the risk of this continuing is significant. As a result, it must be considered that [Child Y] and [Child Z] are at risk…"*, but it goes on to state that Child Z is thriving in the care of their father and recommends that they remain in his care. The Adviser said that in their opinion the two things do not match, as there was still clearly a great deal of concern about what was happening in the home when both parents were there and no clear understanding of what happened. Therefore it could not be assumed that there was no risk from Mr A. The Adviser said that it follows that it could not be assumed there was no risk for Child Z residing with their father.

86. The Adviser said that the National Guidance for Child Protection for Scotland 2014 states:

> *316. Child Protection Plans, which have been incorporated into the Child's Plan should set out in detail the perceived risks and needs, what is required to reduce these risks and meet those needs, and who is expected to take actions forward including parents and carers (as well as the child themselves). Children and their families need to understand clearly what is being done to support them and why.*
>
> *317. Any intervention should be proportionate and clearly linked to a desired outcome for the child. Progress can only be meaningfully measured if the action or activity has a positive impact on the child.*

87. The Adviser said that no comprehensive risk assessment was evident that addressed these issues, but the move home appeared to be based on Child Y having retracted their statements and Child Z having a good relationship with their father.

88. The Adviser also noted that when Child Z returned to their father's care, they moved into a new local authority area, but it was not until three weeks after Child Z moved that the Council sent the new local authority a letter informing them that Child Z was living there and requesting a transfer CPCC. The Adviser said that this is outwith the National Guidance for Child Protection for Scotland, which states that where a child and/or their family move permanently to another local authority area, the original local authority will notify the receiving authority immediately and then follow up the notification in writing. The Adviser further noted that the guidance requires the receiving authority to convene the transfer CPCC within a maximum of 21 calendar days, and said that in this case the Council's failure to notify the receiving local authority in a timely manner resulted in them being outwith the timeframe for holding the transfer CPCC.

89. Finally, as an additional comment, the Adviser noted that at the point of the children being accommodated, a number of Looked After Children forms should have been completed, including medical consent. The Adviser noted that these forms were not completed at the point of removing the children and there was a considerable delay of over four weeks in these being completed. The Adviser considered this to be unreasonable practice.

(a) Decision

90. The Adviser identified a number of significant and concerning failings in relation to the complaint that the Council unreasonably failed to gather and take into account relevant information when making decisions regarding the children's care and education. I accept the advice that the failings were as follows:

- Prior to the children being accommodated:

i. little or no evidence of exploring parenting style, family or other supports; or questioning and challenging what was observed;

ii. little or no evidence of clear assessments of risk and need;

iii. little evidence of the GIRFEC practice model being utilised, including a robust, multi-agency assessment; and

iv. failure to make attempts to engage the family in supporting the prevention of a breakdown in the family or to provide kinship care as a means of preventing statutory care.

- Following the children being accommodated:

i. failure to consider and arrange independent advocacy for the children in a timely manner;

ii. in the absence of independent advocacy, failure to explore ways of communicating with the children to elicit their views and feelings;

iii. failure to include the views and feelings of the children in many reports;

iv. failure to facilitate Child Y attending their hearings when Child Y voiced their wish to attend;

v. when Child Y changed their story about the allegations, it appeared that the allegations were given less weight and there was not enough understanding of the way in which children and young people may retract their stories. Rehabilitation with Mr A went ahead without this being resolved or there being more clarity on the risks and safeguards in place;

vi. failure to reasonably consider and assess potential kinship placements and follow national guidance and legislation in relation to kinship care assessments;

vii. failure to communicate in a reasonable and timely way with extended family in relation to kinship care;

viii. no evidence that Child Z's views were obtained in relation to moving school; or that Child Z or the new school were prepared for the transition;

ix. failure to promote or encourage extended family relationships;

x. failure to inform the parents of Child Z's admission to hospital shortly after they were accommodated; and

xi. failure to complete a number of LAC forms which should have been completed at the point of the children being accommodated, in a timely manner.

91. These are all significant failings. Given the sensitivities and risks involved in a case such as this it is of grave concern to me that the Council have not acknowledged the majority of these failings, and have not provided SPSO with evidence that they have addressed any issues they have identified. The impact of these failings, both on Mrs A and her children should not be underestimated. This, together with the lost opportunity to learn lessons from the case when the complaints were first raised means the potential that these failings could reoccur, has not been acted on. This is deeply concerning.

92. On the basis of all of the above, I uphold this complaint. You will find all of my recommendations for the Council at the end of this report.

(b) The Council failed to deal with complaints raised by Mrs A and Ms C in a reasonable and timeous manner

Concerns raised by Ms C

93. Ms C said that the Council had failed to respond to her and the family's complaints in a timely or reasonable manner.

What happened

94. The following is a timeline of relevant complaints correspondence:

- 27 November and 8 December 2017: complaints submitted by Ms C.
- 25 January 2018: meeting held between Council Complaint Officer, Ms C and Mrs A.
- 19 February 2018: further complaint submitted by Ms C.
- January to June 2018: ongoing communication between Ms C, Mrs A and the Council regarding the complaint investigation, what issues were to be investigated, and ongoing information requests.
- On or around 19 June 2018: a complaint response was provided by the Council. This identified one failing. Many matters remained outstanding and the Council said these would be responded to by an 'independent enquiry officer'.

- 2 July 2018: Ms C wrote to the Council's Chief Executive, expressing her dissatisfaction with the complaint response and making a new complaint about complaint handling.

- 23 July 2018: the Chief Executive wrote to Ms C explaining that the independent review will be delayed until all complaint matters have been reported by wider family members, and noting that one family member has failed to submit requested complaint information.

- 24 September 2018: SPSO formally notified the Council of their investigation.

- 5 October 2018: the Chief Executive wrote to Ms C stating that they were 'still committed to an independent review'.

- In response to SPSO enquiries, the Council said the Chief Executive 'is to commission a review of how this case was dealt with… our social work staff welcome this review'.

- 7 December 2018: the Chief Executive wrote to Ms C stating that they would not be going to an external review but that an internal monitoring group would review the case.

- Late 2018/early 2019: in correspondence between Ms C and the Council, the Council said that they had reviewed matters internally and identified learning points. No further information on what these learning points were was provided.

- 9 August 2019: the Council sent another complaint response to Mrs A, despite SPSO investigation being ongoing at that time. This complaint response acknowledged some failings as noted above at paragraph 13.

The Council's response to SPSO enquiries

95. The Council noted that in relation to their handling of the complaints made by Mrs A and Ms C, this was complicated by several other family members also making complaints, some issues of which overlapped and some of which stood alone. They said that the complaints officer met with Ms C and Mrs A, as well as other members of the family, to discuss their complaints.

96. The Council said that there were delays in the complaint response being produced as Mrs A had said that a further complaint relating to the same issues would be forthcoming and despite requests for this, the additional information was not provided. They also said that one family member failed to respond to communications following making their complaint.

97. The Council said that all complainants were insistent that senior social work staff did not investigate the complaint and this served to delay the process. They said that in the future they would insist that a staff member with relevant department experience assist in the investigation in order to speed up the investigation processes.

98. The Council acknowledged that this complaint was difficult, complex, and took far longer than they would have hoped.

99. In relation to complaints made by other family members, the Council further explained that they had been overwhelmed by the volume of information that needed to be considered in responding to the complaints, and apologised for the delays in issuing responses. They explained that the delays were in part due to the case file records being with another department for subject access request redaction, but again apologised for not processing all of the complaints as quickly as they would have liked and for failing to meet the family's expectations.

100. The Council also accepted that they did not respond to all of the issues raised in the complaints. They explained that at the time of sending the initial responses, the understanding was that the outstanding issues would be covered by an independent enquiry officer who would be more qualified to answer them. The Council acknowledged that as there was a subsequent senior management decision made not to have an independent enquiry, a further response on the outstanding complaint issues should have been provided at an earlier stage. The Council apologised for this failure.

101. In relation to learning taken from the complaint, the Council said the following:

- The complaints officer who dealt with the investigations said that they had previously never dealt with such a complex set of circumstances and complaints of this volume. They said that they would draw on this experience to provide a more robust and structured approach in the future.

- Weekly meetings are now held between the complaints officer and complaints administrator to identify any complaints that are not adhering to complaint process deadlines. This information is then forwarded to department complaint administrators and senior management to ensure adherence.

- They acknowledged that the investigations should not have been undertaken without the assistance of a social work staff member and in the future this would not recur.

- They acknowledged that the independent enquiry should not have been promised to complainants.

- In March 2019, the Council presented on the anonymised circumstances of this complaint to the Local Authority Complaint Handlers Network Meeting, attended by SPSO staff. The complaint handling failures were highlighted so that other Councils could avoid such an occurrence.

Relevant guidance

102. The Moray Council Social Work Complaints Handling Procedure (the CHP) sets out the following:

- Complaints suitable for 'stage 2' investigation (i.e. complex, serious or high risk complaints) should be acknowledged within three working days, and investigated within 20 working days. In exceptional circumstances an extension to the 20 working day timescale may be agreed.

- Though not an exhaustive list, a social work complaint would normally arise from:

    i. Failure or refusal to provide a service
    ii. Inadequate quality or standard of service
    iii. Dissatisfaction with a policy or its impact on the individual
    iv. Failure to properly apply the law, procedure or guidance when delivering services
    v. Failure of administrative process
    vi. Delays in service provision
    vii. Treatment by or attitude of a member of staff
    viii. Disagreement with a decision made in relation to social work services

- Social work complaints should not be initiated when the subject is a matter determined by a judicial body (e.g. a children's hearing). In this circumstance the complainant should be referred back to the judicial body unless the complaint refers to the department's application of the decision.

- Issues not resolved by the service provider at investigation stage should be referred to independent external review by SPSO or 'other'.

(b) Decision

103. It is clear from the correspondence that I have reviewed that there has been significant confusion and deviation from the CHP in relation to this complaint. I acknowledge the Council's position that the complaint was complex, involved correspondence from a number of different people, some of which had overlapping issues, and that there were concurrent information requests. However, it remains that much of the handling of this complaint was unreasonable.

104. For example, one email from the Council to Ms C dated 22 March 2018 stated that many of the complaints raised were associated with a legal process and, therefore, would fall outwith the complaint process and would be subject to an independent enquiry. Ms C sought clarification of what issues these were that were not being considered under the complaint handling process, noting that most of the issues raised were not concerning the legal case (i.e. they would stand regardless of decisions reached by children's hearings or in court). After several weeks with no response, the Council responded that it would be detailed in the complaint response, which issues fall within the complaint process and those which relate to the legal process. When asked again to clarify the issues, the Council said that to do this would delay the complaint response.

105. I consider it unreasonable that the Council failed to clarify which aspects of the complaints they would be considering from the outset, and that they then refused to clarify this on the basis it would delay the complaints process, which had been ongoing for over three months and was not concluded for several more months.

106. The CHP is clear that when the subject of a complaint is a matter which has been determined by a judicial body, it should not be considered under the CHP. However, having considered the complaint response provided in June 2018, I am unconvinced that the issues the Council did not respond to here were in fact matters which had been determined by a judicial body; as was noted by Ms C, they would stand regardless of decisions reached by children's hearings or in court. For example, the Council declined to address the concern that a care plan was not developed with the family. I am unclear why they considered this to be part of the 'legal process'. This is further supported by the fact the Council did respond to these issues later in August 2019. I would further note on this matter that, were the issues that the Council declined to respond to in June 2018 related to decisions made by a judicial body, it would not have been appropriate for these to be subject to an independent enquiry; therefore, it would have been inappropriate for the Council to state that this would occur.

107. Though an organisation may choose to include an independent review as part of their complaint process, they must still comply with the CHP. If an organisation chooses to include an independent review as part of the complaint process it should be applied within the two-stage process and work to the same deadlines. If the

Council's position was that they needed to 'divide' their stage 2 response as some issues required to be addressed by an independent review, they should have made their approach clear, and ensured that both the complainants and the service understood the scope of the investigation.

108. Overall, there appears to have been a fundamental misunderstanding of the social work complaints procedure in this case; as well as significant failures in communication. Again, whilst I appreciate the complex nature of the complaint and the difficulties that can arise from multiple complaints regarding the same subject matter, the Council should have strategies in place to support and guide complaints handlers to manage this and it does not excuse the misinformation that was given to Ms C and other complainants.

109. I note that the Council have acknowledged a number of the complaint handling failings and taken positive action to address these (detailed earlier in this report). However, I am not fully satisfied that the gravity of the complaint handling failings has been addressed by the actions taken so far.

110. Given all of the above, I uphold this complaint.

111. The Council have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Council are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Council to do for Ms C and Mrs A:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint (a) we found that the Council unreasonably failed to gather and take into account relevant information when making decisions regarding the children's care and education. (The individual failings are listed below.) Under complaint (b) we found that the Council failed to deal with complaints raised by Mrs A and Ms C in a reasonable and timeous manner	Apologise to Mrs A, Child Y and Child Z for the failure to reasonably gather and take into account relevant information when making decisions regarding the children's care and education. Apologise to Mrs A and Ms C for the failure to reasonably and timeously respond to their complaints The apologies should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/informationleaflets	Copy or record of the apologies. By: 16 September 2020

We are asking the Council **to improve the way they do things:**

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint (a) we found that there was no clear use of the Getting It Right For Every Child practice model being applied (including appropriate multi-agency and risk assessments) when recording the concerns highlighted in the months prior to the children's admission to care; which would have assisted practitioners to identify the cumulative concerns and collated information from other agencies	The Council's Child protection function should be delivered within the context of supporting families and meeting children's needs through the Getting It Right For Every Child practice model as stated in the National Guidance for Child Protection In Scotland and the Children and Young People (Scotland) Act 2014	Evidence that the findings of this investigation have been fed back to relevant staff in a supportive manner that encourages learning. Evidence that the Council have considered any training needs for social work staff in relation to the Getting It Right For Every Child practice model and child protection. The Council may wish to consider using this case as a training tool. Evidence that the Council have reviewed their Child Protection guidance to ensure it takes into account the Getting It Right For Every Child practice model and the relevant legislation in relation to supporting families and meeting children's needs. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint (a) we found that there was a failure to engage the extended family in supporting the prevention of a breakdown in the family or to provide kinship care as a means of preventing statutory care	In line with the Children (Scotland) Act 1995, the Council should promote the upbringing of children by their families and the possibility of kinship care placements should be considered at the earliest opportunity and if this is not possible, the reasons should be recorded	Evidence that the findings of this investigation have been fed back to relevant staff in a supportive manner that encourages learning. Evidence that there is appropriate policy and guidance in place to ensure that the possibility of kinship care placements are considered at the earliest opportunity By: 9 December 2020
4.	Under complaint (a) we found that there was both an absence and delay in properly seeking the views of the children, including by use of independent advocacy, and including these views in the relevant plans and paperwork	The views of children should be sought in line with the Getting It Right For Every Child Framework and as laid down in the Children (Scotland) Act 1995 and the Children and Young People (Scotland) Act 2014. The views of children should be listened to, considered and recorded; and independent advocacy should be considered for children in a timely manner	Evidence that social workers have been reminded of the importance of recording children's views appropriately and considering the use of independent advocacy. Evidence that the Council have considered any training needs for social work staff in relation to seeking and including children's views. Evidence of an audit being carried out of Looked After Child and Child

Rec. number	What we found	Outcome needed	What we need to see
			Protection paperwork, and Child's Plans, to ensure that children's views are being sought and included appropriately. By: 9 December 2020
5.	Under complaint (a) we found that there was a failure to facilitate Child Y attending their hearings when Child Y voiced their wish to attend	If a child expresses a wish to attend their Children's Hearing, they should be facilitated to attend, regardless of whether they have previously been excused; in line with national guidance	Evidence that social workers have been reminded of a child's absolute right to attend their hearings; and of their responsibility to facilitate this if a child has expressed a wish to attend. Evidence that the Council have considered any training needs for staff in relation to their responsibilities to facilitate children to attend their hearings. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
6.	Under complaint (a) we found that the timescales to complete the kinship care assessments were considerably outwith the recommended timescales laid down by the statutory guidance	Timescales for kinship care assessments should be in line with the Looked After Children (Scotland) Regulations 2009 and the Adoption (Scotland) Act 2007 - Part 9 Kinship Care unless the reasons as to why this is not possible are specifically recorded	Evidence that the Council's policy and procedures on kinship care assessments are in line with the timescales in statutory guidance. Evidence that social work staff at the Council have been reminded of the guidance in relation to kinship care assessments. Evidence that there is a system in place to monitor timescales for kinship care assessment and management action taken to address when timescales are not being adhered to. By: 9 December 2020
7.	Under complaint (a) we found that communication with the extended family regarding consideration and assessment of kinship care placements was delayed, unclear, and not proactive	Communication with extended family in relation to potential kinship care placements should be proactive, clear, and timely	Evidence that the findings of this investigation in relation to communication with extended family members have been fed back to relevant staff in a supportive manner that encourages learning. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
8.	Under complaint (a) we found that Child Z moved school without any proper sharing of information and preparation and the decision was made outwith a Looked After Child review and prior to a Children's Hearing, without reasonable evidence that this was warranted	Prior to any decision that brings about a change to the child's plan, or before a decision to seek a Children's Hearing for a child whose supervision order they think should be varied or terminated, a Looked After Child review should be held	Evidence that social workers have been reminded that significant decisions concerning a child should not be made outwith a formal review. Evidence of an audit to ensure Looked After Child reviews are being held appropriately. By: 9 December 2020
9.	Under complaint (a) we found that when Child Z moved school, the new school were not notified of the background and did not learn of the involvement of other agencies until they received the child's educational file some time later	When a child who has social work involvement moves school, the new school should be informed of this in a timely manner in line with the Getting It Right For Every Child national framework principles of working collaboratively with the child at the centre	Evidence that the findings of this investigation in relation to the Getting It Right For Every Child national framework principles of working collaboratively with the child at the centre have been fed back to the relevant staff in a supportive manner which encourages learning. By: 9 December 2020

Rec. number	What we found	Outcome needed	What we need to see
10.	Under complaint (a) we found that the records evidence that the attitude of social work was at times judgemental and based on pejorative personal opinions	Social workers should avoid making statements based on assumptions and pejorative personal opinion	Evidence that the findings of this investigation in relation to record keeping and attitude towards families have been fed back to relevant staff in a supportive manner that encourages learning. By: 9 December 2020
11.	Under complaint (a) we found that the parents were not notified that their child was admitted to hospital despite still having parental responsibilities and rights	Parents with parental rights and responsibilities should, as far as possible, be consulted prior to medical treatment or in cases of an emergency admission be notified as soon as possible, in line with the Children (Scotland) Act 1995	Evidence that social workers have been reminded of and understand their legal obligations in respect of children and parents. By: 9 December 2020
12.	Under complaint (a) we found that although Child Z moved to a new local authority area, a letter to the authority informing them that Child Z was living there and requesting a transfer Child Protection Case Conference was not sent until three weeks after they moved. This was outwith guidance and also caused the receiving local authority to be	The Council should adhere to the National Guidance for Child Protection in Scotland in relation to notifying the receiving local authority immediately when children and/or their family move	Evidence that social workers have been reminded of their obligations under the National Guidance for Child Protection in Scotland. Evidence that the Council's procedures and guidelines meet the National Guidance for Child Protection in Scotland standards.

Rec. number	What we found	Outcome needed	What we need to see
	outwith the timeframe for holding the Child Protection Case Conference		By: 9 December 2020
13.	Under complaint (a) we found that Looked After Child forms, including a general medical consent form, were not completed at the point of admission to care and there was a delay of almost four weeks following accommodation	The relevant Looked After Child forms, including general medical consent, should be completed at the point of a child being admitted to the care of the Local Authority, or in cases of emergency, as soon as is practicably possible after the child is placed; in line with The Looked After Children (Scotland) Regulations 2009	Evidence of an audit to ensure that Looked After Child forms are completed prior to or at the point of a child being accommodated. By: 9 December 2020
14.	Under complaint (a) we found that there were numerous and significant failings in relation to gathering and taking into account relevant information when making decisions regarding the children's care and education	When making decisions regarding the care and education of children, the Council should appropriately gather and take into account relevant information	Evidence that the findings of this investigation have been reviewed in full by a senior member of staff at the Council and that they are satisfied that all failings have been addressed by the recommendations above or actions already taken by the Council. If they are not, an action plan should be devised to ensure that all issues are addressed appropriately and fully. By: 9 December 2020

We are asking the Council to **improve their complaints handling**:

Complaint number	What we found	Outcome needed	What we need to see
15.	Under complaint (b) we found that there were serious and significant failures in relation to complaints handling	Complaints should be handled in line with the relevant complaint handling procedure	Evidence that the Council have carried out a review into the handling of this complaint, identified where improvement action (such as training) is required, and developed an action plan to improve complaint handling. By: 9 December 2020

Feedback

Points to note

The Adviser noted that there was a regular programme of supervised contact with both parents, but commented that, in their view, the timetable of contact placed a heavy burden on the children as on occasion they were having two contact visits a day, one with each parent and some that included extended family. The Adviser acknowledged that it is always a difficult balance to ensure there is sufficient contact but also that it is relaxed and comfortable to promote a good experience and build relationships. However, they considered the contact plan, while demonstrating a regular arrangement, was a demanding one for everyone, not least the children. The Council may wish to reflect on this matter.

Terms used in the report **Annex 1**

Autism Spectrum Disorder (ASD)	a condition related to brain development that impacts how a person perceives and socializes with others
Child and Adolescent Mental Health Service (CAMHS)	specialist mental health service for children and adolescents
Child Protection Case Conference (CPCC)	a meeting called by the local authority when they have investigated concerns about child abuse and believe the chid is suffering, or is likely to suffer, significant harm
Child Protection Committee Register	a confidential list of all children in the local area who have been identified as being at risk of significant harm
Child Protection Order (CPO)	an emergency legal order granted by a Sheriff which allows the local authority to remove a child from their parent's care, in conjunction with the police where access to the child has been refused
Children's Hearing	a legal meeting arranged to consider and make decisions about children and young people who may be in need of support
Children's Reporter	the Reporter's primary function is to receive referrals for children and young people who are believed to require compulsory (legal) measures of supervision
Child Y and Child Z	the aggrieved's children
Complaints Handling Procedure (the CHP)	the procedure the Council is required to follow when dealing with complaints
Compulsory Supervision Order (CSO)	a legal order which means that the local authority is responsible for looking after and helping a young person, and often specifying where a child should live

Getting It Right For Every Child (GIRFEC)	the Scottish Government's approach to supporting children and young people. It is intended as a framework that will allow organisations who work on behalf of the country's children and their families to provide a consistent, supportive approach for all
Interim Compulsory Supervision Orders (ICSO)	a legal order which lasts for 21 days, which means that the local authority is responsible for looking after and helping a young person, and often specifying where a child should live
kinship care	when a child lives with a relative or friend who isn't their parent
Looked After Child (LAC)	a child who is in the care of their local authority (either on a voluntary or involuntary basis)
Ms C	the complainant
Mr A	Child Y and Child Z's father
Mrs A	the aggrieved
SHANARRI	part of the Getting it Right for Every Child approach. Used to assess the wellbeing of a child at any given time, parents and teachers can compare the child's experience against eight wellbeing indicators represented by the SHANARRI acronym. SHANARRI asks whether a child is Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included
the adviser	an independent social work adviser

List of legislation and policies considered — Annex 2

Child and Young People (Scotland) Act 2014

Children (Scotland) Act 1995

Children's Hearing (Scotland) Act 2011

Getting it Right for Every Child (GIRFEC)

Looked After Children (Scotland) Regulations 2009

National Guidance for Child Protection in Scotland

National Risk Framework to Support the Assessment of Children and Young People