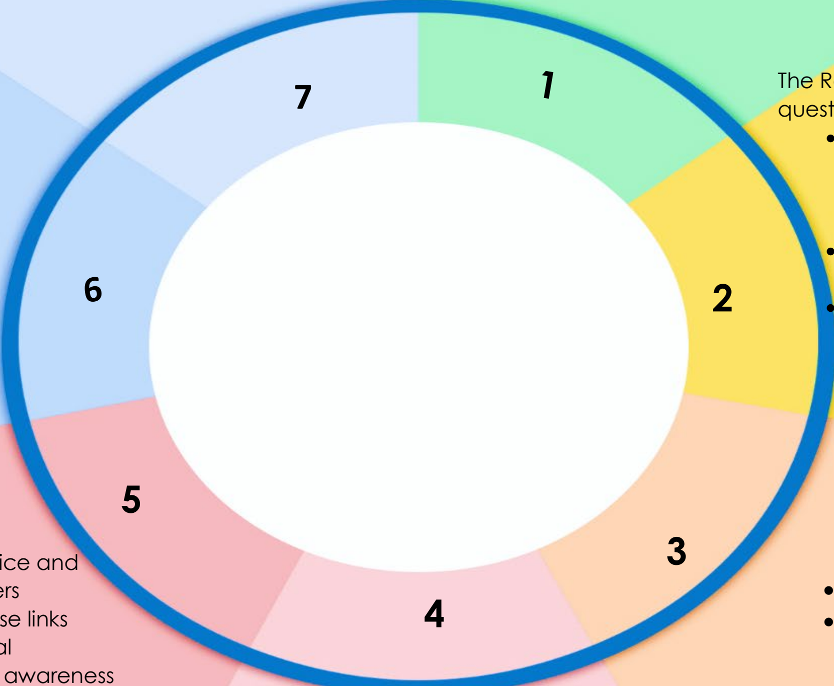

Background - Who was O18?

- Known to services since age 2
- Victim of domestic abuse, neglect, trauma
- Diagnosis of ADHD and ODD
- Part of a wider chaotic family which included other siblings, all with differing needs
- History of self-harm and overdose
- 6 moves of temporary accommodation across 4 towns (All in same local authority area)
- Both an Offender and a Victim of crime
- Significant substance misuse. Died of an overdose at 18
- No family contact since he was 16

The Review

The Review focused on three key research questions:

- To what extent was the information held by agencies in respect of O18 shared appropriately within that agency and with other partner agencies involved with O18
- To determine the extent to which decisions and actions were person-centred
- To what extent did one professional/agency have a lead role and hold the responsibility for O18's protection planning; to monitor what was being achieved, gaps in assessment, planning, decision making and associated risks?

Findings

- 18 Recommendations
- Areas of good practice and areas for improvement identified both for single and multi-agency

Improvement Areas (1)

- Systems to support information sharing both across and between agencies
- Key processes such as use of chronologies and Early Screening Groups
- Transitions between children's and adult mental health services
- Services for young people that do not fit adult criteria
- Multi-agency risk assessment which support the coordination of risk

Improvement Areas (2)

- Access to specialist advice and guidance for practitioners
- Co-morbidity to recognise links between trauma, mental
- Provision of training and awareness raising on Trauma Informed Practice, Suicide and Self Harm
- Co-ordinated approach to risk
- Management of complex cases
- Housing provision to young adults with complex needs

Implementing Change

- Reflect on the findings and recommendations and discuss the implications for your/ service practice.
- Do we recognise any of these issues? What can I do?
- Are there any steps you/your team can take in line with the areas for improvement?
- What do I need from the wider system to support best practice?
- Ask or look at best practice elsewhere that may support addressing the recommendations from SCR

Further Information:

https://www.angus.gov.uk/media/resolution_and_escalation_arrangements

https://www.angus.gov.uk/media/professional_curiosity