REMEMBER MY NAME

A SIGNIFICANT CASE REVIEW INTO THE LIFE OF

MARGARET FLEMING

This report was prepared by independent reviewer,
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THE TITLE

The title of the report comes from a discussion with an Adult Protection Officer in Inverclyde who described training that has taken place locally to ensure that professional staff are able to fulfil their duties effectively. In an introductory exercise, participants are asked to name children and young people who have been killed which results in a significant number of lives being remembered. Then they are asked to name adults who have died at the hands of others. A silence tends to follow, although more recently Margaret's name is sometimes given. This Review hopes to build on that growing appreciation so that we get to a position where the deaths of adults are given equivalent recognition.

THE 'CARERS'

Eddie Cairney (EC) and Avril Jones (AJ) have been extensively described in the media as Margaret's carers. They were not. To describe them as such severely undermines the commitment and dedication of Scotland's actual carers.

They are referred to by their initials alone throughout the report.

They were each asked on two occasions to participate in the Review and have not replied to correspondence.

STRUCTURE OF THE REPORT

Part 1: Context, Methodology, Margaret's Life

This provides an overview of the context and the approach taken by the Commissioners of the Review, the Independent External Reviewer and the Review Steering Group. The focus is on Margaret's life and background and includes her mother's perspective and that of others who knew Margaret well.

Part 2: The Policy Landscape – National and Local

This consists of a high level policy summary which outlines the options available to practitioners in Margaret's lifetime and subsequently. It goes on to describe the current Inverclyde Health and Social Care Partnership Strategic Plan and the findings of the most recent joint inspection by the Care Inspectorate, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland of adult support and protection in Inverclyde. It concludes with an interpretation of Margaret's human rights.

Part 3: Findings, Changes Since and Recommendations

This Part is the heart of the Report as it highlights critical incidents prior to Margaret's death in late 1999. As it was many years before her disappearance became known, it also covers incidents which may have prevented harm had she still been alive between 1999 and 2016.

This leads to Findings and Recommendations agreed by all the agency representatives and concludes what would be the conventional reporting expectations of a Significant Case Review.

Part 4: The Chronology

This is a summarised and sequential listing of events in Margaret's life that enables the reader to get an overview of what it is believed took place and is drawn from a range of available sources.

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PART 1

MARGARET'S LIFE

Chapter One: Context

When atrocities such as this take place, we are outraged by the unspeakable actions of others and look to hold individuals to account and to apportion blame (Butler and Drakeford,2005). So let us begin with the stark fact that Margaret, a young adult with learning disabilities, was killed by two determined people who were allegedly caring for her who exploited her in every way.

She was not killed by her family. She was not killed by those professionals who sought to support her. This is not to shy away from responsibility. Both good practice and known errors or omissions that were made that may have contributed to a different possible outcome are laid out.

However, even legislation cannot prevent such tragedies entirely. But there is much that can be achieved individually and collectively to mitigate the risks.

It is time for reflection as this could have happened in any part of Scotland. There are professionals who are confident that they did what they could and others who openly acknowledge that they could have done more. There were also people who had seen Margaret suffering who did nothing and did not report her situation to the authorities.

Alongside this, it is also appropriate to look to ourselves as members of Scottish society and ask about our collective responsibility for one of our own. It is not acceptable to take comfort in apportioning blame and move on quickly with our own lives. The citizens of Inverclyde have not turned away. They have done some serious soul searching. There is a palpable sense of sadness and guilt that Margaret died as she did and that she was effectively invisible at the time of her death.

This report tries to retrieve something positive from such awfulness and to create and build better support for those who may be at risk of harm. The outcome cannot become a tick box exercise.

The unique circumstances called for a unique response so the first thing to emphasise is the way in which this Significant Case Review has been conducted. It consciously adopts a broad Appreciative Inquiry approach which is explained in more detail in the Methodology Section which follows. In seeking to understand what took place, one element will be calling out poor practice where it has been identified. The principal focus, however, is on individual and collective consensus about the times that the outcome could have been prevented, acknowledging these openly and addressing them constructively to do better.

It may seem easier to take this perspective because the events took place over two decades ago. In many respects it is harder. Piecing together a precious life has proved more difficult given the passage of time, the deaths and memories of key characters and the destruction of records because of retention policies.

The starting place was asking how to be different and not produce yet another report that gathers its proverbial dust on the shelf. How to take the phrases of 'learning the lessons' and promises of this never happening again and instead giving meaning to our commitment to a future that is better than the past?

It was decided to be clear in saying that systemic fault finding does not guarantee the desired change. It does not help to finger point where a natural reaction in response is to be defensive and shrink from the best version of ourselves to become practitioners that are driven by process rather than in belief in the assets of the public we serve.

Instead work has been undertaken collaboratively. Whilst there have been formal structures in place, leadership has been genuinely shared. Each agency has undertaken a self – assessment prescribed by the External Independent Reviewer, has recognised missed opportunities and has created the necessary changes to address these. That work still needs to be done is recognised too. Each agency has shared their separate findings and improvements with all other partners to reach a composite response that everyone is committed to now and in the future – investing in real multi-agency working for the benefit of others. The work plan from each agencies submission will be published on the website to demonstrate the breadth of the work undertaken.

Much has changed in terms of policy and practice since Margaret was alive which is positive and these developments are described throughout the report in considerable detail as well as analysing their impact. Nevertheless, there can be no doubt that further change is needed.

Huge national changes are imminent. Social Security Scotland is taking over benefits that previously were the domain of the Department for Work and Pensions. The Scott Review (Scottish Mental Health Law Review,2022) on mental health, capacity and support and protection has reported recently and has signalled a potential updating of the Adult Support and Protection (Scotland) Act 2007. A new National Care Service is possibly to be established too. History tells us that such huge shifts create their own long-term pressures and churn before their effectiveness can be demonstrated.

But it would not be sufficient to talk about policy and practice divorced from the lives of people with learning disabilities themselves. Which is why their views, their living experience, is front and centre of this Review and a summary of feedback from people with learning disabilities is published on the website, and played a significant role in helping us understand what needs to change.

National and local groups of people with learning disabilities and of carers came together to review Margaret's life as well as their own lives now to convey their realities, risks, hopes and achievements and to inform findings and recommendations. This will ensure that there is a legacy where we can all act in ways that will protect and promote the lives of the Margarets who are alive today and honour Margaret in doing so.

In essence, the Review seeks to find ways to mitigate the risks that continue to exist for present day Margarets and to highlight the constraints that many people with learning disabilities are living under as well as to evidence their clear abilities, achievements and aspirations.

Chapter Two: Methodology

This Review is unique in that Margaret had been missing for nearly seventeen years before anyone noticed. Given this considerable time lapse, taking conventional approaches to understanding the circumstances, and learning from them, is challenging – not least because some central figures in Margaret's life have died in the interim and documentary evidence can be limited as much is destroyed because of retention policy time limits. Nevertheless, a determined effort to ascertain as much as possible has been undertaken with great care and thoroughness using appropriate national guidance.

Use of National Guidance

Margaret was both a child and an adult in the course of her lifetime which means that national guidance policies and practice pertaining to both apply. The local Initial Case Review concluded that there should be a Significant Case Review and that the emphasis should focus more on adulthood given that her situation altered dramatically on the death of her father shortly before her fifteenth birthday.

Scottish Government guidance on Significant Case Reviews for children has existed since 2007 (Scottish Executive, 2007), the latest iteration of which, National guidance for Child Protection Committees undertaking Learning Reviews, was published in September 2021 (Scottish Government, 2021). The first national adult equivalent, Adult Protection Significant Case Reviews Interim Framework was published in November 2019 (Scottish Government, 2019). This sought to improve consistency in Significant Case Review practice across Scotland and to embed the emerging learning into procedures and practice. This Framework was used to inform the work of this Significant Case Review and has recently been updated and replaced by Adult Support and Protection: Learning Review Guidance which was published in May 2022 (Scottish Government, 2022). This has also been taken into account in this report.

Local Leadership and Structures

At a local level, appropriate Governance and support structures were put in place to oversee due process in relation to the Review ranging from a clear mandate from local politicians to broad oversight by the Public Protection Chief Officers Group as well as the Child and Adult Protection Independent Committees. Added to which, a Steering Group of senior agency representatives co-facilitated the implementation of the agreed Appreciative Inquiry approach and an Enabling Group assisted with more routine operational and workflow aspects. Both Groups met virtually every eight weeks throughout the period because of Covid restrictions which also prolonged the timeframe for completion substantially.

Terms of Reference

Underpinning this were clear Terms of Reference which detailed both purpose and objectives and which were lifted and adapted from national guidance.

The purpose was to:

- Understand the full circumstances of Margaret's death;
- Examine and assess the role of all relevant services, relating both to Margaret and also, as appropriate, to relatives, carers or others who may be connected to events which led up to the need for the Review;
- Explore any key practice issues and why they might have arisen;
- Establish whether there are areas for improvement and lessons to be shared, about the way in which agencies work individually and collectively to protect adults at risk;
- Identify areas for development, how they are to be acted on and what is expected to change as a result;
- Consider whether there are issues within the system and whether services should be reviewed or developed to address these;
- Establish findings which will allow the Adult Protection Committee to consider what recommendations need to be made to improve the quality of services.

The objectives were to:

- Keep under review the procedures and practices of the public bodies and office bearers required to co-operate with Councils to which section 43(3) of the Adult Support and Protection (Scotland) Act 2007 applies or the exercise of functions which relate to the safeguarding of adults at risk present in the Council's area;
- Share learning with relevant agencies and make recommendations for action;
- Consider how any recommendations and learning will be implemented;
- Address the accountability, both of the agency/ agencies and the occupational groups involved;
- Increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case about an adult at risk of harm.

The Child and Adult Protection Committees then commissioned an External Independent Reviewer to undertake the Review.

So the national and local parameters were clear in terms of guidance, reporting and supporting structures, detailed Terms of Reference and the appointment of an External Independent Reviewer.

Research

Extensive research was undertaken in relation to legislation, policy, procedures and practice both past and present. The policy landscape section of the Review covers aspects of this in depth. The University of Strathclyde provided a summary of relevant statute. Being so long ago, records had been destroyed and others were archived. Glasgow Life helped with retrieving critical documents that laid out practice expectations of staff. All available case records from the time were recovered and analysed.

In addition, known experts in adult protection work were approached for their knowledge and support. Independent legal advice was also provided. What constitutes past and contemporary good practice was considered through reading, analysing and reflecting on relevant academic contributions. The Five Nations series of lectures, sponsored by Adult Protection Chairs and the Scottish Government, helpfully brought eminent academics and practitioners together regularly over the last two years to consider topics ranging from lifestyle choices and adults at risk of harm, to trauma informed practice, as well as the particular challenges of institutional harm. A conference on Missing Persons was also instructive in laying out the loss and the impact that this brings.

A web page was also created for the Inverclyde community to provide the External Independent Reviewer with any knowledge or comments they wished to make.

Interviews and Workshops

A Significant Case Review cannot compel individuals or organisations to participate. However, all those who were invited to did so with the exception of EC and AJ. This meant that over one hundred people came forward. Margaret's mother co-operated fully and gave all that she could. Those that knew Margaret's father have reminisced about him and about the relationship he had with his daughter. Fellow students have shared their memories. Staff in schools and the College that she attended have talked movingly about her. Health and social care staff have recalled what they knew about her needs and wellbeing.

The Appreciative Inquiry Approach

There can be a degree of scepticism about the mantra of 'lessons being learned' when we know of so many tragic deaths and subsequent reports that do not always lead to the desired outcomes. So whilst the unique circumstances of Margaret's life and death created limitations, predominantly because of the passage of time, they also provided opportunities to approach the task differently in the hope of making a greater impact in terms of change.

Another consideration was how best to strike the appropriate balance between the necessary formality of the investigation, whilst ensuring that those who contributed were not unduly anxious or defensive as individuals can become traumatised by investigative processes. The risk then is that professional practice going forward may become less innovative and more personally protective.

Alongside these considerations about process has been the tangible and prevailing sense of shock and disbelief locally that this could happen in the community of Inverclyde where many of the staff also live.

From the above deliberations, there was a firm commitment to follow the usual widely accepted ways of conducting a Review- through rigorous exploration of relevant research, legislation, policy, procedures and practice as well as the retrieval and analysis of documentation and interviews with individuals.

In terms of opportunity, it was agreed from the outset to adopt Appreciative Inquiry in its broadest sense as the principal method of investigating, fact-finding, analysis and presentation of findings and recommendations. This asks key partners to review major issues, to honestly own any missed opportunities that may have led to harm in each agency and to understand each other's perspectives. Then they commit to creating the positive changes required by devising an Action Plan with individual and collective goals which they hold each other to account in delivering.

An illustration of the approach is when British Airways used Appreciative Inquiry to bring staff together to envisage their collective future. The issue many wished to resolve was the matter of lost baggage. Their solution was to come up with better ways of managing lost luggage. Appreciative Inquiry allowed the discussion to be widened from immediate problem solving to a systems wide positive change of how to create the best flying experience. The emphasis in the latter is on how to improve within existing and created assets.

In similar vein, with Margaret, what did go wrong is made clear whilst also creating systems wide developments to ensure that people with learning disabilities have the best quality of life that is attainable.

Appreciative Inquiry is not a soft option but a mature one that seeks to build something positive out of adversity. Significantly, whilst it can and does call out poor practice, it is not an externally imposed blaming exercise. It asks that all participants actively and equally undertake their own analysis of what went wrong which can be peer reviewed by the other agencies involved. Then all parties carry responsibility for improving practice going forward.

Margaret's Voice and Legacy

Another integral aspect of the Review was both to establish the facts of Margaret's life and death and also to honour her memory by creating a legacy of greater understanding of people with learning disabilities where they are shown equivalent respect in our society to live lives of equality, aspiration and happiness. So both the Steering and Enabling Groups held three Margarets in mind in all their deliberations – Margaret who had lived, Margaret who is living now and Margaret of the future.

Two workshops for people with learning disabilities living in Inverclyde were held to share their experiences of life locally just now.

People First (Scotland), the national peer advocacy organisation for people with learning disabilities, formed an Expert Group to provide their knowledge and skills. They committed because they think that Margaret's life needs to be honoured and remembered. They also committed because they think the work of the Review is important in shedding light on the realities of living in Scotland with a learning disability today. They spoke extensively of fear – referring to Margaret's death as something which 'could happen to any one of us' whilst emphasising the importance of it all coming down to trust in others.

They highlighted the immediate challenges of the pandemic with support becoming more virtual and questioned whether services would ever be returned to the old normal. This left them with feelings of anxiety about potentially being more exposed to harm. They cited the recent Cawston report (Norfolk Safeguarding Adults Board, 2021) and the deaths of young people with learning disabilities. They commented on the remarkable similarities to the deaths in Winterbourne View (Flynn, 2012) a decade before and questioned why history was repeating itself. They also knew of the findings of the Scottish Observatory for Learning Disability which suggests that people with learning disabilities are three times more likely to die of Covid in Scotland than the general population (Henderson et al, 2022).

The Scottish Commission for People with Learning Disabilities, which promotes the human rights of people with learning disabilities, also held three workshops with the External Independent Reviewer where similar experiences and concerns were shared. The views of parents are also incorporated in the report based on workshops held with pamis (promoting a more inclusive society), a national organisation which supports people with profound and multiple learning disabilities, their families, carers and professionals. Their perspectives, whilst acknowledging positive policy changes over the decades, confirmed the deep concerns of those with learning disabilities.

In summary, taking all the threads described above, the report will provide a clear, if incomplete, picture of who Margaret was. It will also set out the life she had - the challenges she endured as well as the happy times. It will give a detailed exposition of the roles and responsibilities of the key agencies. It will assess the standards of practice at the time, the policy and practice changes that have been put in place since as well as the commitment to a better future.

Chapter Three: Margaret's Life - Making Her Real

Margaret's death and the subsequent investigation and trial has, of necessity, made her private life a matter of public interest and concern and portrayals of her personality and behaviour have varied significantly.

This chapter is intended to create a picture of Margaret as an individual, a unique human being who lived a life - not as someone who is remembered principally as a murder victim. Here the emphasis is on drawing as many strands as possible together to create a holistic depiction. In some respects it is the most important element - taking time out to pause and to accurately reflect on who she was as far as is possible. Inevitably, it cannot be a totally crisp portrayal given the passage of time and the reliance on the perceptions of individuals who knew her in a wide range of circumstances and over a protracted period.

Describing her and her circumstances is reliant on the memories of others, records of various types, a handful of photos that confirm her existence and one poignant drawing that she completed at a psychological assessment when she was a very young child.

This element also seeks to erase the inaccurate and distorted primitive descriptions of her behaviour as portrayed by AJ in applications to the Department for Work and Pensions in an attempt to magnify and exaggerate her needs and maximise benefits paid.

Who was Margaret? - A Detailed Portrayal

Margaret was an only child born on 1 November 1980 to parents who had been married for several years but who were not happy together.

There are no available pictures of Margaret as a baby. She was never officially diagnosed as having a learning disability but was treated as such with initial suspicions of her having Sotos syndrome (a genetic disorder characterised by excessive growth and learning disability) which were later disregarded. As the Health Chapter makes clear, available records of her early development are at times contradictory, indicating that she had difficulties and at other times suggesting her development was within a normal range.

What is known is that she was larger than expected for her chronological age range and had some weight issues which would have seen her recorded above average on growth charts. Her father and paternal grandparents were overweight and she was given sweet treats to placate her when she was distressed. Her obesity was investigated to some extent and hospital admissions led to weight reductions which were not maintained on discharge.

In the early days, the picture is not so much about Margaret but of what is going on around her.

Margaret's Family

Her parents met on a blind date arranged by friends. Margaret's mother cannot recall what drew her to her future husband but enjoyed having company and being taken out.

The pregnancy seems to have been straightforward in the physical sense but the relationship was faltering with her husband alleging that the child was not his which her mother found distressing. Margaret was born approximately four weeks prematurely, although of an average full term birth weight.

Margaret's mother had a difficult labour which was traumatising and post-natal recovery was slow. She describes her husband being disinterested in her wellbeing at this point although he did come and see Margaret once in hospital. She thinks it was about a week after the birth that she was able to see her daughter for the first time.

Her mother-in-law was the principal caregiver in the interim and the two women had differing ideas about parenting from the beginning and tensions built over the years with Margaret's mother regarding her mother-in-law as domineering. This friction played out, in part, in disagreements about what Margaret should wear. Her mother would bring her to be cared for while she was at work in one set of clothing and when collecting her would find her in an entirely different set and style.

Margaret's mother is clear that she struggled to bond with her and says she liked her 'well enough' until she became more assertive physically. She remembered an incident when Margaret was somewhere between 3 and 7 where she picked up a heavy four-legged stool and pinned her mother down with it whilst she sat on a sofa. She described the helplessness she felt to respond and the underlying strength that Margaret had. She called her husband to help but he is alleged to have ignored the situation.

Margaret's father was described by her as generally unsupportive financially and emotionally and, if she was ill, she was left on her own and reliant on neighbours for assistance. However, there is no suggestion of poverty in that she had worked in a sugar factory for many years and in retail when Margaret was small. She also supported her husband in a change of career, from working In Babcocks to becoming a solicitor.

Margaret was two when her mother first filed for divorce on the grounds of unreasonable behaviour. They both went to live with the maternal grandmother on a temporary basis but eventually came back to the marital home. She described her husband as promising to change and so she dropped the application with both parents trying to make a go of things for Margaret's sake. The relationship does not seem to have improved however. She alleged that he had at least one significant other relationship in the course of the marriage.

The beginning of Social Work Involvement

Margaret's mother first contacted Social Work services to ask for help in securing a nursery placement for her to improve her ability to communicate and to socialise with others. This nursery no longer exists and there are no records from there. We do not know what progress she made.

School

Both primary and secondary education were in mainstream schools although some professionals believe that specialist provision could have benefitted her. There is a suggestion that she would have been in the top cohort in a specialist environment rather than in the lower groups in mainstream and that this may have meant she would have been more motivated to be engaged and so may have achieved more in terms of attainment and in confidence.

It is in this aspect that the perception of her father's involvement alters with her mother saying that he took a much more active interest in her from about the age of four onwards. Some records show that both parents attended a variety of appointments for Margaret during this period and that they argued openly in some of these sessions.

It would be fair to say that she was in mainstream schooling because her father pushed and sought to understand her condition and her ability to learn. He did, for example, think that she could be dyslexic, as he was, and had tests undertaken to establish if this was the case which proved negative.

Personality and Behaviours

Secondary and further education settings offer relatively consistent views on her personality and behaviours. She had two contrasting aspects that are mentioned time and again – not only in the educational arena but also by her family and others who knew her well. The first feature is that she tended to blend into the background, to be shy – the beginnings perhaps of her invisibility- where she was less likely to have to account for herself or to be pushed to achieve. The second is that she could be sullen. Here the picture is mixed with some that saying that she did not express anger overtly, to others who did witness suppressed anger or, on rare occasions, clear outbursts that could be physical. Within this, others make clear that she could be reasoned with and that any aggression was an expression of frustration at her circumstances – especially after her father's death.

We know from her mother that Margaret could and did use her physical strength to assert herself. She spoke of another parent alleging that Margaret had assaulted her child whilst at primary school. She questioned her daughter who admitted that she had done this. The next day she asked Margaret if she had left the other child alone which she confirmed but added that she had been in a fight with a boy instead.

Margaret also lived in a number of houses in the course of her life. She moved from her original home temporarily to her maternal grandparents as well as spending time with her paternal grandparents and living with them. Accommodation there was limited. She appears to have shared a bedroom with her father although this was not known to services at that time.

Margaret's voice is largely silent up until this point.

Custody

By 1991 her father was granted custody with her mother having agreed access periods. They divorced in 1993. Part of his application for custody alleges that her mother had hit Margaret although this does not appear to be referred elsewhere for investigation at that point and is something that her mother denies. Margaret's father also indicated in the papers that he had retired on health grounds, the implication being that he can be there for Margaret.

Margaret is now in secondary school and more details about her are emerging. Staff that knew her describe her as being of average height, with distinctive brown eyes, who was larger than others. She was 'a very plain looking girl' who was very quiet, gentle and passive, likeable although needy. She could be 'pleasant' but had 'a blank facial expression' and was 'unmotivated', although this was attributed to her possibly 'lacking confidence'. One staff member indicated that Margaret could 'get annoyed, possibly a little sullen, but never aggressive.' Another said that they could not recall any extreme shows of emotion. They did not ever remember Margaret losing her temper as she very rarely responded to someone annoying her, adding that it may often have been the case that a staff member intervened if someone was trying to provoke her.

Her father 'saw to it' that she always wore school uniform in a context where there was an in-crowd that wore short skirts and sweatshirts. Margaret, by contrast, wore a grey pinafore, white shirt and tie, white knee length socks and moccasin type shoes.

Despite these efforts, she did not have a 'cared for look' as she wore the same shirt all week giving a grey appearance and had lank, greasy, hair. Her father was aware of minor hygiene issues and asked staff for advice about this when she was 13/14 years of age.

Her Teachers' Thoughts

She could be hard to motivate academically, learning had to be repeated to be retained and progress was limited.

It was said that she had a 'learned behaviour pattern' of making herself invisible and that this could have been due to her being treated badly by other children in the past. One member of staff said that there was no evidence that she was badly treated by her secondary school peers whilst another thought that there may have been 'some low-level bullying' linked to her size.

It was thought that she 'segregated herself' rather than was 'segregated', although it was acknowledged that 'in reality there was still a lot of segregation of children with special needs in mainstream environments.' Margaret would always sit at the back of the class and kept her head down so that no one would bother her. She could be overlooked. At breaks she would stay near the teachers, perhaps because it was a safe area. This isolation was shared with other young people which resulted in a Girls Group being set up which consisted of reading and then sharing their thoughts. Margaret struggled to focus on a specific book but did enjoy the interaction with others.

It was said that she was almost 'reactionless'. It is thought that if she was challenged by others, this lack of reaction would mean that the challenge would not be sustained. Margaret was said to be astute enough to protect herself from becoming a target. A 'bit of a loner', she did struggle to make friends and staff were delighted when a friendship with a much more outgoing young woman blossomed and lasted.

Margaret's father was 'omnipresent' in Port Glasgow High School in that he was well known to some key staff and regarded as someone who would ensure that Margaret had everything that she needed. They were 'a wee Unit and he was very concerned about her.' He was described as being very 'hail fellow well met', sitting 'for a cuppa and to have a cigarette' and to be 'very grateful when staff took a particular interest' in his child. At parents' nights, the janitor would often have to tell him that it was time to leave as he wanted to lock the school up.

The school understood that Margaret's father worked in the legal profession but most of the time that he was connected to the school he was off with ill health. He would often arrive unannounced and could be described as being persistent. He was clear in saying that Margaret would always need a degree of support in her life.

Relationship with Paternal Grandparents and Significant Others

Margaret moved into her paternal grandparents for the last few years of her father's life as they were made homeless because of a fire/explosion in the property that they had been living in. Her paternal grandparents were very attached to her. She could be loud and assertive there. It was a cluttered home which bordered on hoarding behaviour.

Her mother continued to see her at weekends and at other unannounced times when her father dropped her off.

In 1992/3 Margaret's father began a new relationship and was engaged at the time of his death to someone that Margaret grew to trust. They never lived together with Margaret and her father continuing to live with the paternal grandparents. Margaret's father's fiancée and members of her family have warm recollections of Margaret and provided considerable detail about her. They have family members who have learning disabilities and so were comfortable in Margaret's company. The daughter of Margaret's father's fiancée had also worked with people with learning disabilities.

They indicate that Margaret was 'very shy' when they met her first, that 'she took her time to come around', that 'she stuck to her father's side' and that she was 'a lovely child' with 'a dry sense of humour.' When Margaret got to know everyone she interacted well and was happy to mix with the younger people in the family. This was commented on as she was more used to adult company prior to this and was said not to mix with other children outside school, partly because she spent weekends with her mother.

Margaret's father's fiancée recalled that Margaret wanted more access to her mother during this period and although Margaret's father was reluctant initially he was persuaded that this was appropriate.

New information was offered about how Margaret and her father spent time together. An example was that they attended Church every Sunday with the grandparents which Margaret was said to enjoy, not least because 'she liked to be by [her father's side] all the time.' She enjoyed usual teenage pursuits and 'would be really happy if you made an effort with her appearance – helping her with her hair and make-up.'

She is also said to have found her grandparents 'strict' and 'old fashioned' but understood that she should show them respect. .

Margaret's father's fiancée knew EC and AJ having met them on occasions with Margaret's father who was a business associate of EC.

Her father's death

Margaret lost her father relatively suddenly before her fifteenth birthday at a time when her paternal grandparents were failing too. He had a heart attack years before, was diabetic, had cancer and a brain tumour.

Although Margaret was grieving for her father, this is not clearly recognised when she becomes aggressive with her mother and her grandparents. She is now living with her mother who asks for Social Work support. Befriending by a Social Worker for a period of months stabilised the situation whereby Margaret and her mother are more tolerant and accepting of one another.

When Margaret's father died, his fiancée and her daughter went to their nearest Social Work Department and to a lawyer to clarify if they could have access. They were advised by both that there was a living mother who would have rights and that had she married Margaret's father there may have been room for negotiation. They also phoned EC to ask if they might visit but he is said to have put the phone down on them. They visited with gifts too but these were refused and they were not allowed into the property. It is alleged that EC became aggressive and indicated that Margaret did not want to see them. They were aware that Margaret's mother had had similar experiences and had involved the Police so they had not done so separately.

College

By now Margaret is about to go to College. In College, in particular, another aspect emerges of someone who was ready for new experiences, who was funny and giggled, someone who was 'up for a laugh'. Other themes emerge here too – of a young woman who liked colour, although her clothing was often black laterally, wore make up and liked boy bands. She could be affectionate and was interested in relationships with a couple of boys, although these did not last. She withdrew in year two of the Course and so is further withdrawn from society.

Relationship with EC and AJ

Margaret already knows EC and AJ who are friends of her father who used to take her to their hotel in the evenings where he could socialise and still have Margaret in his care. Margaret's mother had only met them on one occasion prior to Margaret's father's death and was grateful when they offered to provide respite care and readily took up the offer.

The respite becomes more frequent and more prolonged until Margaret is living with EC and AJ on a full time and permanent basis. She makes it known to her mother that she wants to stay there although it cannot be known whether she does so willingly or because she is being coerced into these statements. AJ is now the Appointee for Margaret dealing with her benefits.

Her mother makes some efforts to get access to her but stops after a while having allegedly been threatened by EC.

Margaret disappears from view completely. Her invisibility is complete.

Although the circumstances of her death are tragic - this cannot define her whole life - there were periods of both contentment and joy as well as periods of considerable challenge, sadness and frustration. Her parents may not have been able to tolerate one another, but they each tried to demonstrate their care for her. Her mother struggled to bond with her but tried to be a dutiful mother. She misses her daughter. Her father protected her by pushing for understanding of her condition and potential. His fiancée and her family made her welcome.

But it was Margaret's father's passing and the frailty and death of her paternal grandparents that exposed her directly to the circumstances that led to her death. EC, having been named as an Executor of her father's will, stretched his entitlements to suggest that he had permission to be her carer. This move resulted in him and AJ having access to benefits which sustained them as their own health and earning capacity dwindled.

PART 2

THE POLICY LANDSCAPE

NATIONAL AND LOCAL

Introduction

This Part highlights changes in local government structures and multi-agency practice that took place towards the end of Margaret's life and which would have impacted on the services that would be available to her at that time. The ways in which people with learning disabilities were seen in society were altering dramatically too. In the past, for example, many families had been advised that institutional care was best for their children, often set apart geographically and located on the edge of towns and cities. Now the momentum built to close these establishments and to have care in the community where individuals were to be respected and included as equal citizens.

This section also describes local strategic thinking in Inverclyde and the outcome of a recent inspection of adult support and protection work. It then moves to anticipating forthcoming fundamental changes in the form of the proposed National Care Service and the outcomes and implications of the Scottish Mental Health Law Review which, like others, takes a human rights approach. It concludes by summarising what Margaret's human rights may have been as outlined by the External Independent Legal Advisor.

Chapter One: Legislative and Policy Changes 1995 - 2007

This chapter details major legislative and national policy changes affecting children, young people and adults that were introduced between 1995 and 2007 which laid the foundations for practice today. Other descriptions of statute and policy also appear in the report where each agency lists the legislation and policies that they each consider to be central to the exercising of their duties.

Local Government Reorganisation

Any detailed consideration of the policy landscape of the time must begin by acknowledging the magnitude of local government reorganisation which took effect in April 1996 as a result of the Local Government etc. (Scotland) Act 1994. This completely replaced the previous structure of Regions and Districts with Unitary authorities and its anticipation and implementation created immense churn that impacted on all aspects of staffing and service delivery for several years to come.

Other forms of modernisation were also set in train such as computerisation of records. This transition from the written word to the electronic meant that there were periods where both systems existed side by side which made it difficult to be confident that workers had all records to hand when on duty and meeting members of the public.

Staff who worked in Inverclyde at this time recall it as a period of dramatic change and uncertainty in day-to-day functioning and decision-making which affected performance and morale. Their situation was by no means unique.

Children, Young People and Adults

The policy landscape is unrecognisable when compared with Margaret's time. In her era, the principal statute was the Social Work (Scotland) Act 1968 which promoted general welfare and provided for child care and protection via the Courts and the Reporters Department. The latter was regarded as ground-breaking in its day as matters of proof were referred to the Courts, ensuring that the Children's Hearing System could then focus on the welfare of the child or young person.

For many present day practitioners it is impossible to contemplate what professional life was like prior to the Children (Scotland) Act 1995 and the Getting It Right For Every Child framework (Scottish Government, 2008) which was introduced in 2006.

The Children (Scotland) Act 1995

This was passed 'to reform the law of Scotland relating to children, to the adoption of children and to young people who as children have been looked after by a local authority, to make new provision as respects the relationship between parent and child and child and guardian in the law of Scotland.'

The principles behind the Act (The Scottish Office,1993) were that:

- Each child has the right to be treated as an individual;
- 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;
- Parents should nominally be responsible for the upbringing of their children and should share that responsibility;
- Each child has the right to protection from all forms of abuse, neglect or exploitation;
- 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;
- Any intervention by a public authority in the life of a child must be properly justified and should be supported by services from all relevant agencies working in collaboration.

There were three main themes including that:

- The welfare of the child is the paramount consideration when his or her needs are considered by the Courts and Children's Hearings;
- No Court should make an Order relating to a child and no Children's Hearing should make a supervision requirement unless the Court or Hearing considers that to do so would be better for the child than making an Order or supervision requirement at all; and
- The child's views should be taken into account where major decisions are to be made about his or her future.

Getting it Right for Every Child

The Getting it Right for Every Child approach has been operating in Scotland since 2006 and elements have subsequently been made statutory by the Children and Young People (Scotland) Act 2014. It is at the heart of all Government policies that support children and young people and their families. It too, is based on principles and values on children's rights including:

- Being child focused;
- Being based on an understanding of the wellbeing of a child in their current situation;
- Tackling needs early and joined up working.

Adults with Incapacity (Scotland) Act 2000

The first legislation passed by the Scottish Parliament, a year after Margaret died, was the Adults with Incapacity (Scotland) Act. It set out to protect the welfare of adults who were not able to make decisions for themselves and included individuals with a learning disability. It meant that others could make decisions on behalf of the adult about financial and welfare matters such as managing money and arranging services.

The same as you? Scottish Government Review of Services for people with Learning Disabilities 2000 (Scottish Executive, 2000)

It was also in 2000 that The same as you?, the first Scottish Government Review of services for people with learning disabilities for over thirty years, was published. For the first time, this explicitly focused on what individuals with learning disabilities could do.

Its ten-year programme was clear that the social model of disability would be at the forefront of implementation. In doing so, the Report stressed that people with learning disabilities should be able to lead 'normal' lives. It stated that people with a learning disability should:

- Be included, better understood and supported by the communities in which they live;
- Have information about their needs and services available, so that they can take part, more fully, in decisions about them;
- Be at the centre of decision-making and have more control over their care;
- Have the same opportunities as others to get a job, develop as individuals, spend time with family and friends, enjoy life and get the extra support they need to do this; and
- Be able to use local services whenever possible and special services if they need them.

It stressed the importance of agencies working well together and defined structures, procedures and processes to enable this to happen. The pace of long stay hospital closure programmes, which were already ongoing, was scaled up. The emphasis in all settings was on ensuring better information, better communication and more advocacy so that there were 'stronger voices and better choices.' Other aspects were focusing on where people with learning disabilities lived and how they could achieve full lives through day opportunities, lifelong learning and development, employment, leisure and recreation as well as improved transport and better respite. A critical component was increasing public awareness and ensuring that staff were appropriately educated and trained.

Recommendation 23 of the Review focused on safeguarding and advocated that 'all local authorities in association with Health Boards, NHS Trusts and other agencies should develop policies and guidelines on protecting vulnerable adults. Social Work Departments should review their procedures on Guardianship to include making a formal assessment of risk as a normal part of deciding whether an application should be made.'

The Mental Health (Care and Treatment) (Scotland) Act 2003

This legislation increased the rights and protections of people with mental disorders which again included people with learning disabilities.

It placed a duty on Councils to provide care and support which was to be designed to develop community-based mental health services with involvement of service users and unpaid carers in decisions about treatment. It also made clear that the least restrictive interventions were to be put in place when compulsory measures of care were required and that these should only be used if there was a significant risk of harm to the individual or to others.

The Miss X Case

In Spring 2002 a woman with learning disabilities was admitted to hospital in the Scottish Borders with multiple injuries caused by physical and sexual assault. A subsequent joint Social Work Services Inspectorate and Mental Welfare Commission investigation 'revealed a catalogue of abuse and assaults' with three men ultimately being convicted. (Mental Welfare Commission and the Social Work Services Inspectorate, 2004)

In a section of the investigation Report the following observations are made:

'A series of events had led to her being cared for by one of the convicted offenders. Over many years, there were events and statements in records held by Social Work, Health services and the Police that raised concerns about this person's behaviour towards this woman.

Other individuals were receiving care under the same circumstances. They had varying degrees of learning disabilities, physical disabilities and mental health needs, which were largely neglected, to the point of becoming potentially life-threatening for some.

Health and Social Work records contained numerous statements of concern about their care, including allegations of serious abuse and exploitation that were not acted upon. From late 2000, the lives of those individuals became increasingly chaotic. They were neglected, lived in unsuitable and unsanitary conditions and were financially and sexually exploited.'

What happened to Miss X shocked Scotland and numerous recommendations were made including 'the introduction of a comprehensive Vulnerable Adults Bill to the Scottish Parliament.' This was what became the Adult Support and Protection (Scotland) Act 2007. It is this statute that is the basis for adult support and protection work in Scotland today.

The Adult Support and Protection (Scotland) Act 2007

This introduced new measures to identify and protect individuals who were considered to be adults at risk. The Act defined them as being sixteen or over and who:

- 'are unable to safeguard themselves, their property, rights or other interests;
- are at risk of harm; and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected.'

All three components of the definition had to be met.

As with other legislation, any intervention was to be of benefit to the individual and was to be the least restrictive. It was also to take into account:

- 'the wishes and feelings of the adult at risk (past and present);
- the views of other significant individuals, such as the adult's nearest relative, their primary carer, guardian or attorney; or any other person with an interest in the adult's wellbeing or property;
- the importance of the adult taking an active part in the process;
- providing the adult with the relevant information and support to enable them to participate as fully as possible;
- the importance of ensuring that the adult is not treated less favourably than an adult in a comparable situation; and
- the adult's abilities, background and characteristics (including their age, sex, sexual orientation, religious persuasion, racial origin, ethnic group and cultural and linguistic heritage).'

The Act has the following duties and powers:

- to undertake inquiries where there may be a need to intervene;
- provision of independent advocacy and other support services;
- to carry out investigations although the individual does not have to answer any questions or to agree to medical examination;
- to ensure that public bodies co-operate with local Councils and with each other if there is harm or this is suspected;
- to provide three types of Protection Order – assessment, removal and banning.

The Act makes clear that a Sheriff may not grant a Protection Order if it is known that the individual has refused this unless it is reasonably believed that the person has been 'unduly pressured' to do so. The Act also introduced the creation of multi-agency Adult Protection Committees to oversee local adult protection policy and practice.

Chapter Two: Local Strategic Thinking - Delivery and Evaluation

The above national coverage of policy needs to be complemented by a greater understanding of local strategic thinking within Inverclyde and appreciation of local adult protection practice, management and governance. The next section provides this by summarising the most relevant aspects of the Inverclyde Health and Social Care Partnership Strategic Plan Refresh 2022-2024 (Inverclyde Council, 2022) as well as the recent Care Inspectorate Joint Inspection of Inverclyde Adult Protection (Care Inspectorate, 2021).

Inverclyde Health and Social Care Strategic Plan 2019-2024 (Year Three Refresh 2022-24)

This is the latest iteration of the second five-year Plan for the Integrated Joint Board which was developed by the Health and Social Care Partnership and the Strategic Planning Group. This has been refreshed in the light of Covid and sets out key priorities focused on what are termed the Six Big Actions to be addressed in the course of the next two years serving a population of over 77,000 people.

The Six Big Actions, which link to National Outcome Measures, are:

1. Reducing inequalities by building stronger communities and improving physical and mental Health
2. A nurturing Inverclyde will give our children and young people the best start in life
3. Together we will protect our population
4. We will support more people to fulfil their right to live at home or within a homely setting and promote independent living
5. Together we will reduce the use of, and harm from alcohol, tobacco and drugs
6. We will build on the strengths of our people and our community.

Each Big Action has areas of responsibility to lead on in terms of delivery, all of which are pertinent to the quality of life of its residents. The steps under Big Action 3 about protecting the community are as follows:

- We will implement the learning and recommendations from 2021 Adult Protection Inspection and any Significant Adverse and Critical Incidents;
- We will continue to deliver our Clinical and Care Governance Plans and ensure appropriate reporting on feedback and learning to be presented to Health and Social Care Partnership Clinical and Care Governance group and the Integrated Joint Board;
- We will fully implement the national Child Protection Guidance (Scottish Government, 2021) with a strengthened focus on children's rights, engagement with families and more holistic approaches to reduce stressors on families and communities;
- We will continue to support the national Child Abuse Inquiry as required and implement learning and recommendations once available;
- We will roll out trauma informed approaches across all Health and Social Care Partnership staff and commissioned services to ensure delivery of trauma informed services;
- We will continue to progress the Woman in Criminal Justice System Project.

Some aspects of Big Action 4 are also relevant to this Review especially the commitment to continue to roll out Access 1st to all adult services across the Health and Social Care Partnership to ensure easy access and the right support to people accessing adult social care services.

It also signals the opening of a new Learning Disability Hub to provide transformational support for people with learning disabilities.

The Inverclyde Adult Support and Protection Joint Inspection

Scottish Ministers had requested that the Care Inspectorate led joint Adult Support and Protection inspections (in collaboration with Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland) to be completed between 2020 and 2023. The Inverclyde findings were published in 2021.

The aim was 'to provide timely national assurance about individual local partnerships [and] effective operations of Adult Support and Protection key processes' with a focus on whether adults at risk of harm in the Inverclyde area were safe, protected and supported (Care Inspectorate, 2021).

Inverclyde was one of twenty-six inspections to be completed in the period, the findings of which will be put alongside those of a previous round of inspections in 2017/18 to 'shape the development of the remit and scope of further scrutiny and/or improvement activity' (Care Inspectorate,2021).

The two key questions were about how good the Partnership's core adult support and protection processes were and how good strategic leadership was.

There were four scrutiny activities:

- The analysis of supporting documentary evidence;
- A staff survey;
- The scrutiny of the Health, Police and Social Work records of adults at risk of harm;
- Staff focus groups.

Well over two hundred staff from across the Partnership completed a survey with replies coming from Health, Police, Social Work and Third Sector organisations. Different levels of experience were factored in, with questions being asked about outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. Records were scrutinised in relation to those that resulted in no further action after investigation as well as those records that had at least gone to the investigation stage. Staff also discussed the impact that Covid had on the work.

The following strengths were identified:

- 'The Partnership has taken positive steps to ensure there was improvements in the lives of adults subject to Adult Support and Protection processes, and that they were safer because of the support and protection they received;
- Effective communication, information sharing, collaboration and joint work were positive features of the Partnership's response to Adult Support and Protection work;
- There was a high degree of confidence amongst staff that strategic leaders, including the Adult Protection Committee, provided good leadership for Adult Support and Protection work' (Care Inspectorate, 2021).

There were also some areas for priority improvement which were that:

- 'The Partnership's practice standards and operating procedures need to be revised to ensure Service managers apply a more consistent approach to adult support and protection chronology, risk assessment and protection planning work;
- The Partnership should review its key processes documentation and ensure it more accurately records the three-point test. The focus should be on screening, inquiry, and investigation activity;
- The Partnership's quality assurance performance framework should be further developed and more consistently applied to ensure a better understanding of results and the improvements required;

The Chief Officers' Group and the Adult Protection Committee should scrutinise quality assurance work more robustly and ensure identified improvement work is carried out' (Care Inspectorate, 2021).

In summary, what both these local reports evidence is a strong commitment to serving the population and to delivering to as high a standard as possible in the challenging circumstances of Covid and other significant pressures. The Big Six Actions recognise the criticality of sound protective measures and demonstrate the willingness to listen and to learn from Reviews such as this one. Community and staff engagement underlines a respect and appreciation for both and gives confidence that what can be done will be done.

Chapter Three: Forthcoming national changes

As in the early 2000s as described above, a major period of change in how services are delivered is underway as well as fundamental changes in mental health law and practice.

A National Care Service

The National Care Service (Scotland) Bill was introduced in the Scottish Parliament in June 2022. It has four Parts, Parts 1 and 2 being the most substantial and relevant. Part 1 establishes a Scottish National Care Service which Scottish Ministers are responsible for organising and would mean transferring responsibility for care services from local authorities by 2026. Care Boards are to be created with Ministers having the power to transfer Health and social care functions over from the local authorities. Part 2 gives Ministers powers to make records about people's Health and social care more consistent and better integrated.

There is to be a publicly available National Care Service Charter which will describe people's rights and responsibilities in relation to the National Care Service as well as the mechanisms that are to uphold these rights.

The policy memorandum for the Bill provides a statement of what the vision for the National Care Service is as follows:

- Enable people of all ages to access timely, consistent, equitable and fair, high-quality Health and social care support across Scotland;
- Provide services that are co-designed with people who access and deliver care and support, respecting protecting and fulfilling their human rights;
- Provide support to unpaid carers, recognising the value of what they do and supporting them to look after their Health and wellbeing so that they can continue to care, if they wish to do so, and have a life beyond caring;
- Support and value the workforce;
- Ensure that Health, Social Work and social care support are integrated with other services, prioritising dignity and respect, and taking account of individual circumstances to improve outcomes for individuals and communities;
- Ensure there is an emphasis on continuous improvement at the centre of everything;
- Provide opportunities for training and development, including the creation of a National Social Work Agency providing national leadership, oversight and support;
- Recognise the value of the investment in social care support, contribute to the wellbeing economy, make the best use of public funds, and remove unnecessary duplication.

The Bill is still being debated within the Scottish Parliament.

The Scottish Mental Health Law Review and the Rome Review

The Review of Scottish Mental Health Law Review has been published recently and will bring its own sweeping changes.

It was preceded by the Rome Review which considered mental health law as it applies to people with learning disabilities and autism and reported in 2020. What it said was that 'there should be a new law for people with learning disabilities and autistic people to make sure that their human rights are protected' (Rome Review, 2019).

The Rome Review also emphasised that people with learning disabilities and autism should have support in making their own decisions about what affects them such as support, care and treatment. Importantly, it said that learning disability and autism should not be called mental disorders in law and that this needed to change.

The Scottish Mental Health Law Review reviewed the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007. Its principal aim was 'to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder and remove barriers to those caring for their 'health and welfare' (Scott Review, 2022).

The Mental Health Law Review had three parts, described by them as follows:

- 'In the first part of the Review we will find out what people's experiences are of the law and how the law affects people's human rights;
- In the second part of the Review we will tell people what we have found out and what we think might be needed to make the law better;

In the third part of the Review we will tell people what we have found out and what we think might be needed to make the law better' (Scott Review, 2022).

As with other reports, this takes a human rights approach, which is summarised as being about supporting people's human rights in:

- Achieving your best level of health;
- Making your own decisions;
- Being free and safe;
- Not being abused;
- Standards of living;
- Independent living and being part of the community;
- Dignity, equality and non-discrimination;
- Accessibility;
- Implementation and monitoring (Scott Review,2022).

The key relevant recommendation from this work is that the Adult Support and Protection (Scotland) Act 2007 will continue to be a free-standing piece of legislation and will not be fused with the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) Act 2003. It will be subject to updating and recommendations are made in the next Part on possible amendments on the basis of the findings of this Significant Case Review.

Learning Disability, Autism and Neurodiversity (Scotland) Bill

This Bill is scheduled to come before the Scottish Parliament in 2024, alongside a new Human Rights Bill that will enshrine the UN Convention on the Rights of Persons with Disabilities into Scots law.

Chapter Four: An Interpretation of Margaret's Human Rights

This summary of the overarching human rights that drive practice was written by the Independent External Legal Advisor to the Significant Case Review. As the date of Margaret's death is uncertain, it is not possible to state definitively what Human Rights instruments might have been applicable to her circumstances.

Three International Treaties may be relevant.

European Convention on Human Rights

The United Kingdom was a Signatory to the European Convention of Human Rights in November 1950 and ratified the Convention in March 1951. Nevertheless, the process of enforcing any Convention Rights directly against public bodies such as local authorities remained indirect until the Human Rights Act 1998 was enacted. The 1998 Act came into effect on 2nd October 2000. In the case of Scottish Ministers, the terms of the Scotland Act 1998 also reflect the applicability of Convention Rights.

In broad terms, Margaret's circumstances could have involved Article 2 (Right to Life), Article 5 (Right to Liberty and Security), Article 8 (Right to private and family life) and Article 14 (Enjoyment of Convention Rights without Discrimination). It should be noted that the interpretation of these Convention Rights by the European Court of Human Rights has evolved considerably during the 21st Century and may have had a lesser effect at the time of Margaret's disappearance.

In some respects, Scottish Domestic Law reflected these provisions in the protective powers provided under the Adults with Incapacity (Scotland) Act 2000 and, more specifically, the Adult Support and Protection (Scotland) Act 2007. Even so, the exercise of such powers by a public body required to be made in a manner which is both compliant with the Convention Rights of persons affected and in a proportionate manner.

It is doubtful that, in the absence of any known threat to Margaret's life, that the State would have been required to do anything under its Article 2 obligations.

At the time Margaret was known to be alive, on the information known to Social Work and the Police on the occasion Margaret was spoken to, there appears to be nothing to suggest that she was not free to leave her home. If there had been reason to believe otherwise, the English High Court determined in 2010 that a local authority would be required to act to terminate the deprivation of liberty (Re A [2010] FLR 1363).

There is a tension between a protective intervention by State Authorities and an individual's Article 8 Right which will underlie interventions made under either the 2000 or 2007 Acts. A Court considering applications is bound by the Human Rights Act 1998 not to act in a manner which is incompatible with, amongst others, an individual's Article 8 Right. Above all, it has to be established that any attempted intervention surmounts the hurdle of "being necessary in a democratic society".

Again, it is impossible to assess how a Court might have acted in the event of protective measures being sought for Margaret after 2nd October 2000. What can be said perhaps is that the justification required to obtain any Order may have required to be more fully supported than had been the case previously, as a result of the incorporation of Convention Rights in Scottish Domestic Law.

United Nations Convention on the Rights of Persons with Disability

The Convention on the Rights of Persons with Disability was signed by the United Kingdom on 30th March 1997 and ratified by it on 8th June 1999. It has recently been made clear during the prolonged litigation relating to Archie Battersbee that as a Treaty which has not been incorporated into Domestic Law – such as the Convention on the Rights of Persons with Disability– does not form part of the law (Dance and Others v Barts Hospital Trust and Others [2022] EWFC 88).

In Margaret's case therefore, the Convention would not have imposed any direct obligations on public authorities to act in any specific way, nor would it have provided any rights enforceable by Margaret as a person with a Disability. In Scotland, the position may be changed if a proposed Human Rights Bill which is understood to incorporate this Convention is passed by the Scottish Parliament. As yet, there is no clear date for when this would become part of Scottish Domestic Law.

Under this Convention, various rights available to a "person with disabilities", which include:

- Equal Recognition before the Law (Article 12)
- Liberty and Security of Person (Article 14)
- Protecting the integrity of the Person (Article 17)
- Living independently and in the community (Article 19)
- Respect for the Home and Family (Article 23)
- Education (Article 24)
- Health (Article 25)

Implicit in Article 12 particularly is the principle of maximising the legal agency of a "person with a disability", which already is reflected to some extent in the 2000 Act.

By contrast, the Scottish Parliament has passed the United Nations Convention on the Rights of the Child (Incorporation) Bill, which if enacted, would add its terms to Scottish Law. In format, it has some similarities to the terms of the Human Rights Act 1998. However, certain powers contained in the Bill allowing Scottish Ministers to make Regulations have been challenged successfully in the UK Supreme Court. At the time of writing, proposals to resolve the position have been mooted by the Scottish Government, but the precise stage at which the United Nations Convention on the Rights of the Child takes legal effect remains uncertain.

United Nations Convention on the Rights of the Child

Rights created under this Convention will apply to any "child" below the age of 18 (Article 1). Amongst such rights are:

- Best Interests of Child to be a primary consideration (Article 3)
- Right to Life (Article 6)
- Separation of child from parents and maintenance of Contact (Article 9)
- Giving weight to views of child (Article 12)
- Protection of child's privacy home family and correspondence (Article 16)
- Common responsibilities of parents (Article 18)
- Protection from abuse and violence (Article 19)
- Mentally and physically disabled child to enjoy a full and decent life (Article 23)
- Health (Article 24)
- Right of Child to Social Security (Article 26)
- Health (Articles 28 & 29)

Again, some of these principles are reflected in various items of legislation, primarily perhaps in the Children (Scotland) Act 1995 and Children (Scotland) Act 2020. The Scottish Parliament has also passed the Children and Young People (Scotland) Act 2014, establishing the Commissioner for Children and Young People in Scotland. The Scottish Human Rights Commission was also established by the Scottish Commission for Human Rights Act 2006.

PART 3

FINDINGS CHANGES SINCE AND RECOMMENDATIONS

Part 3: FINDINGS, CHANGES SINCE AND RECOMMENDATIONS

Introduction

Recognising that not all readers of the Review will require the level of detail that is provided overall, this Part reiterates and condenses the main elements and combines these with the Findings, changes since and Recommendations. For those who read the full report this means a degree of repetition and reinforcement of key themes.

A separate summary which encapsulates the views of people with learning disabilities and their families today (outlining their thoughts on necessary changes in services, support and being included) is published on the website.

Part 3: Findings, changes since and Recommendations

Chapter One: Context

Events, findings and recommendations need to be understood against the broader backdrop of national policy and practice at the time, as the scale of change since makes what existed then unrecognisable in many respects.

The Children (Scotland) Act of 1995 centred on the needs of children and families and set out parental responsibilities as well as those of public authorities. The reorganisation of local government from 1996 onwards created organisational churn for years to come. Computerisation and the migration of documents from written to digital was another source of disruption with a mixture of both existing side by side making confidence in records challenging.

The biggest changes came just after Margaret's death including the introduction of the Adults with Incapacity (Scotland) Act 2000, the Regulation of Care (Scotland) Act 2001, The Mental Health and Treatment (Scotland) Act 2003 and the publication of The same as you?, which was the first review in a generation of support for people with learning disabilities and autistic individuals in 2000.

We are living through an equivalent, if not more significant, period of legislative and policy developments. The future introduction of a National Care Service will be one such systemic change. The completion of the Scottish Mental Health Law Review and the rollout of its findings is another as is the Disabled Children and Young People (Transitions to Adulthood) (Scotland) Bill.

Alongside this period of uncertainty, each agency acknowledges that there are aspects of its practice that fell short, although it is not possible to make a direct causal link between these omissions and Margaret's death. It is also clear that there continued to be missed opportunities after Margaret had died but before this became known to the authorities.

Agencies also accept that there are elements of performance that can be improved and have been progressing those aspects on an ongoing basis. As with many Reviews of this nature, there is evidence that inter-agency communication broke down which resulted in missed opportunities. Interpretation of General Data Protection Regulations may still mean that information known to one agency is not shared with others for fear of breach and could adversely impact on effective joint working. Collectively they accept that inter-agency, multi-disciplinary information sharing, assessment, delivery and evaluation can and should be subject to continuous improvement to mitigate the likelihood of any similar tragedy.

Chapter Two: Overarching Findings

An Unremarkable Life, a Tragic Death

Despite its challenges, Margaret's life was not an unusual one. Key events in her teenage years exposed her to dangers that she could not protect herself from which ultimately resulted in her murder.

Margaret did not benefit from the consistent and united support of both her parents. She was born prematurely several years into her parents' failing marriage and had a number of physical and developmental challenges.

Her mother cared about her but indicated that she found it difficult to bond with her, considering her behaviour challenging from a young age. Following their divorce, Margaret's father gained custody. Margaret's mother had access although the quality of visits varied in that she continued to find Margaret demanding at times and thought that this was attributable to her 'having her own way' in her paternal grandparents home where she lived with her father. He would also leave Margaret in her mother's care without any prior arrangement. Margaret's behaviour during these visits could alternate between warmth and fun to verbal aggression towards her mother. Margaret's mother acknowledged that she could retaliate in kind occasionally out of frustration.

Although an unconventional arrangement of its time, Margaret's father was her main advocate and protector. Described by those who knew him as a larger-than-life character, he had trained late as a lawyer using his home address as his office.

Having been relatively uninvolved when she was a baby, there is substantial evidence that he became pro-active when it became clear that she needed additional support from her pre-school years onwards. He may not always have ensured that her physical presentation was pristine, but consistently questioned professionals about her diagnosis and management in a range of settings, notably in relation to her health and education. His assertiveness probably ensured that her education took place in the mainstream rather than in more specialist provision which had both advantages and disadvantages.

When Margaret's father died, EC and AJ slowly and systematically took over Margaret's World.

The Impact of Margaret's Father's Death

Had Margaret's father lived, it is highly unlikely that his daughter would have died. Although he had a number of underlying health conditions, his death was relatively sudden and left Margaret exposed. She was grieving which may have contributed to her being observed to be physically challenging to her ailing grandparents. This resulted in her coming to live with her mother who was initially grateful for the respite being provided by EC and AJ and her subsequent permanent residence with them.

Becoming Invisible

Margaret was invisible at the time of her death. Her father was dead. Her paternal grandparents' health failed and they died.

When her mother tried to continue contact she alleged that she was attacked by EC. She reported this to the Police and the matter was investigated and concluded with insufficient corroborative evidence because of conflicting accounts to charge any person with a crime. Margaret's mother recalled feeling intimidated by EC and so she withdrew when Margaret had also indicated to her that she was happy to stay where she was. Her remaining efforts to retain some link consisted of gifts brought to Margaret by others which were also rejected by EC. She reluctantly withdrew and never saw or heard from her daughter again. She believed this to be her daughter's choice whom she considered to be an adult by this point.

Margaret's father's fiancée, who felt that she had developed a good relationship with Margaret, said that she was threatened and refused ongoing contact. She sought advice on her rights to access from a lawyer and from a Duty Social Worker in her local Social Work office in Glasgow. Both sources advised her that she may have had some rights had she been married to Margaret's father at the time of his death. They indicated that as Margaret had a living mother,

and that her father's Will had indicated that EC was an Executor, there was little that she could do. She reluctantly withdrew too.

Others who knew Margaret had similar experiences.

In terms of her visibility to services, her GP records were not transferred by EC and AJ when she moved to live with them at Seacroft. Social Work had no ongoing involvement. The DWP continued to pay benefits but its processes did not require routine visits. Similarly she was withdrawn from College and there was no response to follow up enquiries.

Her physical environment isolated her too. She lived with EC and AJ in a house on a strip of land sandwiched between a busy main road on one side and a large river on the other. There are a handful of adjacent properties where the positioning of each means that there is little day to day contact. When interviewed by the Police as part of the criminal investigation, neighbours had little recall of anyone matching her description being there. By then, the property was in a state of disrepair with what look like blown out elements, although it is comforting to know that the fabric of the building was not so damaged when the last visit from a professional took place in December 1999. Nevertheless, she was alone, and while she would be capable of defending herself physically to some degree, those she lived with were stronger.

Exploitation and Abuse

EC and AJ were approached on two occasions requesting that they participate in the Significant Case Review. They have failed to respond. It is evident that they exploited Margaret, the primary motivation being financial gain. They also abused Margaret and were found guilty of her murder.

Margaret's father used a local hotel that EC and AJ were operating as a place to relax. Margaret was able to come along with him and this led to the development of the relationship between them all which evolved to include respite for Margaret.

Margaret's father had a Will which named a number of Executors. EC was a late addition. The Will makes general provision for Margaret's care and is not explicit about the direct involvement any Executor should have. EC appears to have used this role to indicate that he was fulfilling Margaret's father's wishes by caring for Margaret.

Margaret's mother recalled meeting EC and AJ at her ex-husband's funeral when they offered to support her. The periods that Margaret spent in Seacroft became more frequent and prolonged and drifted to become a permanent arrangement with AJ becoming Margaret's Appointee for all benefit entitlements.

It is not known exactly when exploitation tipped to abuse or what this consisted of. Although there is a date when benefits began from the Seacroft address, there is no way of definitively knowing when a part time arrangement became a full time one.

It is also known that whilst Margaret would sometimes choose to stand back and let things happen around her, at other times, she could be assertive, and sometimes physically so.

Retrospective allegations were also made by EC that Margaret had been raped whilst a student. These were fully investigated by the Police and there was no evidence to substantiate a crime had been committed. It may be that EC created the allegation as a means to remove Margaret from that environment. It may also have been to create a picture of someone whose testimony could not be relied upon should she make any allegations about her care.

Margaret's Right to Choose Where She Lived and the Status of Her 'Carers'

Given that there is no exact date that can be pinpointed as to when Margaret moved into Seacroft, there are different considerations to be made about her rights and protections. If she was 15, her mother could be viewed as having agreed to a private fostering arrangement. Such direct and overt permission was never explicitly given. Margaret's mother would have required to report any such arrangement to Social Work who could then have explored its suitability. She did not know that this was necessary. Equally, she did make Social Work aware of Margaret's whereabouts in mentioning the initial support that EC and AJ gave. The major concerns arose when she was 17 and Margaret made it clear to her mother and the Police that she wanted to stay where she was. Whether this was an authentic choice or whether she was coerced can never be fully known.

When EC and AJ assumed carer status this went unchallenged. In the case of one of the GPs, he accepted their status at face value. He saw that Margaret was slim when her weight management was a lifelong issue and attributed this positive change to her carers. He was not the only professional to accept their carers status.

Failure to Report Harm

As the trial made clear, Margaret was also observed by people who visited Seacroft with tubes on her arms, duct tape on a wrist and calling in distress from a bedroom window. The explanations variously offered by EC and AJ were that Margaret needed to be stopped from picking at her skin and that the restraints were a form of punishment.

Those who witnessed these abuses did not report them. Services cannot respond if they are not advised that abuse may be happening. Margaret may have been supported and protected had those individuals who saw her suffering reported this.

Impact on Family, Professionals Involved and the Community

Margaret's mother lives daily with what happened to her daughter. Although she has adjusted to some degree over the intervening years, she continues to grieve for her adult child and the relationship that they have not had – including the prospect of being a grandparent.

Margaret's father's fiancée has also been deeply affected.

Professionals who knew Margaret have been impacted too. They continue to question what they could have done differently and carry that with them in their everyday lives. Some found what they perceived to be the adversarial nature of the trials acutely challenging, citing the lack of any follow up from the Courts system.

Others simply wished to put events behind them to be able to carry on

Yet others have chosen to address failings that they became aware of to mitigate the likelihood of any recurrence. Their dedication to positive change is evidenced in ongoing policy and practice developments directed at further improving the lives of clients with learning disabilities in Inverclyde today.

Citizens of Inverclyde are also affected by the nature of Margaret's death and are in disbelief that this could happen in their community. Some of those living in Inverkip, where Margaret lived latterly, have a deep-rooted need to understand what took place and are committed to being part of positive change going forward.

Chapter Three: Findings Relating to the Agencies Involved

Department for Work and Pensions Findings

The Department for Work and Pensions continued to provide benefits for over a sixteen-year period without seeing Margaret. In doing so, they largely followed their stated policies and procedures. Proof of life does not rest solely with them and their principal role is not to safeguard, but this stark fact is difficult to comprehend and to accept.

Yet, as people with learning disabilities themselves have said, a sensitive balance needs to be struck between supporting those who have benefits and intruding in their lives. Which has led to Social Security Scotland recently announcing that visits to customers whose circumstances are unlikely to change will not be the norm. This has been welcomed by those who advocate on behalf of individuals with learning disabilities. Visits will therefore be less and this explicitly tips the responsibility for safeguarding to other partners.

The Department for Work and Pensions accepted that Margaret was too scared to see them on several occasions and their good cause criteria reinforced no further action being taken with the exception of a failed referral to the Social Work Department.

The correct guidance was followed when Margaret's 1996 Disability Living Allowance Child Application was made. Margaret's mother made this application confirming in writing that the payments would be used in Margaret's best interests. A visit was not required due to Margaret being a child.

When the later 1999 Disability Living Allowance adult application was made by AJ, a visit was required to confirm the suitability of the Appointee and for the claimant to confirm that they needed an Appointee. The Department for Work and Pensions was unable to confirm if this visit took place because the relevant documents were retained for fourteen months only as instructed in the Retention Guidance.

There was no requirement to routinely review Appointees pre-2008. Appointee reviews were generally not completed unless an allegation of financial abuse had been made. Whilst the correct process was followed pre-2008, a long time passed without Margaret's Appointee being reviewed. When new Appointee Guidance came into force in 2008, requiring Appointees to be reviewed every eight years, a Review was not arranged.

Routine Disability Living Allowance Reviews at that time were paper based only, not requiring a face–to-face contact with Margaret and her Appointee. As the award was given indefinitely due to Margaret's reported conditions, regular Reviews would not have been required.

In 1996 Margaret was claiming Incapacity Benefit. This was then replaced with Employment and Support Allowance from 2008 and as part of a phased migration Margaret was moved onto this in 2012. A claimant's capability for work is assessed under this allowance and after reviewing medical evidence received from Margaret's GP, a decision was made that Margaret should attend a face-to-face assessment. Margaret could not attend three work compatibility assessments scheduled between January and September 2012 as she had been dead for approaching thirteen years.

Good cause for non-attendance was accepted by a decision maker based on the explanations given by Margaret's Appointee – that Margaret was too scared to attend and had a fear of officials.

Based on Margaret's continued non-attendance, failed attempts to contact the Appointee by phone, and the lack of medical evidence from Margaret's GP, a home visit was made by a Department for Work and Pensions Visiting Officer who visited Margaret's home address. Margaret's Appointee was present at the visit and stated that Margaret would not come and speak to the Visiting Officer. The correct process was followed.

The Visiting Officer subsequently made a referral to the Social Work Department based on the visit. The Social Work Department did not progress the referral because the Visiting Officer did not confirm that Margaret had given permission to make the referral.

After Margaret failed to attend three assessments, repeated failed attempts to make contact with the Appointee, and not being able to see Margaret when the home visit was made, a decision was made to accept good cause for non-attendance and award Employment and Support Allowance for three years.

Whilst the Guidance that was in place at the time was followed, it could be argued that further enquiries could have been made before deciding not to review Margaret for three years based on lack of contact.

Medical advice was sought from the GP on a proforma. Such asks are routine and there are many of them which may mean that they do not always get the attention that they may merit. Margaret's condition was still thought by the Department for Work and Pensions to be Sotos syndrome and mental health issues, the latter apparently relating to her behaviours.

These conditions were not independently appraised by the Department and the words returned on the proforma were accepted. In fact, Sotos syndrome was excluded as a potential diagnosis for Margaret when she was young but continued to be listed as part of her condition and needs.

In 2016 the Personal Independence Payment was introduced and the content of AJ's application for this triggered alerts which led to another referral to Social Work which revealed that Margaret was missing.

Changes to Department for Work and Pensions Policy and Practice

The Department has conducted its own internal review about Margaret which remains confidential to the organisation. At least one issue in the Significant Case Review has also been escalated to the Serious Case Panel within the Department.

It is evident that evolving practice now is more overtly compassionate in that staff are encouraged to escalate any feelings of concern that they have without any necessary tangible evidence. The growing culture is that staff who express these views will be respected and believed which, in turn, is more likely to ensure that more customers experience concern and compassion too. The creation of the Department for Work and Pensions Advanced Customer Support Service is one tangible example of such developments.

Whilst the correct process was followed at that time by not reviewing Margaret's Appointee pre-2008, the Department for Work and Pensions has since strengthened the legislation and associated Appointee guidance in 2008. This includes new guidance which confirms the responsibilities of an Appointee, the requirement to carry out an independent assessment of the claimant's ability to manage a claim to benefit, and extensive guidance on interviewing a prospective Appointee.

This new Appointee guidance which came into force in 2008 would now require Appointees to be reviewed every 5 years (for Appointees who represent children) or 8 years (for Appointees who represent working age adults).

Earlier reviews can be carried out if, for example, it is likely that the customer will be able to manage their own affairs before the next 5 or 8 year review is due. The Appointee review system provides assurance that an Appointee is required to ensure that a claimant's financial affairs are being managed properly.

As in Margaret's case, if there is a lack of up-to-date medical evidence and a refusal by the Appointee to attend a face-to-face assessment, but no evidence that her financial affairs were not being managed properly, an earlier Appointee review may not have been considered or required.

However, a failure to attend face-to-face assessments can directly impact a claimant's benefit payments and therefore under the present guidance, the role of the Appointee could come under scrutiny, but this is not an automatic response.

Following today's guidance - and due to Margaret's health conditions and vulnerability - a referral could also be made to an Advanced Customer Support Senior Leader. The Advanced Customer Support Service forms a network with relevant internal and external stakeholders to provide support for all Department for Work and Pensions customers, providing national coverage whilst also building local relationships with partners in their regions. Part of this role is to ensure that chances to flag concerns to agencies with statutory safeguarding responsibilities are not missed.

Due to Margaret's vulnerability and behavioural issues, her situation could be referred to an Advanced Customer Support Senior Leader who would be able to flag concerns to agencies with statutory safeguarding responsibilities e.g. Health and Social Work services. They would have the option to make a referral to Social Work as they did in 2012. They would also be able to hold a case conference with Health and Social Work to consider next steps or contact Margaret's GP for further evidence or information.

A Vulnerable Customer Champion may also be able to support Margaret where a potential risk to the customer is identified i.e. there is a history of mental

health issues or problems in contacting the customer. The Vulnerable Customer Champion will work 'out of process' to take whatever action is necessary to support the customer and colleagues.

Revised Health Care Professional guidance now also requires the appropriateness of medical evidence to be considered. This means that Margaret's GP could be asked to provide more up-to-date medical information.

More generally, the Customer Experience Directorate was created in the Department for Work and Pensions in 2019 to coordinate policy development, guidance, and learning, as well as monitoring the implementation of change.

Through this new Directorate the Department is examining how to listen and learn as an organisation – using customer experiences, insight and data to improve the service offered to customers. The Department has also created central teams in the Customer Experience Directorate to focus on strategically supporting our most vulnerable customers.

Every Jobcentre has a complex needs toolkit containing links to local organisations who can help and provide support to those who require it. The toolkit was developed by a range of experienced officials across the Department to support, signpost and raise awareness of claimants with various complex needs. Designated contacts from each Jobcentre attended training sessions where they were coached on how to use the toolkit. The toolkit is now covered within Universal Credit training for all new starters.

All Work Coaches and Child Maintenance staff have received mandatory training to raise their awareness of domestic abuse, which was developed in collaboration with domestic abuse charities. Every Jobcentre has a Domestic Abuse Point of Contact to raise awareness of this issue, and support staff to deal with it appropriately.

Health Findings

Whilst her mother is clear that Margaret had a learning disability, there is no evidence of a formal diagnosis being made with the exception of a single reference to 'learning disability' in a referral letter in November 1999 by the GP to the Psychology Adult Learning Disability Team. Not having a specific diagnosis was not uncommon.

A potential diagnosis of 'Sotos syndrome (cerebral gigantism), which is associated with rather slow psychomotor development', is recorded in a letter from the Consultant Paediatrician in January 1982 to the GP. Whilst this was disregarded quickly, the label continued on records for years to come and is recorded as the basis for Employment and Support Allowance in December 2011 and November 2015.

The lack of a definitive diagnosis overall may have impacted on Margaret's access to appropriate clinical pathways and signposting to relevant supports. It speaks to a fragility of systems and how information is used and interpreted.

Margaret almost gets lost in Health services overall as she does not have any complex issues. She has some routine contact that any young person would have. Some children who have a learning disability have a wider genetic condition or complex health issues that are visible to Health services. As Margaret did not have that, Health services were probably reliant on other services informing them of any issues.

No Health professional ever raised any child protection concerns about Margaret and no other agency contacted Health to raise any concerns or gain any further information. In her earlier years there are presentations where today neglect may be considered an issue and agencies would work in collaboration with a Getting It Right For Every Child model to assess and support.

Medical case files do reference previous psychological trauma, psychological problems and behavioural disturbances. Social and emotional issues within the family home are also acknowledged. Margaret's parents are said not to be pulling together, although these observations are not correlated with wider social circumstances. Based on the academic evidence, it is likely her exposure to adverse childhood experiences impacts on her health and wellbeing, including her obesity, developmental and behavioural issues.

It is clear that the GPs played a key role in addressing routine health issues. The surgery they occupied then and the expectations placed on them are unrecognisable today. They dedicated a total nearly 60 years of practice to a recognised area of deprivation. They lived through the transition from a system that operated on the basis of their ready availability, working phenomenal hours in a pre-digital age, to having an expanded workforce (both professionally and administratively) that migrated written case records to computerised versions. Given their workload, much of their report writing was historical and not based on up-to-date assessment of their patients. Nevertheless, both GPs recognised and emphasised the benefits of multi-disciplinary and multi-agency working and continuity of care giving in the early years.

Health systems modernisation, in particular, was challenging and disruptive and Margaret's move to Seacroft was not followed through competently, although the onus to make the administrative change to another practice was for her and her carers.

The role of the Health Visitor and the School Nurse are also largely unknown as files are no longer available. It is known that there was 'a lot' of Health Visitor involvement with the family from an entry in a Psychologist's record. There is a preschool assessment form completed by the Health Visitor in February 1985 where there is no reference to Margaret having a learning disability. A few letters seem to reflect an awareness of involvement of other services e.g. Social Work but are limited in terms of care planning and expectations.

Margaret was seen by paediatricians almost on a monthly basis regarding concerns about her development and obesity during her early years, her contact with paediatrics ending in 1992. She had a couple of inpatient stays prior to her starting school to observe her weight and development. Her weight came down and her development improved while an inpatient but no connection was made to why that might be. These contacts would not happen if Margaret was a child now and they would be managed by a Health Visitor or community-based teams.

Margaret is recorded as having attended Accident and Emergency on five known occasions between 1988 and 1994 which were not regarded as unusual or concerning.

When her father died, her mother seemed to struggle to meet Margaret's needs and she eventually resided with EC and AJ. Bereavement issues and loss could have had a significant impact on Margaret's functioning and behaviour and it is not clear how well this was understood.

There is no obvious evidence within the case files of Margaret's views in the context of exploring the things

that matter to her to support decision making and the development of health and social care plans. There is little evidence that clinicians or professionals met with Margaret on her own specifically in her teenage years with the exception of some GP appointments and one with the Psychologist. She was always accompanied by either parents or EC or AJ.

Realistically if an individual attends an appointment with another adult one could assume they have consent to be there and if the learning disability was less significant it may be difficult to notice any obvious concerns regarding this situation. Some attempt to recognise the importance of seeing someone on their own despite any objections from another adult should be made.

This last referral to psychology in 1999 was from Margaret's GP who genuinely believed that contacting a Psychologist in the Community Learning Disability Team would naturally lead to a Social Work assessment which it did not as a separate process was required. This failure to understand the referral process was ultimately overtaken by the refusal of EC and AJ to co-operate in what was a voluntary process.

There was no record of any formal care arrangements for Margaret within the Health records. The status of EC and AJ as carers was accepted by more than one Health professional. One GP thought that they were responsible for addressing Margaret's lifelong weight issues.

The Psychologist did not consider Margaret's carers to be exceptional in that, although they and the house seemed relatively unkempt, they were content for Margaret to be seen on her own. With hindsight, her behaviour in that one-to-one exchange is said to have oscillated between politeness and latent aggression which may have been indicative of stress. What she was feeling in this interview can never be known. So whilst it is clear that adults with capacity should make their own informed choices, it is equally clear that the status of carers should be subject to scrutiny.

Changes to Health Policy and Practice

The language used to describe children or young people with a learning disability or difficulty has changed as has the support available which makes individuals more visible to the community and professionals. Some patients are also now required to have formal reviews and improved recording in relation to their capacity and care status.

Throughout the latter part of the last century the standard diagnostic approach included the use of a variety of tools to assess IQ and functional ability. The main difference between learning disability and difficulty is the presence of problems with global functioning which affect an individual's ability to learn and function across all domains. A learning disability may also have a known cause but can also be of unknown origin. In current practice it is more common for genetic testing to be carried out in an effort to confirm the underlying cause, which can also be helpful in terms of ongoing support.

In contrast, a learning difficulty may indicate problems with one or more areas of learning and include conditions such as dyslexia but does not include the more general impairment noted above.

The other key factor is the presence of health problems, some which may be directly attributed to the cause of the learning disability itself, which are often greater in number and complexity as a result of the level of learning disability.

Margaret today would have access to universal Health services and better integrated working, backed up by modern electronic systems that would alert the practice if a patient had not moved their records on changing address. One of the GPs summarised this as being much more proactive and careful.

Primary care has shifted towards a more preventative model of medicine and standards set for managing certain health conditions. Consideration would now also be given regarding the impact of a disability and how a person may or may not manage their health problem with professionals being more proactive in providing support.

Margaret today would also benefit from improved communication between GPs and Health Visitors and a greater understanding of emotional development and the impact of trauma on child development. The Getting it Right for Every Child national practice model is used by Health staff and assessments would seek to triangulate the concerns within the family life including risk factors and protective factors.

What is less developed and similar today is the communication and relationship between School Health, Education and GPs. For children who do not have complex physical health needs and as such are not seen by specialist Health services, the GP remains a key professional with that child's life. As such there should exist strong working relationships between

Education and GPs for all children but in particular those with a learning difficulty, learning disability and other vulnerabilities. It is not clear from Margaret's Health records what her difficulties were in school and what her transition or support arrangements were.

Health Visitors have a very strong role and remit, concentrating on needs from pre-birth to 5 years with School Nurses taking on responsibility thereafter. The Health Visiting universal service offers a minimum of eleven visits including a pre-birth visit designed to build a therapeutic relationship. The school nursing contribution is also critical within the wider integrated team context, working across Health and Education to support early identification and intervention, and promote Health, wellbeing and attainment for the most vulnerable children and families and those at risk of significant harm.

All children will also have a comprehensive assessment of their needs using the Getting It Right For Every Child National Practice Development model which will define appropriate levels of support in partnership with parents and carers.

The Health Plan Indicator should be allocated by six months but can be put in place ante-natally and is subject to changes in response to emergent risk. In Margaret`s life, it is anticipated that the Health Visitor would have allocated an additional Health Plan Indicator depending on the Getting it Right for Every Child (GIRFEC) National Practice Model assessment and Margaret and her family would have had access to more support with signposting to other agencies and services as appropriate. There are two categories of HPI - 'Core' (receiving the universal health visiting service) and 'Additional' (receiving additional health visiting support and/or support from other disciplines or agencies. In her earlier years there are presentations where today neglect may be considered an issue and agencies would work in collaboration to assess and support.

It is known that childhood obesity is patterned by socio economic deprivation which is anticipated to worsen as families continue to experience the impact of increasing costs of living. Margaret of today would be monitored carefully in relation to her weight, and the focus of support would be in the community, involving a range of professionals including infant feeding advisors, community paediatricians and paediatric dieticians with appropriate oversight from a Health Visitor. The Health Visitor would be monitoring weight up until age five or until entry to school. Thereafter, support and signposting would continue to be offered, depending on the assessment of the School Nurse Several targeted programmes would be available to her including The Weigh to Go Programmes which helps young people to reduce their BMI and become more physically active.

A recent and significant positive change is that in May 2022 Scottish Government announced the implementation of annual Health checks for people with a learning disability to be undertaken by Health Boards or by those that the Health Board had entered agreements with. Such checks had been undertaken previously in Scotland as part of an NHS Local Enhanced Service between 2002 and 2016. This was undertaken on an opt-in basis and several Boards, including NHS GGC, took it up enthusiastically. The information, research and known benefits in addressing the number of Health inequalities faced by people with a learning disability in the area is largely available as a result of NHS GGC work. Since 2016 the Scottish Government has engaged in further exploration of the benefits of Health checks and have run a pilot programme in NHS Grampian which informed the changes to come.

Education Findings

School

Back in the 1980s there was not such a clear understanding of the different profiles or types of additional support needs that exists now. The Education (Scotland) Act 1980 was the statute that would have underpinned provision for Margaret which was progressive in its time in that it identified the concept of special educational needs. It was limited to those who had a diagnostic label, having been assessed, possibly on a snapshot basis, by an Educational Psychologist. We know that Margaret was assessed as she had a Record of Need. Children would have been regarded as being of low ability or spoken about in terms of their intellectual capacity rather than facing barriers to learning. There were also perceptions about children's finite capacity for learning.

There is a better understanding of how people learn, how they are able to use that learning and how people scaffold their own learning. Margaret was intellectually challenged. She may have flourished with a different pathway that allowed her to build skills incrementally.

Margaret's placement in mainstream schooling throughout her childhood appears, in part, to have been because that was what her father wanted for her. He took a very active interest in her learning and requested a variety of assessments and interventions to better understand the underlying causes of her limited capacity.

Margaret benefitted from the professional expertise of skilled and committed teachers in Secondary School who cared for her within an environment that prided itself in having a strong ethos of kindness.

She made limited academic progress in school (needing to go over the same input regularly to retain understanding) and made few friendships preferring to stay in the background and avoid attention.

Teaching staff only knew what Margaret and her father revealed about their personal circumstances. They were unaware of Social Work involvement with Margaret and would not have referred her for support given what they believed to be her positive and protective relationship with her father.

Transition to College

Margaret was subject to regular reviews and was actively managed in terms of her transition from Primary to Secondary School and from Secondary School to College. Transition planning did not extend to other agency involvement.

Staff attended Future Needs Assessments in schools when invited, not least to ease the transition from school to College. Port Glasgow High School was acknowledged as being proactive - always inviting College staff to Future Needs Assessments and recognised as having good links with the Careers Service.

Some schools invited the College at the end of third year and others in the January of fourth year, a primary function being to provide reassurance about post school options. What was involved in the College Step Course would be covered at the Future Needs meeting. This did not routinely involve other agencies.

College Life

Margaret attended James Watt College which was recognised as being advanced in terms of meaningful inclusion of students with additional needs and which offered both academic and pastoral opportunities. Students and staff alike recalled that the College placed a strong emphasis on student safety, encouraging any conflicts to be openly shared and resolved. So there was promotion of general welfare support for all students prior to the evolution of safeguarding policies which were formally introduced gradually around 2015, based on National Child Protection Guidance published in 2014.

Although very much in the background in James Watt College, and not progressing much academically, her College Tutor and fellow students believe that she largely enjoyed this experience. She was offered new opportunities to socialise with others and to go on age appropriate residential excursions where she was described as being visibly more at ease, brighter

and upbeat. Margaret did have a couple of short-lived relationships with fellow students which were not considered significant by her peers.

The retrospective rape allegation made by EC was something that College staff who were interviewed for the Review said that they were unaware of at the time.

Margaret's departure from College was noticed and staff, both past and present, are confident that actions would have been taken to establish reasons for this.

One ex-student recalled asking about her absence and staff saying that they had tried unsuccessfully to contact her. When a young person dropped out this would routinely be followed up by the College making contact with them and their family. This was standard practice when Margaret was a student but records no longer exist because of retention rules to show whether this did happen. Where there were concerns, an additional step could be a referral to Social Work for further investigation.

Changes in Education Policy and Practice

School

Educational provision has radically altered. Records of Need were based on a deficit model, tended to be snapshots, and did not inform educational establishments how to support a young person. Through a range of legislation introduced since, ongoing planning and processes take a strengths based approach focusing on what a child can do and could do.

Replacing the concept of special educational needs with additional support needs means that all forms of barriers to learning can be addressed including those that are transitory e.g. a child experiencing bereavement.

Inverclyde also has an unexplained absence policy which has been in place for a year. Essentially it covers day one, day two and breaks it down into detail. There are different levels of escalation throughout the course of the first twenty-four to forty-eight hours. There was no policy prior to that and it was something Education worked on with Social Work to produce. That route map is now part of the child protection and safeguarding programme for staff training. There is quick escalation to Social Work from this process with clear timelines.

There is more scrutiny of what happens at the end of a child's experience in school. In Margaret's time there would have been some crossover between school and further education or employment. This has been greatly improved by legislation and policy around school leavers, including positive and sustained pupil destinations.

In the past the Government would consider data on where a child had gone every year – into further education, training, or employment or not. Success was viewed as a high percentage in further education, training or employment. This data is still considered but it is more about sustained destinations and a young person's journey rather than a one-off data point.

A noteworthy good practice development is the Inverclyde Offer. In six weekly meetings between the More Choices More Chances Team, Skills Development Scotland and a number of other partners, data is considered from the sixteen plus data hub on every young person between sixteen and twenty-four. The aspiration is to have no unknown young people in Inverclyde in that age range and this has been the case for over a decade. Contact is made with a young person if they are not in some form of positive education, employment or training activity to see what can be done about it. Although the primary driver for this is not safeguarding it is a by-product and there have been occasions this has led to escalation beyond the Inverclyde Offer group.

At any one time there can be between twenty and thirty children or young people placed out of authority. There is a specific Inverclyde Offer group who consider what happens to these young people when they return to Inverclyde when they turn sixteen or seventeen. The process for this starts when a child turns fifteen so there is a plan in place when they come back.

Another recent joint working initiative is that the Inverclyde Offer is changing as a virtual School Head has been appointed specifically for care experienced children and young people. This is rightly regarded as a dynamic partnership between Social Work and Education, the post being jointly funded for two years as a test of change with a view to extending beyond that. This is driven by key markers of vulnerability like engagement, attainment and attendance. If a child is experiencing issues there is an expectation measures will be taken.

Another important component of change is the recognition of trauma which Margaret did experience but was not understood in the way that it is now. Within Inverclyde, a Trauma Project Lead, is a new post designed to promote understanding across the disciplines and to enhance joint practice.

College

Safeguarding policy in West College (which James Watt College was merged into) now rests with the Director of Communications and Student Experience who reports to a Senior Management team which reviews and approves policy revisions. This role provides a sensitive and effective bridge in the transition between school and College. Staff are trained and unafraid to escalate any concerns within the College and to other disciplines. Where there is an immediate concern, the Police are likely to be contacted. For more long-term support, Social Work will be contacted.

Specific practice in respect of investigating alleged rape in College is now rigorous and robust. Staff are trained (both in generalist and specialist roles) to ensure that appropriate investigations and support take place. External expertise is also called on when needed.

Children and Families Findings

The Children and Families offer to Margaret, her family and significant others varies considerably in terms of process, outcomes and quality. To some degree, there has to be a reliance on the written word to review involvement but not everything was written down, paper casefiles were destroyed because of retention rules and the limited amount that was available on electronic files was able to be sourced. The flow of what does exist is not always clear and is disjointed.

What it does demonstrate are two significant opportunities to act positively in ways that could have resulted in a different outcome. These are not wholly attributable to Children's services as the gateway to assessment and allocation was through a generic Duty system which was staffed by front line and managerial staff from across Social Work.

The first contact with Social Work took place in the early 1980s and relies on Margaret's mother's recall. Her daughter was struggling in her general development and a nursery place was sought and provided which also improved Margaret's ability to socialise with other children and adults.

From mid-October to late November 1995 major changes took place in Margaret's life resulting in a referral to Children and Families which responded slowly and ineffectually. Margaret's father was dying in hospital, she was worried about him but was unaware of the seriousness of the situation and was left in the sole care of her paternal grandparents. An altercation began, instigated by Margaret, where she was physically and verbally aggressive to them. Their Home Help was concerned and reported this to Social Work and to Margaret's mother who comes to assist. Margaret's father died a few days later.

Both mother and daughter attended interviews during this period. Margaret made her distress clear. During these exchanges she alleged that her mother had hit her in the kidneys. Her mother denied this. Whilst there is a lengthy assessment process that involves Margaret being interviewed twice on her own, what the available records fail to show is the worker's thinking regarding thresholds being met for formal investigation under Child Protection Procedures and/or a referral to the Children's Reporter. This could have been possible under Section 32 of the Social Work (Scotland) Act 1968 on the grounds that Margaret was outwith parental control or on the basis that Margaret alleged that she had been assaulted by her mother. What is apparent from the records is that the workers assessed tensions in the mother and daughter relationship and sought to address this through the allocation of a social worker which both agreed to.

Margaret was living with her grandparents and additional support could have been given to them to support a kinship placement. When her father died, individualised assessment and support should also have been given to her mother to enable her to care for Margaret.

Some confusion ensued in that there was some dubiety about a Social Worker being allocated, attributable to inefficient duty and allocation systems. Margaret's mother expected immediate support but it was nearly a month later, in late November, that this is done, prompted by her further visits to the office.

The allocated Social Worker worked well with Margaret over a period of months in fulfilling what they believed to be the task by befriending and spending one to one time with her, helping her to make sense of her physical and emotional changes, and advocating that she be gentler in her interactions with her mother. The worker also worked with Margaret's mother on how to de-escalate tensions when they arose and to understand the World from a teenager's point of view. The relationship improved.

The worker's knowledge was partial however. The worker knew Margaret's father had died but not that he had been the principal caregiver. The worker stated that they knew little of all that Margaret had endured up to this point and so did not address loss and trauma directly. No contact was made by her with any other agency. The worker did not know that EC and AJ were already providing support. In terms of agency communication, there needed to be a clearer definition of roles and responsibilities in terms of allocation to a social worker.

It is unlikely that the case would be allocated today given how the presenting need was defined as the allocated Social Worker recalled it. Demand for support vastly outstrips supply and means that eligibility criteria are usually only met when the identified need is defined as critical or substantial. Margaret's situation would have been categorised as medium or low level. Present day assessment and good practice for what

could loosely be termed befriending could result in diversion to a voluntary sector provider although this is by no means guaranteed.

The formal decision by a Senior Social Worker to close the case shortly after the worker went on maternity leave in the Summer of 1996 was a reasonable one in that the ongoing need was to further develop Margaret's friendships and independence which the College place she had secured was to provide.

The next referral to Children and Families came in early February 1997 when Margaret's mother presented at the Social Work office seeking support from the Children with Special Needs Team, asking for the previous Social Worker to come back as their intervention had improved Margaret's behaviour. Had this request been handled effectively it may have prevented the move to live permanently with EC and AJ.

She indicated that Margaret's behaviour had significantly deteriorated, that she persistently refused to cooperate leading to verbal and aggressive outbursts. She acknowledged that she had come without Margaret knowing as she was likely to object. She also talked about the good support she has from friends, believed to be EC and AJ, who provided respite but who did not experience the same behaviour.

What happened next is not entirely clear. The Senior Social Worker in Child Care spoke to the Senior Social Worker in the Children with Special Needs Team and it was agreed that the main Area Team would assess. Files are sent from one office and returned as not needed from the recipient. No assessment or allocation appears to have taken place. Margaret's mother feels strongly that this request for help was ignored.

The next and final referral prior to Margaret's death is made by her mother on 20 October 1998.

Margaret's mother explained that she had been assaulted by EC herself in November 1997 and that he had now assaulted Margaret's paternal grandfather who was living in Seacroft following his wife's death. His money and bank books had allegedly been stolen and it was Margaret's mother's view that this had been done by EC. In this context, Margaret's mother had come to express concern for her wellbeing, noting that she had a learning disability and that she was living with EC and AJ permanently. She made clear that she was not allowed to see her daughter.

A decision was made through discussion between the Duty Worker and a Senior Social Worker (who had some prior knowledge of Margaret) to pass concerns to the Female and Child Unit (FACU) at Greenock Police Station given their known ongoing work with the grandfather. Margaret's mother agreed with this proposal.

The Senior Social Worker spoke to an Officer in the FACU who subsequently indicated that another named Officer was dealing with matters as he was already investigating the allegations in respect of the grandfather. The Social Work records dated 2 November note that no further action was to be taken. The Senior Social Worker cannot account for why they did not follow up and the Police have no available record to aid understanding.

Changes in Children and Families Policy and Practice

From 2008, the flagship national policy, Getting It Right for Every Child, made fundamental changes to child care policy and practice. This is embedded in practice of all children who require a child's planning meeting and multi-agency supports are supported to do this through education. Margaret at the very least would have been subject to a Child Planning Meeting and Transition Plan.

If an individual, with needs similar to those of Margaret were born today her mother may have been viewed as vulnerable and as such may have been referred to the Special Needs in Pregnancy Service. This service would ensure that the child's mother received any additional supports she might need to look after and bond with her baby.

Any sign of developmental delay in the child herself would be picked up her Health Visitor or, if this did not manifest until she was older, by her nursery or early years setting.

Health visiting services and Social Work now work together within the HSCP. Health Visitors undertake a twenty-seven - thirty-month assessment and this is an opportunity to identify any developmental concerns. Parents also have access to parenting support delivered by the Third Sector including Barnardo's and Home Start.

Additional support may be offered within Education with a potential referral being made to the Additional Support Needs Social Work team if the child's parents required specialist support or advice with her care. In relation to the legislative expectations around the Getting it Right for Every Child approach Inverclyde has adopted a system known as the Getting it Right for Every Child Pathways. This can lead to the generation of a single-agency wellbeing assessment and plan, which would normally start within education. Education establishments may bring other education resources, such as Inverclyde Educational Psychology Service, to support them at this stage of the pathway if this is deemed appropriate. This takes place through a planning meeting between the establishment and the Educational Psychology Service and the generation of a document known as a Practice Level Agreement.

Within the latter stages of the Getting it Right for Every Child Pathways an establishment may present a child or young person's situation to the education led Additional Support Needs Forum for consideration of more intensive support.

The team around the child might recognise vulnerabilities in the parents and help could be provided in this area. The team around the child might also have picked up on family relationship issues which might be adversely affecting the child.

Once her parents separated they would have expressed concern about a child sharing a bedroom with her father had they been aware of this (which they were not). The principles of Getting It Right for Every Child would ensure that the child always had a named person to stand up for her and it is certainly possible that education support services would continue to augment the work of the education establishment.

When her father was admitted to hospital Margaret would have been offered support and her grandparents would have been referred to the kinship team for assessment and support directed at them. If the grandparents were unable to care for Margaret then alternative placements would have been looked at whilst the child protection process was concluded following the disclosure about her mother.

If Margaret was placed with her mother she would have been offered support and her mother would have been offered parenting support and guidance.

When Margaret's father died support would have been coordinated through a Child's Planning Meeting. She would have been offered support through the Butterfly Project which is a support service for children and families struggling to come to terms with the death of a loved one or the impact of a life-limiting illness. Home-Start, too, works with families to help them overcome issues similar to the ones Margaret and her mother were experiencing. She could also have benefitted from the Inverclyde Children's Wellbeing Service which is open to all school age children.

There is more awareness now of the impact of trauma and adverse childhood experiences. So the support and approach would likely be more trauma informed.

Additionally, a young person's disclosure of physical or emotional abuse may lead to an Inter-agency Referral Discussion where Police, Health and Social Work, with support from Education, would share the information they hold on the family. A decision would be made whether to conduct a Child Protection Investigation

and whether the young person herself would be interviewed using the Scottish Child Interview Model. A trauma informed approach where specially trained Police Officers and Social Workers would support her to tell them what is going on in her life.

The outcome of an investigation would identify a proposed plan and whether this would be best supported through Child Protection registration or not. With the updated National Guidance, this could be offered, for some young people as an additional support up to eighteen years of age.

Parents may have legitimate reasons for involving someone else in caring for their child over an extended period of time. This is deemed to be a private fostering arrangement and there is a legal obligation on any parent to notify the local authority of the arrangement. This would trigger an assessment by Social Work including safeguarding checks. A case record and Child's Plan would be maintained.

The wellbeing of children who are privately fostered is broader than a Social Work function since all have access to universal services. The Getting it Right for Every Child approach and United Nations Convention on the Rights of the Child highlight the need for all service providers to be alert to the wellbeing of children and information and guidance is available on what action to take if a private fostering arrangement is thought likely.

Every young person leaving school has a destination and this is tracked through More Choices More Chances. A child with additional support needs should have a Transition Plan between school and College. If a child dropped out of school or College this would be picked up and acted upon and Education Services now have robust procedures around this.

The National Missing Persons framework looks at how agencies work together to prevent people from going missing and to limit the harm associated with going missing built on objectives of – prevention, response, support and protection.

Depending on the young person's needs and legal status they may be eligible for aftercare and continued support into adulthood and transition to Adult Services.

Margaret's paper case file was retained within the recording and retention policy. Case recording has evolved since Margaret's involvement with Children's Social Work Services and whilst retention periods remain there is overall improvement on standards of recording. There is a specific child and families module where a child's information is recorded and where all assessments, plans and chronologies can be stored and updated. The Health and Social Care Partnership is currently commissioning a new updated electronic system which will further enhance how information is stored and collated.

There is also a lot of work emerging from The Promise, which drives changes arising from the Independent Care Review, in terms of the support that could have been provided to Margaret's mother around caring for her. The question would be whether Margaret met the threshold for Community Learning Disability Team involvement.

Adult Social Work Findings

Some elements of transition work were undertaken between the school and College but not more widely with or across other agencies. This meant that the first referral to Adult Social Work was made when Margaret would have been thirty-one had she been alive.

On 18th June 2012 the Department for Work and Pensions Visiting Officer contacted Adult Duty Social Work following a home visit to the home of EC and AJ. They were unable to see Margaret throughout their visit and only saw AJ. There is a divergence of views about the underlying reason for the referral. The Department for Work and Pensions state that they were concerned for her welfare and noted that the house was in a state of disrepair. This request was treated as a Community Care assessment for Margaret by Adult Social Work. The Department for Work and Pensions Visiting Officer did not tell AJ that this request was being made. Adult Social Work are clear that this was not explicitly flagged at the time by the referrer as either an adult protection or an adult welfare concern.

On 11th September 2012 the First Line Manager (Social Work) closed the referral dated 18 June 2012. This was on the basis the Department for Work and Pensions Visiting Officer did not ascertain Margaret's permission to make a referral to Social Work and therefore no further action could be taken.

The First Line Manager (Social Work) explained that they and others were stressed by work pressures at this point and that they considered the referral to be principally about 'a dirty house' rather than a vulnerable person's welfare. The First Line Manager's view was that such domestic circumstances were not uncommon. Although the decisions reached made no material difference as Margaret was already dead, the First Line Manager deeply regretted their inaction.

This decision did not take account of the full statutory basis for Social Work intervention. Under the 1968 Social Work (Scotland) Act, the statutory body can instigate an assessment if they consider it is appropriate to do so and potential need could be identified-without the consent of the individual concerned.

While consent is an important and primary element of the Social Work process there was no statutory basis for the decision or the rationale stated that Margaret's permission was needed to progress the referral from Department for Work and Pensions Visiting Officer. It is clear efforts were not made to contact Margaret to ask if she would consent to an assessment.

Procedures within the then current legislation were not followed for any of the three statutory framework options available to adult services Social Work to progress an assessment of Margaret's situation (Social Work Scotland Act 1968 Duty to enquire Adult Support and Protection Act 2007 and the Adults with Incapacity (Scotland) Act 2000).

The decision and recording of rationale for decision was out with acceptable timescales. Whilst it was not known at this time that Margaret had been murdered between December 1999 and January 2000, a referral to Police should have been made in June 2012 if procedures and legislation had been followed.

A very similar referral was made on 28th October 2016. A Department for Work and Pensions Practice Nurse contacted the Assessment and Care Management Duty System. The referral was received by a qualified Social Worker, who collated all relevant data and information available. This included accessing the Personal Independence Payment claim form submitted by AJ in respect of Margaret from the Department for Work and Pensions. Other relevant professionals were contacted including Practice Nurse. GP and Community Learning Disability Services to undertake further inquiries to ascertain as full an understanding of the facts around Margaret that were available at the time.

The same First Line Manager (Social Work) as the 2012 referral followed the guidance and procedures correctly authorising a home visit by two Social Workers and escalation to Duty Service Manager.

Following the home visit by the qualified Social Workers and their inability to access Margaret, the First Line Manager instigated the referral to Police Scotland due to the significant concern for Margaret's health and wellbeing negotiating a visit by Police Scotland that day.

Changes in Adult Care Policy and Practice

These predominantly relate to developments in Transitions policy and practice, systems changes and improved staff supervision (including staff development on safe, evidenced based decision-making).

There has been a review of the Transitions process involving schools, Children's Services and Adult Services with consultation events held and an information leaflet drafted for families and professionals. The most recent Transitions guidance from March 2017 has been updated and includes the expectation of Transitions Planning meetings being arranged by the school for all young people with additional needs. Those meetings should start from two years before school-leaving age and discuss the plans for post-school destination. Inverclyde is signed up to the Principles of Good Transitions guidance and is carrying out a test of change around this process.

A review of the Adult Duty System was undertaken in 2014 and became part of a wider Review which reset Adult Social Work Services including Adult Support and Protection, Adults with Incapacity, Hospital discharge and Assessment and Care Management guidance. The service was rebranded as Assessment & Care Management to give a clear focus in terms of role, remit and responsibility.

There were a number of key changes.

Firstly, there was a comprehensive revision of guidance and management of the Duty System. Prior to August 2014 Duty was covered by Teams with no designated Duty worker. All referrals were taken by Business Support and passed to Team Leader for screening and decision to pass to appropriate worker. This was a large task placed on an individual given their fuller remit. It delayed responses and volume of referrals meant delay in any response.

The designation of a Duty Social Worker meant a fair distribution of these tasks across the work force allowing for screening action and escalation to the Duty Team leader for an appropriate decision and action. This allowed more time for the Duty worker to screen referrals, interrogate information and make appropriate recommendations.

The Adult Service Duty System in 2014 also incorporated the Community Learning Disability Team. A significant action was to separate the Duty for adults with learning disability from the Assessment and Care Management System which freed up the Community Learning Disability Team to focus on adults with a learning disability.

In addition, Health and Community Care Services put in place a more comprehensive Duty Screening and Response Service called Access 1st which was implemented in January 2019. Inverclyde Access 1st is the single point of contact for Adult Support and Protection Referrals and Welfare Concerns. The ASP procedure for the processing of adult protection referrals and concerns was also reviewed.

A review of these changes in 2020 identified the key benefits of having a bespoke Referral Service for service users and the management and staff operating the system whilst offering reassurance around performance and outcomes.

Making the system smoother and more efficient means those with critical or substantial needs receive an expedient service. Those with low or moderate needs can be signposted to community resource or can be provided with the appropriate advice to maintain their independence. As a single point of contact, Access 1st has also created stronger links with community based services to support service users, their carers and relatives.

Review of all referrals across Adult community care services indicate 20,000 individual contacts across a 12-month period. Channelling through Access 1st contact will reduce the number of contacts individuals currently make and ensure people will receive the correct service when it is required, 'Getting it right 1st Time'.

The Quality Assurance framework for Adult Support and Protection was reviewed. A programme of Self-Evaluation is in place to determine how effectively legislative duties and functions are being fulfilled through single and joint case file audits. The findings of the Audit process inform the continual improvement programme and Business Plan of the Adult Protection Committee.

A review of Adult Support and Protection learning and development opportunities and content of courses was undertaken with a particular focus on the learning needs of Social Workers who fulfil Council Officer Functions under the Adult Support and Protection (Scotland) Act 2007. The Inverclyde Adult Protection Committee developed a multi-agency Adult Support and Protection Learning and Development Strategy, Standards and Programme for 2018 to 2020. This Strategy, Standards and Programme is updated on the basis of a review of courses, their content and method of delivery with the 2022 to 2024 version implemented.

Inverclyde Health and Social Care Partnership also implemented a supervision policy for all staff in 2015 which was updated in 2018 and which focusses on supporting staff to make safe and evidenced based decisions. It sets a minimum standard of professional development that promotes consistency across the Partnership, giving opportunity for each service to individualise their strategic goals and plans. The intention is to review the effectiveness of this policy in the next year.

Police Findings

Police involvement relates to three incidents.

The first was on 26th November 1997, where Margaret's mother claimed she had been summoned and attacked by EC when she had wanted to secure ongoing contact with Margaret. The only formal record is an Initial Crime Report. Margaret was interviewed and made clear that 'she is perfectly happy living at Seacroft with EC and AJ and did not wish to return to her mother's house or to communicate with her in any way.'

It was noted by the Police that Margaret was 'obviously mentally handicapped and would not be able to give evidence.' An investigation took place and at the conclusion, there was insufficient, corroborative evidence to charge any person with a crime. Margaret's mother's view of this is that it was 'their word against mine.'

The lens that this incident was being viewed under was Margaret's reliability as a witness to an alleged assault. Her needs and safety were not considered when they should have been.

The second incident related to the referral in 1998 from Children and Families in respect of an expressed concern for Margaret's mother about her welfare based on the alleged theft by EC of monies belonging to Margaret's paternal grandfather whom it was also claimed had been assaulted by EC. No record can be found of this involvement.

The third element related to the retrospective investigation of Margaret's alleged rape whilst a student which was thoroughly investigated and no evidence found that this had taken place.

Changes in Police Policy and Practice

If the same circumstances presented today, the Police would take a more holistic view. They would record a Concern Report which would document the risks that they believed Margaret was exposed to. They would share information with colleagues from other disciplines and would participate in multi-disciplinary discussions designed to support and protect Margaret. They would also assess and address the need for her to be supported by an Appropriate Adult whether she was perceived to be a victim or a witness.

Specifically, if the rape allegation was brought to the attention of the Police now there would be an interest around capacity to give consent. The Sexual Offences (Scotland) Act 2009 provides the context to dealing with vulnerable adults in terms of capacity to give consent and how that can be expressed when supporting vulnerable victims of sexual assault.

Findings from Input from People with Learning Disabilities and Family Carers

Both local Inverclyde and national groups were asked to describe what life is like today for a number of people with a learning disability and their family carers. Most participants would acknowledge that there is more awareness of people with learning disabilities and of the positive potential that they offer to our society. They also acknowledge that there is still much to be achieved in terms of their safety and inclusion.

Whilst not part of the formal Terms of Reference for the Review, their observations sit alongside the direct work on understanding Margaret's life and are published in greater depth on the website, ending with their own recommendations for the future.

Here are some key themes:

1. There are many talented adults with learning disabilities who could provide support for their peers (in both citizen advocacy and supported decision making) although translating this into a reality is hampered by lack of resource as well as lack of understanding of this untapped potential.

2. People with learning disabilities are still subject to hate crime and exploitation.

3. Some people with learning disabilities do not feel safe. They say that when they have 'the watchful eye' of a family member or a friend they feel more protected. Several individuals who participated in the Review expressed their fear that what happened to Margaret could happen to them or to a friend who also has a learning disability.

4. People with learning disabilities who are content and happy living with their parents live in fear of the day that they are no longer there.

5. Parents caring for their adult children at home say they have been greatly impacted by service support being withdrawn during Covid and that, for some, this has meant making the decision to apply for supported housing with their child far sooner than they otherwise may have done. In doing so, they are advised that places are not available and that residential care, sometimes with older people, is what could be offered. Others indicate that they have been advised that placements with digital support overnight may be feasible which means that those who are incontinent will not be changed until the next day.

6. Families are acutely aware of the crisis in care and the associated inability to recruit staff via self - directed support.

7. Parents of adults with profound and complex needs also reported that they live in fear of their child needing hospitalisation as paid carers are not always allowed in Wards to provide their usual support alongside nursing staff. This means that parents go and stay for the duration, fearing that their child, often non-verbal, may not have their needs understood or responded to. Some reported experiences that fell below what could reasonably be accepted.

8. Some parents described how they had reported service concerns and felt that they were not believed which impacted on their ability to report any subsequent incidents. Exhaustion played a part in this. A foster parent spoke of one of her foster children with profound and complex needs being subject to abuse and when she made allegations not being believed initially. She did not have Guardianship at this point and felt that she was only listened to when she secured those powers. Staff were ultimately charged.

9. Parents spoke movingly of their efforts to represent their adult children and to protect them. While Guardianship has proved useful, there is sometimes a sense that having your relationship with your child placed on a legal footing does not feel comfortable.

Chapter Four: General Recommendations

The recommendations below are supplemented by some key questions which were created by Inverclyde colleagues to assist in implementation planning.

An Inverclyde Implementation Group

Senior representatives of key agencies need to continue to meet as an Implementation Group following the publication of the Review to further develop effective inter-agency working and to address specific findings and recommendations.

Historically, the boundaries between roles in agencies were not totally understood by colleagues in other services which led to breakdowns in communication and expectations. To prevent this happening in the future, local child and adult protection services, mental health services and the Community Learning Disability Team should conduct and share a Review of their respective roles to ensure coherence and to avoid unnecessary overlap in provision.

A National Audit

What happened in Inverclyde could happen in any part of Scotland and so the work undertaken, findings and recommendations should be widely disseminated to improve understanding and to instigate necessary changes.

When the Borders case was reported in the early 2000s, an audit of each local authority's practice was sought by national inspection agencies. Much has improved in the intervening years in terms of inspection and continuous improvement but an overarching and specific audit in relation to this unique Report may be valuable in preventing future harm.

It is recommended, therefore, that all Chief Officer Groups consider commissioning an analysis of numbers of people with learning disabilities and autism in their area to ensure that all individuals are known and are not hidden in plain sight. This will require sensitive and proportionate data sharing. There is some evidence that people with autism may be hidden and isolated in their communities which requires specific clarification.

Putting Appreciative Inquiry Principles to the Forefront

The broad principles of the Appreciative Inquiry model should continue to be used in Inverclyde and across Scotland as they have proved effective in generating and implementing solutions. All agencies have actively participated in open and honest ways where they have owned shortcomings and have either already addressed them or have considered how what remains to be done can be done. This investment has already meant that partners have led their own research, analysis and service improvements and have also benefitted from the appraisal of colleagues from other disciplines in creating system changes.

Diagnosis of Learning Disability

There is a general confidence that formal diagnosis of learning disability now takes place and that specific care pathways ensure consistency in practice. However, there is also a sense that such diagnoses may only crystallise over time which may impact on the effectiveness of intervention. Because of this uncertainty about the true picture and its potential variations, it is recommended that all Health Boards explore and review their practice in terms of diagnosis of those with learning disabilities to ensure that, where possible, all children, young people and adults have an appropriate diagnosis as early as possible to be able to meet their individual needs.

Learning the Lessons from Workflow and Communication Breakdowns

Those who have participated in the Review do not wholly concur about what took place and what should have taken place as outlined in the Children and Families sections of the Report.

It has been suggested that failings were attributable to the Duty system of the past, given that it was generic in nature and consisted of a rota involving both front line and managerial staff. There needed to be clear definition of roles and responsibilities when supporting Margaret. The social workers intervention was successful in that she supported both Margaret and her mother, which Margaret's mother acknowledged. Child care practitioners also pointed out that Margaret was over sixteen in two instances and could legitimately have been seen by adult care colleagues. The latter indicated that a formal transition from children's to adult services may have been possible.

Although there is some evidence of practitioners taking time to assess the situations they were faced with in the Duty sessions, there were delays in allocation, no allocation and insufficient systematic follow through.

The allegations made merited much more scrutiny and could and should have been referred to the Children's Reporter by Children's Services to consider whether Margaret was out of control and whether she was at risk of harm or being harmed.

Although there have been major positive changes since then, the fundamental errors of failure to refer to the Children's Reporter, poor communication and ineffective follow up could still apply today. It is therefore, recommended that all local authorities consider these shortcomings and ensure that they have steps in place to mitigate the risk of any repetition.

Continuing and Updating Adult Support and Protection (Scotland) Act 2007

The outcomes from the recently published Review of Scottish Mental Health Law are welcomed because the Adult Support and Protection (Scotland) Act 2007 measures will continue and the statute is to be updated. The recommendation to enhance supported decision making is particularly pertinent.

Some members of society do not report harm when they see evidence of this. Services cannot respond if they are not advised that abuse may be happening. In updating of the Act the Scottish Government should therefore consider making the failure to report suspected or known harm an offence.

The leadership role and responsibilities of the Independent Chair of Child and Adult Protection Committees has expanded considerably since their inception and it is recommended that the Scottish Government as the creator of the posts and duties, evaluates, updates and future proofs their contribution to care and protection.

Scrutiny and Developing Learning

All Chief Officer Groups should consider how to ensure that support is adequate for scrutiny and learning development purposes, especially in terms of time and resource to support Learning Reviews.

The Voice of Families

Families see high level national policy and its enactment at local level as being in a state of flux. Whilst they are largely grateful for the national policy developments over the decades, they are concerned that person centred provision may be returning to institutional models of care and that community based support is shrinking.

It is recommended that Scottish Government and Chief Officers Groups consider their existing methods of community engagement about policy development and implementation in the light of the observations made by people with learning disabilities and their families as part of this Review.

Expanding the Scottish Government Health Checks National Rollout

The Scottish Government should consider the expansion of the annual health check for adults with learning disabilities to ensure that no shows should trigger an alert and subsequent investigation.

Inverclyde Community Learning Disability Service is already supporting this by identifying eligible adults and informing them of this right.

What the Review found is that assumptions are made about the role that different disciplines play in safeguarding e.g. it has become evident that the Department for Work and Pensions has legitimate limitations in this regard. So the Health Check could be the means to ensure that the human rights of individuals with a learning disability are respected by making this the main mechanism for being 'a watchful eye' that people with a learning disability think would be helpful without the State becoming overly intrusive.

Beyond the obvious existing benefits of Health management and Health promotion to close the longevity gap, the Check, through face-to-face contact, could ensure basic proof of life and could be the means to understand any caring arrangements that may be in place and their legal status. Questioning the status of those who describe themselves as carers causes unease in a range of professionals, based on a fundamental belief that those who take on this role do so for altruistic reasons. Whilst this is generally the case, it is not universally so and a means of clarification is needed.

Transitions

It is recommended that the learning from this Review about what constitutes good, multi-disciplinary, transitions is shared with those who are currently taking the Disabled Children and Young People (Transitions to Adulthood) Bill through the Scottish Parliament in order to maximise the impact of this forthcoming legislation.

Further and Higher Education Recommendations

Further and Higher Education facilities should ensure that they have sufficient understanding and procedures for adult protection. Safeguarding procedures should be implemented led by Further and Higher Education, the National Safeguarding Forum and the National Adult Protection Convenors Group.

The safeguarding procedures within the local College are currently subject to review and would benefit from an Adult Protection component as they are currently based on Child Protection guidance. This may be true of other areas and it is suggested that the Further Education National Safeguarding Forum should undertake a national survey of current practice with a view to ensuring that guidance covering all of life is used.

West College should have a Further Education representative on the Inverclyde Adult Protection Committee and all Adult Protection Committees should review their membership to ensure this coverage.

The Further Education National Safeguarding Forum and the National Adult Protection Convenors Group should meet to share and resolve common concerns at least annually.

Some individuals with learning disabilities may also have reason to participate in University life e.g. through short Courses or employment. It is recommended that safeguarding procedures in that environment are evaluated, further developed as necessary and regularly reviewed to ensure that they are on par with that which happens in other educational establishments.

The Benefits System

The benefits pertaining to Margaret are transferring to the Scottish Social Security system, Social Security Scotland. It is recommended that the learning from this Review is shared with them to further enhance their understanding of policy and practice in respect of people with learning disabilities, their Appointees and family carers.

Information Sharing, Communication and the Place of Interpretation

This Significant Case Review highlights what many others have done before which is that appropriate Information sharing and sound communication are critical in supporting and protecting individuals with a learning disability. Underpinning this is a growing appreciation of professional curiosity which means going beyond procedure and process to questioning and going with feelings when things do not seem right.

A key task for the Chief Officers Groups will be to appraise themselves on how information sharing takes place across all the agencies, what shortfalls there may be in communication expectations, alter operations accordingly and design a multi-disciplinary, mandatory staff development programme to address their findings.

Human transactions can never be totally relied upon, and the analysis of Margaret's life shows several points where information could have been shared productively. Communication between professionals, too, was sometimes unclear and more focused on processes rather than desired outcomes, simply did not take place or was critically not followed through after initial contact. Passing it on is not good enough.

Specifically, it has become evident that General Data Protection Regulation requirements may sometimes impede the flow of what is needed as people move from one service to another, particularly for those moving to Further Education. The execution of General Data Protection Regulation guidance should be subject to review and clarification across the agencies to ensure that all appropriate data is shared in transitions.

Information sharing across the agencies has improved but could be further strengthened. What is less developed and similar today to Margaret's experience is the communication, relationship and recording between School Health, Education and GPs. Health services are reliant on other services to let them know about broader concerns. It would have been helpful and relevant to record some of the things described in terms of Margaret's needs in her Health record to allow Health services to understand and triangulate any contact with her. Going forward, there should be strong working relationships between Education and GPs for all children, but in particular those with a learning difficulty, learning disability and other vulnerabilities, Understandings gained through the assessment undertaken by Education should reflected in the Health records.

Interpretation of what a practitioner hears and sees is skilled and nuanced and must be subject to continuous reflection and change. The Department for Work and Pensions believed they were making a welfare referral for Margaret. This was interpreted by Social Work as a dirty house. The GP's interpretation of Margaret's weight loss in his final consultation is another example.

Given the much longer development of Child Protection policy and practice, there may be knowledge from those sources that is transferable to Adult Protection.

Mapping and Enhancing Local Support Services

There are many valuable services and supports in Inverclyde that are innovative and serve the community well e.g. Compassionate Inverclyde. There is such a proliferation that some Review participants indicated that they were unclear about all that there was or how initiatives linked to each other.

It is recommended that a mapping and stocktaking exercise is undertaken to review and promote these activities as well as to assess whether further co-location or amalgamation and pooled funding is necessary or desirable.

Recommendations About Inverclyde as a Community

There is a palpable sorrow and disbelief in Inverclyde about what happened to Margaret and citizens are open to seeing and understanding that they have an active role in preventing further deaths. There needs to be a campaign which encourages societal participation in calling out potential harm that is not vigilante in nature but about being a watchful eye and a supporter of those who may need protection.

The residents of Inverkip have been particularly affected and should be offered a specific session on the Significant Case Review and its findings and recommendations. A Remembrance event should be held in Inverclyde which should be open to everyone in the community and everyone who has contributed to this Review to acknowledge Margaret's life and to commit to actively seeking to protect others who are alive today in a way that respects their human rights.

Implementation Planning – Some Pointers

	Recommendation title	Questions
1	An Inverclyde implementation group	Have Inverclyde public protection committees separated out national and local recommendations to take forward the learning from the review.
2	A national audit	How do services in your area identify children, young people and adults with learning disabilities? What evidence do you have of triangulating the information you hold with other services?
3	Putting Appreciative Inq uiry principles to the forefront	Who might be at risk of being invisible to services? What policies, procedures, protocols should be reviewed with any such finding in mind?
4	Diagnosis of learning disability	How clear and accessible is the process for diagnosis of learning disability in your area for both those who work within services and those who need to access them?
5	Learning the lessons from workflow and communication breakdowns	What steps do social work services (Children and Families and Adult Services) take to quality assure decision-making around thresholds being met or not for investigating referrals under relevant child/adult protection procedures?
6	Continuing and updating the Adult Support and Protection (Scotland) Act 2007 including Scrutiny and developing Learning	How well does current adult support and protection legislation protect adults with learning disabilities?
7	The voice of families	What steps do your services take to co-produce those services with those who use them and their families/carers?
8	Expanding the Scottish Government Health Checks National Rollout	What steps do GPs/practice managers take in your area to routinely review patient lists to highlight those who have not accessed health services for some years. What action is subsequently taken?
9	Transitions	How is multidisciplinary planning undertaken for transitions?
10	Further and Higher Education recommendations	How well planned and recorded are Transitions plans from school to further/higher education settings? How do further and higher education providers know their safeguarding procedures are sufficiently robust?
11	The Benefits system	Do staff in Social Security Scotland understand policies in respect of people with learning disabilities?
12	Information sharing, communication and the place of interpretation	How is information about children, young people and adults shared across health and education services? How is this recorded? How do learning and development opportunities for multi-agency partners support a culture of professional curiosity within services to protect those who may be at risk of harm?
13	Mapping and enhancing local support services	How easy is it to find information on services in your area? Is this available in one place? How can people locally find help and support?

PART 4

CHRONOLOGY

Part 4: CHRONOLOGY

	DATE	EVENT
1	1 November 1980	Margaret is born at Rankin Memorial Hospital in Greenock. She went home with her parents at 26 Cuillins Avenue in Port Glasgow.
2	Early February 1981	Seen by Paediatric Registrar at Health Centre Clinic. Developmentally no concerns. Weight gain is satisfactory.
3	Late February 1981	Seen by Consultant Paediatrician at Health Centre Clinic who raises concerns about her development. More positively, she was smiling.
4	April 1981	Seen by Consultant Paediatrician at Health Centre Clinic and is discharged from further review. Notes concerns about her weight and dietary advice given. Though not quite sitting she is reaching, grasping and transferring to the mouth. She is vocalising well and developmentally she would seem quite normal for her age.
5	January 1982	GP referral to Consultant Paediatrician due concerns about her weight. First discussion regarding a possible genetic disorder (Sotos syndrome) causing weight gain concerns.
		Developmental concerns raised in relation to psychomotor and speech development - no word development yet.
		Reference is also made to her parent's behaviour.
		Dietary advice is offered to Margaret's mother.
6	March - June 1982	Margaret is seen regularly and her weight goes both down and up. On restricted diet but there is a question about whether the dietician is confused about dietary plan. In May it is thought that Margaret has a multi system complaint involving delayed psychomotor development and gigantism and she is admitted to hospital for investigation of development and metabolism including blood tests and x-rays.
7	July 1982	Margaret is seen by a Clinical Psychologist and it is recommended that she is given a place in Nursery.
8	February 1983	Consultant Paediatrician expresses concern about Margaret's diet and that aspects of her speech and development were poor.
9	July 1983	Margaret's mother thought that she may have a squint but an ophthalmologist finds no evidence of this.
10	March 1984	Consultant Paediatrician assesses Margaret as developmentally normal but raises concern about her weight. Hospital admission was suggested but deferred to give the parents the opportunity to get her weight down.
11	May 1984	Margaret kept in hospital to try and lose weight.
12	June 1984	Clinic visit acknowledges a weight reduction and an improvement in appearance as a consequence.

	DATE	EVENT
13	September 1984	Consultant Paediatrician notes a weight increase and challenges father regarding sticking to dietary advice.
14	November 1984	Consultant Paediatrician writes to GP saying Margaret was developmentally normal and that she would see her again by the time she goes to school.
15	February 1985	A Health Visitor sees Margaret with both parents present, possibly for a routine pre-school examination although this is not clear.
16	May 1985	Consultant Paediatrician writes to GP indicating concerns about Margaret's weight whilst indicating that she would probably cope with mainstream school despite some developmental concerns. Expects to see her again for one last time in about six months.
17	January 1986	Consultant Paediatrician discharges Margaret from their care saying that she seemed to be coping with school but would have to continue being on a strict diet.
18	August 1987	Ear, Nose and Throat Consultant Surgeon sees Margaret because of a persistent cough.
19	September 1987	Margaret attends A and E with minor illness.
20	January 1988	Attends A and E with minor illness.
21	June 1988	Hospital admission for fracture of right radius.
22	July 1988	Consultant Paediatrician gives Margaret more dietary advice.
23	October 1988	Margaret reviewed by Consultant Paediatrician who notes that she has not lost any of her newly gained weight.
24	December 1988	Consultant Paediatrician says Margaret has lost some weight but that her behavioural problems remain.
25	February 1989	Consultant Paediatrician referral to Psychology due to behavioural difficulties.
26	April 1989	Consultant Paediatrician comments that there are possible family concerns impacting on Margaret's behaviour and that Margaret is to be seen by a Clinical Psychologist in June.
27	September 1989	Seen at A and E with minor injury.
28	October 1989	Weight reviewed by Consultant Paediatrician which had not increased. Referral made for eye problems.

	DATE	EVENT
29	December 1989	Weight reviewed by Consultant Paediatrician which had increased although her father says she is swimming. He also says that he is dyslexic and speculates that Margaret might be too.
30	1991	Sometime this year Margaret's father brings Margaret to a GP saying he was sure that she was dyslexic and that he could not understand her slowness whilst questioning that she was his child.
31	January 1991	Admitted to hospital for obesity and loses weight before being discharged. Thyroid function tests are normal.
32	June 1991	Margaret's weight remains stable.
33	July 1991	The outcome of a referral to Eye Hospital is that Margaret has right amblyopia, possibly anisometropic, meaning that her two eyes have a different refractive power causing an unequal focus.
34	1992	Margaret lives with her father and they move in with Margaret's paternal grandparents in Port Glasgow.
35	March 1992	Consultant Paediatrician writes GP confirming that her weight has been stable over a period of time.
36	1993	Margaret's mother and father divorce. It is now that Margaret's father frequents the Castle Levan Hotel, AJ's business, for its music nights and leaves Margaret there. EC is there too.
37	Hogmanay 1993	Attends A and E with minor illness.
38	June 1994	Genetic blood test appointment made for Margaret. She does not attend.
39	July 1994	Attends A and E with minor injury.
40	October 1994	Attendance at the Genetics clinic with her father who thinks she may have a chromosomal abnormality but none is found. In this consultation, Margaret is described as significantly overweight and as having scars on her arms.
41	November 1994	School Medical Officer report says Margaret needs glasses.
42	September 1995	Margaret given Dip/Tet/Polio immunisation at school.

	DATE	EVENT
43	18 October 1995	SWIFT record for this date indicates the Senior Social Worker phoned and made an appointment for Margaret and her mother to come to the Social Work office that day because it had been alleged that Margaret had been arguing with her grandparents and that the situation had got out of control. Margaret said that she was unhappy living with her grandparents. Her father was in hospital.
44	20 October 1995	Meeting held with Social Workers attended by Margaret and her mother. Margaret said that she wanted to continue staying with her grandparents as she had for three years and it was the only place that she felt safe. She eventually agreed to stay with her mother until her father got out of hospital. She was described as being very upset and tearful saying that her mother had hit her in the kidneys and that she was afraid that she would do so again. Her mother wanted Margaret to be given 'a fright' by taking her to a children's home or hospital.
45	25 October 1995	Margaret's father dies.
46	November 1995	Margaret's mother alleges that EC approached her at the funeral and indicated that he and AJ would assist her in caring for Margaret. A pattern of visits begin to their home and these become longer in terms of duration.
		Margaret stays with her grandparents for a few weeks after her father's death and then goes to her mother.
47	23 November 1995	Margaret's mother comes to the Social Work office saying that Margaret is verbally and physically abusive to her grandparents and that she has hygiene issues. The case is allocated.
		The allocated Social Worker sees Margaret approximately weekly until she goes on maternity leave in July 1996. She sees Margaret being short with her mother but never violent.
48	18 December 1995	Margaret's mother tells GP that she is concerned about Margaret's behaviour.
49	22 December 1995	GP sees Margaret who is relaxed and uninhibited and expresses anger at her father's death and says that she is unable to speak to her mother. She makes it clear that she likes her father's fiancée and that she wants to live with her grandparents.
50	Christmas 1995	Margaret's father's fiancée gets a phone call from his parents saying that EC and AJ are not allowing them to see her.
51	1996	Margaret's father's fiancée tries to see Margaret but alleges that EC would not let her in and also changed his mobile number.
52	February 1996	Hospital visit for a plantar wart.

	DATE	EVENT
53	March 1996	Doctor from Hospital Child and Family Centre writes GP having seen Margaret, her mother and a friend. She describes Margaret's mother as having recently taken over her full time care and is experiencing considerable behavioural problems from her. Margaret's mother says that the paternal grandparents have protected Margaret and never really admitted the severity of her difficulties and that [Margaret's mother] is bearing the brunt of some of that. Doctor notes Mother is struggling to manage Margaret's behaviour and is relieved to have her friends, A and E, to help.
		This letter also acknowledges that there is Social Work and Educational Psychologist involvement and that Margaret has a Record of Needs and learning support with no behavioural issues being displayed in school. It concludes that Margaret's main difficulties surround her limited intellectual endowment and her perception of those in authority over her and her lack of any outside interests or social relationships.
		There is to be follow up in the form of asking other agencies for their reports though Doctor notes has limited understanding of what is available locally to support Margaret.
54	July 1996	Social Work close Margaret's case as her Social Worker is going on maternity leave, the intervention has stabilised matters and Margaret is scheduled to go to College. Personal recall and records vary on this timeframe, the latter indicating contact was from 24.11.95 to 08.03.96.
55	August 1996	GP appointment.
56	December 1996	AJ and EC move into Seacroft.
57	1997	Extracts from AJ's calendar indicate that she and EC are involved in caring for Margaret's paternal grandparents throughout this year.
58		In 2016 EC and AJ say that Margaret alleges that she was raped during a 1997 College trip but later withdraws this claim. College staff do not recall this incident. Fellow students do remember Margaret having short term relationships with two young men on her Course.
59	February 1997	Margaret's mother goes to the Social Work Department and asks for Margaret to be supported again as her behaviour has deteriorated since her case was closed. She says then that she has good friends that have offered to care.
60	May 1997	Letter from Consultant Psychiatrist to GP saying Margaret appears to have slipped through the system as there had been no follow up.
61	November 1997	Social Work records indicate that EC has contacted them to say that he is looking after a couple and that saleable property has been removed from their home. This is Margaret's paternal grandparents.

	DATE	EVENT
62	December 1997	Margaret's mother attempts to send a Christmas gift to Margaret via others which resulted in their being told to get off the property. Margaret's mother then received a letter purporting to be from Margaret saying she did not want further contact which she believes was written by EC.
63	31 December 1997	Strathclyde Police called Margaret's mother to discuss the alleged assault.
64	1998	AJ snr notices that her daughter gives Margaret a lot of work to do and once witnessed her putting her arms out so that EC could put tubes on them. AJ tells her mother that Margaret had attacked her once and was always looking for EC's attention.
65	January 1998	Police Officers visit Seacroft to discuss the alleged assault. EC and AJ say Margaret's mother had attacked EC. Margaret seemed relaxed and indicated that she wanted to stay where she was and did not want to communicate with her mother.
66	May 1998	Guests staying with AJ say that Margaret liked EC and that he was good to her but that AJ did not like Margaret being in the company of the visitors and would get her to leave the room. She was described as 'a wee slave.'
67	July 1998	Margaret's paternal grandfather goes to live in Seacroft as her grandmother is terminally ill and in hospital. EC and AJ claim that the grandparent's home was ransacked and pension books and purses stolen. Grandmother dies.
68	August 1998	Margaret's paternal grandfather contacts a friend asking for help saying EC has beaten him with a belt.
69	October 1998	Margaret's paternal grandfather goes home to find things taken and the Police get them back from EC and AJ without charging them. He tells someone he knows that he had been assaulted by EC and AJ and that they had taken Margaret to the Bank and got her to sign over her money to them. He also asks the Social Work Department (9th) to help him to take control of his finances and says that he is worried that Margaret will be put out of Seacroft. Margaret's mother and an aunt come to the Social Work Department (20th) saying that they are concerned about her and talk about the alleged assaults and thefts. The Senior Social Worker who interviews them refers the case to Greenock Family and Child Unit which was a specialist investigative unit of Strathclyde Police. Margaret visits her GP the next day who notices that she has lost a lot of weight.
70	March 1999	AJ's parents celebrate their Golden wedding and Margaret is there looking thinner. AJ's brother visits Seacroft and hears Margaret moaning at a bedroom window and she has guttering on her arms which AJ explains this is to stop her self-harming. The bedroom is said to be locked as a punishment for misbehaving.

	DATE	EVENT
71	June 1999	The first DLA claim is made for Margaret by AJ which says that Margaret is much less able than she was.
72	July 1999	AJ applies for Carers Allowance and has it backdated to her.
73	October 1999	Department for Work and Pensions have Margaret living at Seacroft since the 7th and they visit on 22nd. Margaret is seen the day before by her GP in the company of a male. Her considerable weight loss is noted and her skin picking which is attributed to losing her father.
74	November 1999	A couple visit Seacroft and see that Margaret's hand is blue because her blood is being restricted by duct tape which was said to be there to stop her scratching.
75	4 November 1999	GP makes Psychology referral saying that Margaret has lived with EC and AJ since 1997 and is well cared for but socially isolated. He refers to her weight loss and to her bizarre behaviour at times.
76	25 November 1999	Margaret is seen by a Clinical Psychologist in the Community Learning Disability team. He reports that EC and AJ say she was abused by her mother and that her father and grandfather had behaved inappropriately towards her e.g. bathing her when she was 15. This was the last reliable sighting of Margaret although there are two other sightings about a week later but there are doubts about their accuracy.
77	2 December 1999	Margaret's follow up appointment with the Psychologist is cancelled by AJ.
78	9 December 1999	Benefits Agency sent a letter saying that Margaret had passed the Incapacity test and that they did not require further information.
79	2000	The Police were told by EC and AJ that Margaret had gone to London and that they went to find her unsuccessfully, although she is alleged to have turned up at a Service Station in Cumbria as they were driving home. There are several visitors to Seacroft in the course of the year and none of them see Margaret. Most believe that she has left home in the company of travellers.
80	August 2001	Benefits Agency says it is satisfied that Margaret has passed the incapacity test and that they do not require any further medical certificates. They acknowledge that they may contact the GP in the future.
81	December 2001	Margaret's paternal grandfather dies and Margaret is not at the funeral. AJ's brother was at Seacroft for Christmas and Margaret was not there.

	DATE	EVENT
82		Years pass with people visiting Seacroft but Margaret is not seen.
83	18 June 2012	Department for Work and Pensions Visiting Team at Seacroft and left not having seen Margaret as AJ advised that she was not going to speak to her.
84	23 September 2012	Limited capacity for work assessment declaration completed by AJ on Margaret's behalf.
85	1 February 2016	Medical request sent out from Employment Support. AJ informed Department for Work and Pensions that Margaret could not face an appointment and this was accepted.
86	24 June 2016	AJ asked a neighbour who had the appropriate skills to help her complete the new Department for Work and Pensions Personal Independence Payment form for herself.
87	13 July 2016	Home visit for AJ following her claim where she said she had a partner and pets.
88	30 September 2016	Personal Independence Payment form completed for Margaret which lists many bizarre limitations and behaviours that she is alleged to have.
89	27 October 2016	Visit from ATOS (working on behalf of the Department for Work and Pensions) to query the contents of Margaret's Personal Independence Payment application.
90	28 October 2016	Social Work Department contacts the Police having seen the contents of Margaret's Personal Independence Payment form.

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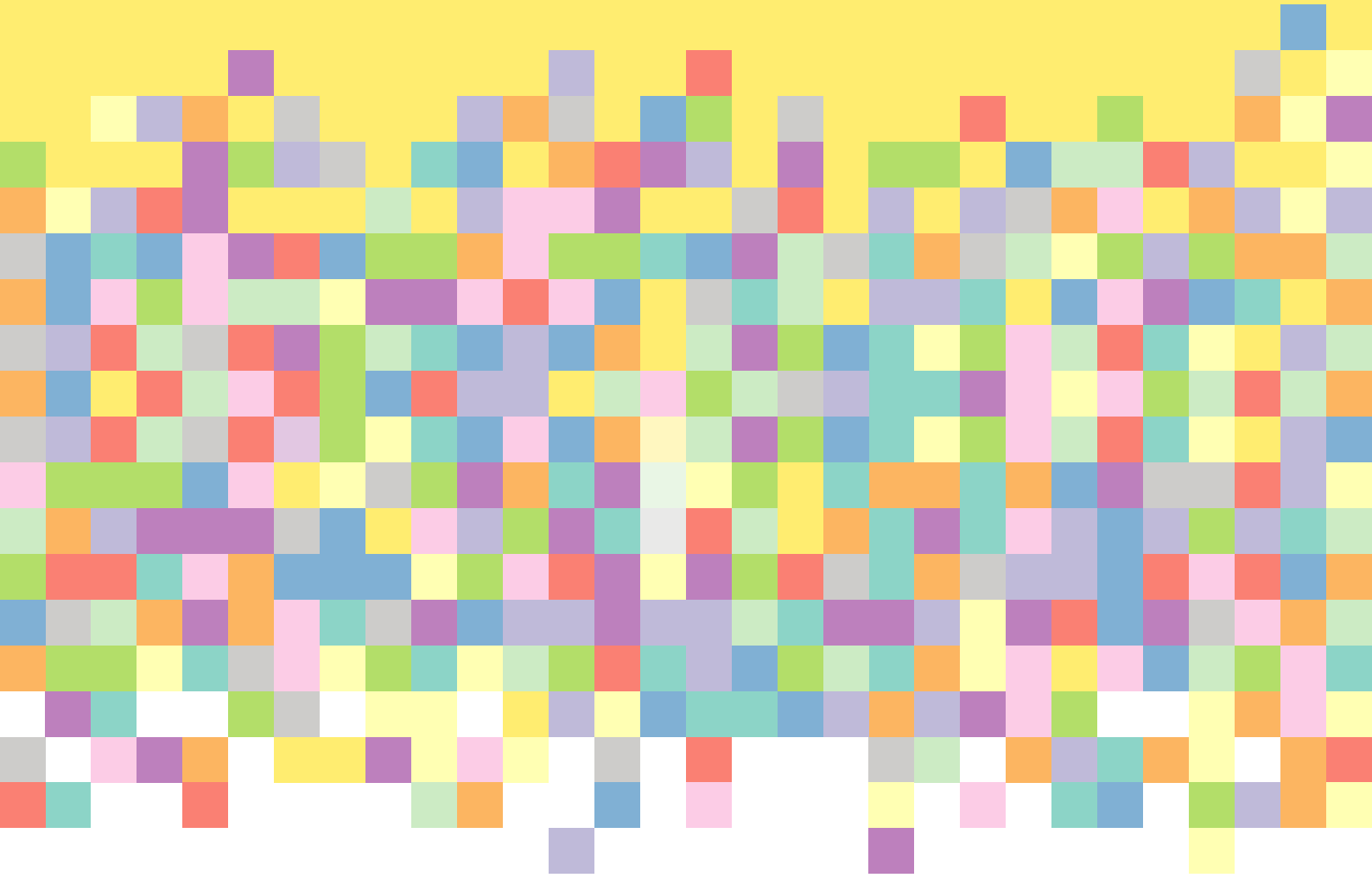

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A SIGNIFICANT CASE REVIEW INTO THE LIFE OF

MARGARET FLEMING