REMEMBER MY NAME

A SIGNIFICANT CASE REVIEW INTO THE LIFE OF

MARGARET FLEMING

THE WORK BOOK

WHAT THE AGENCIES SAY
BACKGROUND PAPERS

This report was prepared by independent reviewer,
Professor Jean MacLellan OBE.

THE WORK BOOK

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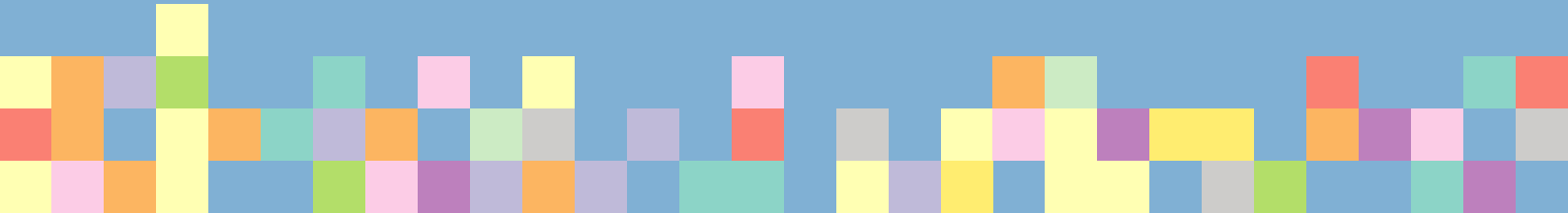


CONTENTS

The Work Book: What the Agencies Say – Background Papers

Introduction

The material in this Part is presented largely as each Agency laid it out and its inclusion extends beyond what would normally be expected of a Significant Case Review. It underpins the Review as a whole because it is based both on research undertaken by present day staff about the past and on the documentation that they were able to access given retention policy rules. The strands are both separate and overlapping in the way that they describe the services and supports that Margaret received.

Whilst each Agency carried out this request forensically and diligently, it needs to be understood that there are limitations to looking back over several decades. Nevertheless, what is offered is done in the interests of transparency, honesty and ownership.

Using the Appreciative Inquiry approach, each Agency was asked to provide a high level contextual paper on the major legislative reforms, policy and practice developments and organisational changes since Margaret's birth in 1980. They were then requested to identify the missed opportunities in terms of her support.

Given the historical nature of the investigation, and to avoid hindsight bias, each Agency considered the policy, practice, and expectations at that time and reflected on whether these were met or not.

They also provided details of policy and practice changes since and what would happen today to an individual who presents with similar needs to Margaret.

Notes on redaction of this document

This document contains additional background information compiled by relevant agencies, including Inverclyde Council, Police Scotland, Department for Work & Pensions and the NHS, in relation to the Significant Case Review relating to Margaret Fleming. In the interests of transparency, every effort has been made to disclose as much of this information as is lawfully possible. A decision has, however, been taken to redact personal data, disclosure of which cannot be justified under the UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018 (DPA) and the redaction of data which cannot be lawfully placed in the public domain. Although there has been a criminal trial and extensive media coverage of this case, and a significant amount of both personal data and special category data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with the UK GDPR and DPA The process of redacting this document has involved careful consideration of:

- The need for transparency and the overall purpose of the SCR in the identification of any lessons learned.
- The public interest in disclosure.
- Considering whether information is personal data, and if so whether its inclusion in the SCR complies with data protection legislation.
- Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to Margaret herself and other people whose history was closely linked to Margaret can only be released if it is lawful, necessary and proportionate to do so.
- The law of confidentiality.

Following this consideration, the Chief Officer Group concluded that it would not be appropriate to release this document in its entirety. Parts of this document could not be redacted so as to remove all information carrying an identification risk or the possibility of causing harm to third parties.

Any redactions are clearly marked with the word "[Redacted]". Text redacted is considered exempt from a request under section 1 of the Freedom of Information (Scotland) Act 2002 as a result of exemptions contained within that that Act.

Department for Work and Pensions Contribution

Introduction

The Department for Work and Pensions are relevant stakeholders to the Review as the Department was responsible for the administration of Margaret's benefits, namely payment of Incapacity Benefit, Disability Living Allowance (DLA) and Employment and Support Allowance (ESA) at various times between 1996 and 2016. EC and AJ were also in receipt of Carer's Allowance. They continued to claim £182,000 in benefits until it emerged that Margaret was missing in 2016.

The Appreciative Inquiry Steps

SCR Step	Focus area	Section
Step 1	Identify the missed opportunities in Margaret's life – taken to mean missed opportunities in the administration of Margaret's benefits claims that could have resulted in a different outcome.	Sections A-C
Step 2	Consider specifically why opportunities were missed and if they were not missed then why were they not handled or progressed and why were they handled in the way that they were.	Sections A-C
Step 3	Consider the policy. Practice and expectations of that time and whether these were met at that time – without hindsight bias.	Section D
Step 4	Provide details of what has happened since in terms of DWP policy and practice, both in Scotland and the UK	Section D
Step 5	What the Department would do now with an individual who presents with similar needs	Section E

Approach

Steps 1 and 2:

To answer steps 1 and 2, the following areas were reviewed and the sections below give detail of the guidance that was in place at the time, whether there were any potential missed opportunities, as well as the learning and changes made, and explains how these changes might impact an individual who presents with similar needs to those of Margaret today:

- **Section A** - Appointee review process and DLA Award
- **Section B** - ESA decisions, medical evidence, and work capability assessments
- **Section C** - Compliance during Carer's Allowance customer journeyS

Steps 3 and 4:

Secton D - provides a comprehensive summary, in chronological order, of the policies and guidance, covering both UK and Scotland and explains how they were applied (and therefore met or not met) in Margaret's case.

Step 5:

Section E - gives detail on what the Department for Work and Pensions would do now to support an individual who presents with similar needs to those of Margaret and describes both the individual processes and the broader measures the Department has put in place to support what they term as vulnerable customers.

Data Retention

As the Review panel is aware, the Department's historic Information Management Policy in place at the relevant times required documents to be retained for a period of 14 months and we therefore hold very little documentation detailing the administration of Margaret's benefits. This has limited the Department's ability to determine with any great accuracy the extent to which there were missed opportunities regarding the administration of Margaret's benefits entitlement which are relevant to the scope of the Review.

We have therefore, as appropriate, provided details of the business-as-usual DWP practices that should have been followed at the relevant times in lieu of formal documentation confirming the same and consider from the available evidence that these practices were, on balance, followed appropriately.

Missed Opportunities

With the above in mind, the DWP has identified two issues in this report which relate to the administration of Margaret's benefit entitlement, namely (1) the reviewing of Margaret's Appointee in 1999 and 2011; and (2) the assessment of Margaret's capability to work and the decision to award ESA.

These issues largely post-date Margaret's likely date of death, recorded by the Courts as somewhere between December 1999 and January 2000, and the DWP does not therefore consider that these issues are missed opportunities capable of demonstrating a causal connection to Margaret's death.

Steps 1 and 2:

- Identify the missed opportunities in Margaret's case, and
- Consider specifically why opportunities were missed, and if they were not missed then why were they not handled or progressed, and why were they handled in the way that they were.

Section A: Appointee Review Process and DLA Award

Some people with a severe illness, disability or mental health condition are unable to manage their own affairs. If required, an agreement can be made for someone else to act on this person's behalf. DWP call this person an Appointee.

Margaret had two Appointees during the administration of her benefit – (1) her mother; and (2) AJ.

Appointment of Margaret's Mother

The correct guidance was followed when Margaret's 1996 DLA child application was made. Margaret's mother made this application confirming in writing that the benefit payments would be used in the best interests of Margaret. A visit was not required due to Margaret being a child. In November 1996 when Margaret turned 16 and thereby ceased to be a child for DLA purposes, her mother would have been made an Appointee via the then standard visiting process. This would have confirmed that she was suitable to carry on acting as Margaret's Appointee.

Appointment of AJ

Margaret's 1996 claim for DLA ended in 1998 when her mother did not make a renewal claim. A new claim was made in 1999 by AJ. At that time, she was not Margaret's Appointee, and so the business-as-usual process would have been followed to confirm AJ as Margaret's Appointee. This would have included a visit to confirm the suitability of AJ to be Margaret's Appointee and to confirm that Margaret did indeed need an Appointee, that is, she was incapable of managing her own affairs and needed an Appointee.

However, due to the data retention rules considered above, we are unable to confirm that this visit took place. That said, the fact that AJ was made the Appointee suggests the Department was satisfied she was at that time suitable to so act and that she understood and agreed her responsibilities as an Appointee.

Issue 1: Appointee review process and review of DLA award

There was not a requirement to routinely review Appointees pre-2011. Appointee reviews were generally not completed unless an allegation of financial abuse had been made. Although we hold no evidence which either suggests or confirms that any concerns had been raised about Margaret's Appointee at the relevant times, our conclusions are limited by the documents we hold in line with relevant data protection retention rules.

From 2011, a review process was introduced requiring Appointees to be reviewed every 5 or 8 years, depending on the age of the customer and the benefit being received. The review is paper based requiring the appointee to answer several questions about their conduct and management of the Appointeeship in the recent past.

It is recognised that the review being paper-based and completed by the Appointee has its limitations as it is highly unlikely that financial abuse would be self-reported.

The 2011 Appointee review process applied to new Appointees. It did not apply to existing Appointees until such time that the case was worked on for whatever reason. There is no record to suggest that Margaret's case was marked up for an Appointee review, nor that a routine review took place. This may have been picked up if Margaret's entitlement to DLA had been reviewed but whilst routine reviews of DLA were the norm, Margaret did not require a regular review because her DLA award had been awarded indefinitely.

So, there would have been very little activity on her case in respect of this benefit, in particular during the period of 1996-2011 when DLA was in payment up to the 2011 migration of her Incapacity Benefit to ESA.

Activity on Margaret's case began again when Margaret was migrated over to ESA in 2011, but that appears not to have resulted in an Appointee review being arranged – and her ESA was awarded for three years, which meant there was very limited activity in relation to that benefit, which again, would not have triggered an Appointee review.

In summary, between 1996-2011 Margaret's case appears to have progressed as expected through the DLA customer journey – there were no red flags for DWP to respond to on the information that we hold. Had an Appointee or routine review taken place it is unlikely that we would have picked up on any concerns about the suitability of the Appointeeship, but the limited information we hold due to data protection restricts our ability to make any definitive conclusions.

General Improvements in the Appointee Process

Aside from the introduction in 2011 of the new Appointee review process, the Appointee process has been updated in recent years to ensure it remains fit for purpose. The process of Appointment itself has been reviewed with added guidance for Visiting Officers in relation to determining the capacity of the customer and the suitability of the prospective Appointee, with the guidance in relation to allegations of abuse being streamlined to ensure these allegations are responded to.

Application of new Appointee Review Guidance – if applied to a similar case today

Appointee has its limitations as it is highly unlikely that financial abuse would be self-reported. However, we do not consider this is a meaningless process as it serves as a deterrent in that it puts the appointee on notice that although they may be out of physical sight, they are not out of the Department's mind. But it remains the case that the Department primarily relies on allegations of abuse being made by a third party in the absence of self-reporting.

Section E provides more detail on broader changes and improvements made in supporting vulnerable customers.

Section B: Employment and Support Allowance Decisions, Medical Evidence, and Work Capability Assessments

In 1996, Margaret was claiming Incapacity Benefit. This was then replaced with Employment and Support Allowance (ESA) from 2008 and as part of a phased migration, Margaret's case was moved onto ESA in 2012.

A customer's capability for work is assessed as part of the migration to ESA. After reviewing medical information received by Margaret's GP, a decision was made that Margaret should attend a face-to-face work capability assessment. Margaret did not attend three work capability assessments scheduled between January 2012 -September 2012.

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 (who had not consulted with Margaret for over 10 years), a home visit was made by a Visiting Officer who visited Margaret's home address. Margaret's Appointee was present and stated that Margaret would not come and speak to the Visiting Officer. The Visiting Officer subsequently made a referral to Social Services based on the visit. Social Services did not progress the referral because the Visiting Officer could not confirm that Margaret had given permission to make the referral.

Issue 2: ESA Awarded for Three Years

Review periods are recommended as part of the WCA process. The Decision Maker (DM) can choose between three months to three years based on the assessment.

After Margaret failed to attend three work capability assessments, repeated failed attempts to contact the Appointee, not being able to see Margaret when a home visit is made followed by a referral to Social Services – the DM decides to accept 'good cause' for non-attendance and awarded ESA for three years. A DM is expected to take all circumstances into account when deciding the review period required. In this case, the DM followed the guidance in considering all of the relevant evidence provided, including the GP citing lifelong conditions and formed the view that three years was appropriate in this case. However, another DM may have taken a different view on the facts given the inherent discretion that DMs have to arrive at their decisions and a shorter period may have been awarded. The DM in this case followed the relevant guidance at that time. The medical information provided by the GP citing Margaret's lifelong condition (Sotos Syndrome) and her mental health were considered by the DM, which is why Margaret was awarded ESA with no plans to review for three years.

Learning and Changes Made

Under current guidance, due to Margaret's vulnerability, her health conditions and lack of contact, a referral could now be made to an Advanced Customer Support Senior Leader. They would have the option to make a referral to Social Work, as was done at the time of the home visit in 2012 and to follow-up with Social Work to establish what action they have taken. They would be able to liaise with Health and Social Work to consider Margaret's next steps or contact the GP for additional information.

A Vulnerable Customer Champion role was created in late 2020 to provide additional support to customers and colleagues from within their respective service centres. Where a potential risk to the customer is identified - i.e., there is a history of mental illness or problems in contacting the customer - the Vulnerable Customer Champion can be alerted. They will work 'out of process' to take whatever action is necessary to support colleagues and the customers, where required, through the customer journey.

Discussions are ongoing within the Department for Work and Pensions and with the Work Capability provider on how guidance might be strengthened in light of lessons learned from this case.

Section E provides more detail on broader changes and improvements made in supporting vulnerable customers.

Section C: Compliance During Carer's Allowance Customer journey

The Carer's Allowance (CA) system shows entitlement to standard CA was awarded from 18 October 1999 to AJ. There were no compliance issues raised that may have triggered further investigation into AJ's CA claim and potentially her other role as Margaret's Appointee.

An annual entitlement letter is sent to all CA customers, detailing weekly entitlement and reminding the customers to report any change of circumstances. However, from the nature of this case it would have been unlikely that AJ would have reported Margaret missing as a change of circumstances.

Steps 3 and 4

Consider the policy, practice, and expectations of that time and whether these were met at that time.

Section D

Date	Policy change/ Margaret case scenario	What did the policy/guidance state?	Policy, practice, expectations met?
April 1992	Disability Living Allowance (DLA) introduced to replace Mobility Allowance and Attendance Allowance for the under 65s.	DLA is a self-assessment benefit and a Decision Maker awards it based on the needs described in the claim pack by the customer. No mandatory assessments required.	**YES** DLA claim made in 1996 by Margaret's mother and is awarded based on self-assessment information. Award ended 1998 as no reply to renewal. 1999 a new claim is made by AJ. She is made Margaret's Appointee. DLA is awarded based on self – assessment information and GP report. DLA continued without interruption until 2016 when Margaret is invited to apply for Personal Independence Payment (PIP).

Date	Policy change/ Margaret case scenario	What did the policy/guidance state?	Policy, practice, expectations met?
14/03/2008	Margaret's Appointee in place since 1999.	To comply with legal requirements, Appointees for adults and people who have been appointed to act on behalf of children must have their appointments renewed. This is to ensure that appointed persons are fulfilling their responsibilities. Reviews will also determine if adult customers still have the continuing need to have a person act on their behalf. Reviews take place: • Every five years for Appointees who represent children or pension age customers; • Every eight years for Appointees who represent working age customers, or • When Visiting Officer, Team Leaders or DM indicate that an earlier review is appropriate. Case types which are excluded from the Appointee review system are: • Fraud cases (only when FIS – Disability and Carer Team enquiries or investigations are ongoing); • Special Rules; • Deceased customers; • Appeals (only when appeal action is ongoing); • Corporate Appointees; • Power of Attorneys and Deputies Claimants may be called to attend a medical examination by an HCP approved by the Secretary of State where it has been determined whether they have limited capability to work. The purpose of the medical examination is to enable the DM with the benefit of a medical opinion to determine whether a claimant meets the threshold for limited capability to work. If a claimant/ Appointee says that they were too ill to attend because of the nature of their disability, the DM should ask for evidence to support this. If the claimant is usually able to get out e.g. to the GP, good cause should only be accepted if it is unreasonable to expect the claimant to have attended on that occasion. Exceptionally a claimant may be examined at home if they are unable to travel.	**YES** until 2011 After 2011 As explained above Margaret's Appointee status was not reviewed. Whilst there was no requirement pre-2011, to review Appointees, new guidance from 2011 states that reviews should take place every 5-8 years, dependent on the age of the claimant. The limited information held due to data protection restricts the ability to make any definitive conclusions as to whether the policy/guidance was followed.
13/02/12	Appointee failed to return calls and messages left about failure to attend face to face appointment.		
20/04/2012	Appointee advised Margaret has a fear of officials and will not attend medicals, and if a home visit was arranged, she would run away.		

Date	Policy change/ Margaret casescenario	What did the policy/guidance state?	Policy, practice, expectations met?
03/09/2012 to 27/09/2012 22/12/2012	Attempts made to arrange a Work Capability Assessment. Appointee states that Margaret cannot attend and Appointee provided reasons on BF223 form. The Incapacity Benefit claim was migrated to ESA. During this process four appointments to attend a Work Capability Assessment were issued. Two were cancelled by the Appointee as Margaret was unable to attend and Margaret failed to attend the other two.		**YES** Followed guidance at the time to consider good cause due to Margaret's mental state and her having a lifelong condition unlikely to improve.
18/06/2012	A DWP Visiting Officer went to the home address and was advised by the Appointee that Margaret would not come out to see her. The Visiting Officer who spoke to the Appointee had concerns and made a referral to Social Services	Visiting Officers were in place from 1999 -2012. DWP Visiting team helps those claimants who are unable to complete their benefit related transactions through any of the other channels. This may be due to their vulnerability, or the complexity of the transaction required or may be driven by a legislative requirement that some activities must be handled face to face. DWP Visiting Officer will support the claimant by undertaking home visits or occasionally at an alternative agreed address as required to meet business or claimant/customer need, Visiting Officers have experience within the Department and have delivered some extremely difficult messages in challenging situations. Some examples of appropriate referrals are • Obtain information/signatories • Obtain necessary verification • Complete a full benefit check • Encourage customers to attend • Help the vulnerable	**YES** Visiting Officer went to see Margaret at her home and the Appointee stated that Margaret refused to be seen. The Visiting Officer was concerned about Margaret and the Appointee's living conditions, state of mind and the fact that Margaret was not registered with a GP. Therefore the Visiting Officer referred concerns to Greenock Social Services.

Date	Policy change/ Margaret case scenario	What did the policy/guidance state?	Policy, practice, expectations met?
25/06/2012	Decision made allowing good cause for not attending the face-to-face assessment on 13/02/2012. It was made after the outcome of the home visit was completed.	When a claimant/ Appointee fails to return the questionnaire or fails to attend or submit to examination, consideration of good cause includes whether the claimant was outside GB at the relevant time, the claimant's state of Health at the time, and the nature of any disability the claimant has.	**YES** Guidance on implementing good cause followed correctly.
	Decision made accepting good cause for not attending the face-to-face assessment on 19/09/2012.	The claimant will have been asked to give the reasons for not complying with the Secretary of State's request for information or to attend or submit for examination. The DM should bear in mind the guidance about considering evidence.	
01/10/2012		The list is not exhaustive – the regulations state 'include'. The onus of proving good cause lies with the claimant who fails to comply. The test of good cause is whether the DM judges the reason for non-return or non-attendance or failure to submit to be reasonable and likely on the balance of probabilities. The DM needs to ascertain the precise facts and apply the concept of good cause.	

Section E: 'Current and Future Margaret'

The Review refers to a 'past, current and future Margaret'. In this section, the Review has asked DWP what would happen now with an individual who presents with similar needs to those of Margaret.

This section details how many of the improvements, changes and learning implemented would be applied if Margaret were to be a current customer and goes on to describe actions that the department believes will build on and learn from best practice arrangements.

Current Margaret

- New Appointee guidance means that Margaret's Appointee may be reviewed at least every eight years with the option to carry out an earlier Appointee review where, for example, there is a lack of up-to-date medical evidence and a refusal by the Appointee to attend a face-to-face assessment, as in the case of Margaret.
- Due to Margaret's vulnerability and mental health conditions, her case could be referred to an Advanced Customer Support Senior Leader who would be able to escalate concerns to agencies with statutory safeguarding responsibilities e.g., Health and Social Work.
- They would 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, highlighting the lack of up-to-date medical evidence or recent consultations.
- A Vulnerable Customer Champion may also be able to support Margaret and DWP colleagues in the management of the case where a potential risk to the customer is identified i.e., there is a history of mental illness or problems in contacting the customer. They will work 'out of process' to take action to support colleagues and the customers, where required, through the customer journey.
- More generally, discussions are ongoing within DWP and with the Work Capability Assessment provider on how guidance might be strengthened in light of lessons learned from this case

How we listen and learn as an organisation supporting vulnerable customers – Building Good Practice

The Customer Experience Directorate was created 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 we listen and learn as an organisation – using customer experiences, insight, and data to improve the service we offer to our customers. The Department has also created central teams in the Customer Experience Directorate to focus on strategically supporting our most vulnerable customers.

We are always looking to maximise our opportunities in our interactions with customers to signpost vulnerable customers towards support. We want to ensure that chances to flag concerns to agencies with statutory safeguarding responsibilities, or otherwise, are not missed.

The Department frequently collaborates with these Agencies. For individual customers, we can liaise with Health and Social Work to consider next steps, contact GPs for evidence for disability benefits decisions, or access HMRC salary records to calculate Child Maintenance.

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 customers 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.

More than thirty Advanced Customer Support Senior Leaders previously known as Senior Safeguarding Leaders) have now been appointed across Great Britain.

Their role is to reach across local communities to underpin our relationships with other organisations that provide support to our customers. They are also seeking greater participation for the Department in forums such as local Multi-Agency Safeguarding Hubs.

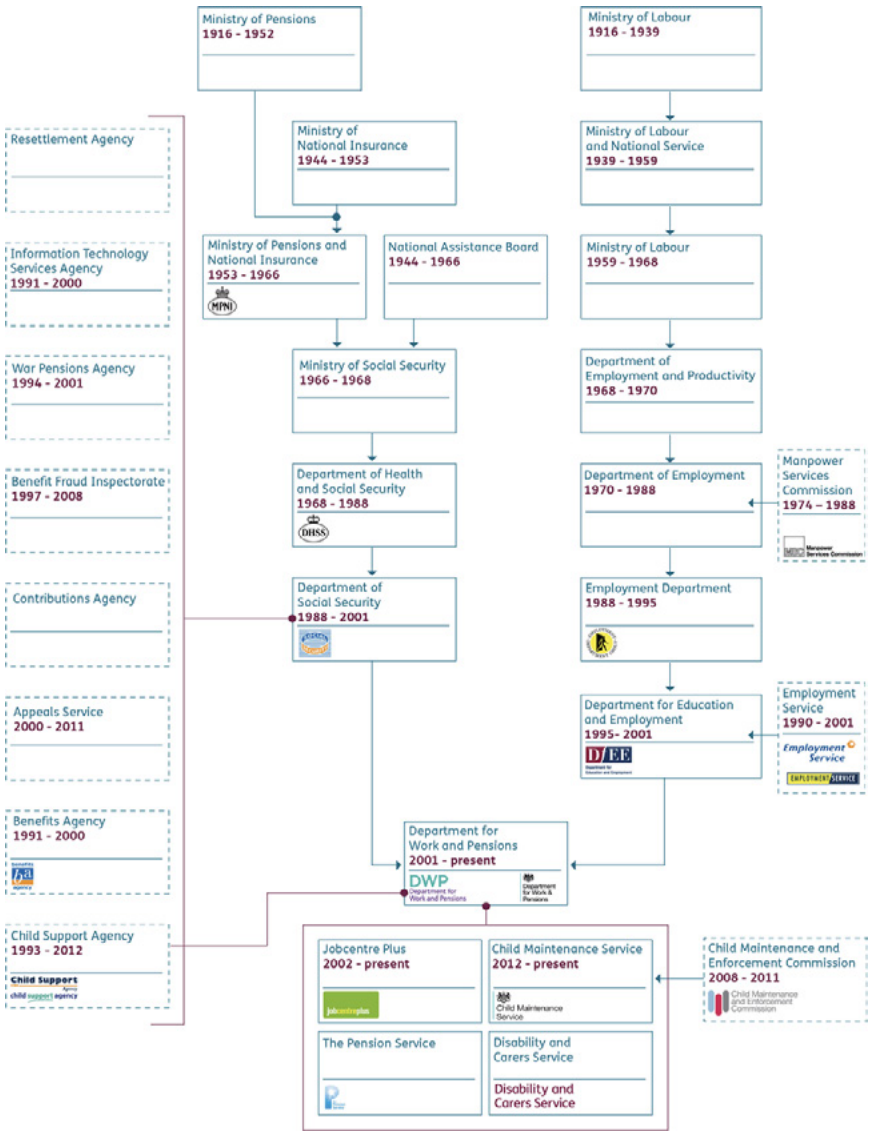
Department for Work and Pensions – Context and Timeline 1980 Onwards

The initial high-level diagram of organisational and machinery of government changes relating to the Department for Work and Pensions is followed by the main timeline running from 1980.

High-level Organisational Changes

The chart below highlights the high-level changes to DWP and predecessor departments over the last century.

The key changes during the period from 1980 were the split between Health and Social Security in 1988; and the creation of DWP in 2001 from the Department of Social Security, Employment Service and employment components of the Department for Education and Employment.



Policy Timeline

1979

- Conservative Government elected (to 1997).
- End of the post-war consensus and gradual move towards a more market-oriented policy in regard to employment and welfare policies.
- Universal Child Benefit replaces both Family Allowances and child tax allowances.

1980

- Social Security Act 1980 removes the earnings link to the basic pension – making it linked to inflation only.

1983

- Housing Benefit introduced, replacing rent rebates and allowances and now part of social security. Overall, the number of individuals in households dependent on at least one of the major means-tested benefits doubled over the period 1979-98 - from one in six to one in three.
- Statutory Sick Pay introduced. Start of withdrawal of direct state provision in this area with obligation being transferred to employers.

1986

- Social Security Act 1986 legislates for personal pensions (cutback of original State Earnings-Related Pension Scheme ((SERPS)) scheme), Income Support (replacing Supplementary Benefit) and Family Credit, Statutory Maternity Pay.
- Restart programme introduced to reduce long-term unemployment. (Ended 1991. Do not confuse with 2021 Restart scheme)

1987

- Job finding and Unemployment Benefit re-integrated.
- Statutory Maternity Pay introduced. (Social Security Act 1986)

1988

- Department of Health and Social Security split; Department of Social Security created
- Personal pensions introduced (Social Security Act 1986)
- Income Support arrangement of personal allowances and automatic broad-brush premiums for family needs, age and disability was introduced; full integration of income-related benefits for people in and out of work. (Social Security Act 1986)
- Family Credit introduced, replacing Family Income Supplement. (Social Security Act 1986)

1991

- Child Support Act 1991 sets up Child Support Agency.

1992

- Disability Living Allowance introduced.

1993

- New scheme for child support maintenance operated by Child Support Agency.

1995

- Department for Education and Employment created (to 2001).
- Pensions Act 1995: equal pension age for men and women to be phased in between 2010-2020. Also strengthened the regulation of occupational pensions and altered the terms for contracting out of the State Earnings Related Pensions Scheme.
- Incapacity Benefit reform

1996

- Jobseekers Allowance introduced, replacing Unemployment Benefit and integrating it with Income Support.

1997

- New Labour Government (to 2010).
- New Deals created: New Deals for Young People, Long Term Unemployed People, Lone Parents and Disabled People.

1999

- Welfare Reform and Pensions Act 1999 introduced stakeholder pensions.
- National Insurance contributions moved to Inland Revenue.
- Working Families Tax Credit introduced, replacing Family Credit.
- Disabled Persons Tax Credit introduced.

2001

- Department for Work and Pensions created by merger of Departments of Social Security and employment functions of the Department for Education and Employment.

2002

- Simplicity, security and choice: working and saving for retirement - Green Paper proposes better pension information, simpler pensions and tax treatment and more flexible retirement.
- State Pension Credit Act 2002 introduces Pension Credit, replacing Income Support for people over 60 and guaranteeing a minimum income, and also a savings credit for those aged 65 and over.

2003

- New Tax Credit system replaces former system including Working Families and Disabled Persons' Tax Credits.

2004

- Pensions Act 2004 reforms pensions regulatory system with a new Pensions Regulator, introduces Pension Protection Fund and Financial Assistance Scheme to protect the rights of members of insolvent pension schemes.
- First Report of the Pensions Commission ("Turner Report") published, analysing the current UK pensions system and challenges.

2005

- The Pensions Regulator created (Pensions Act 2004)
- Second Report of the Pensions Commission ("Turner Report") published, setting out recommendations for a new policy direction.

2007

- Pensions Act 2007 reforms state pensions to improve access for carers and women, re-links basic state pension to earnings and increases state pension age from 65 to 68 between 2024 and 2046.
- Towards Universal Credit: In “Reducing dependency, increasing opportunity: options for the future of welfare to work” (DWP, 2007), David (now Lord) Freud set out the case “for moving towards a single system of working age benefits, ideally a single benefit, to support the Government’s ambition of work for those who can and support for those who cannot”.

2008

- Pensions Act 2008 introduces automatic enrolment and makes further changes and update to pension’s legislation.
- Employment and Support Allowance introduced to replace Incapacity Benefit.

2009

- The Centre for Social Justice publish the policy report “Dynamic benefits: towards welfare that works” outlining the concept of a simplifying social security benefits under a new single benefit, Universal Credit Scheme.

2010

- Conservative/Liberal Democrat Coalition government formed (to 2015)
- Start of gradual increase in State Pension Age for women from 60 to equalise with men (Equality at age 65 reached in 2018).
- The Coalition government publish a consultation on welfare reform: “21st Century Welfare” (Department for Work and Pensions. Cm 7813, July 2010) outlining numerous reforms with the centrepiece being a new benefit system, Universal Credit, which would “be a new approach to supporting working-age households.”
- In October the Department for Work and Pensions announces the introduction of Universal Credit as a means to “simplify the benefit system and improve work incentives.”
- A white paper is published: “Universal Credit: welfare that works” (DWP. Cm 7957, November 2010) outlining the evidence for change, how Universal Credit will work, how it will affect benefit recipients and its broader impact on the benefit system.
- This is followed by an Impact Assessment and Equality Impact Assessment

2011

- Change of Benefits indexing from Retail Prices Index to Consumer Prices Index.
- Pensions Act 2011 makes further changes to pension’s legislation, notably bringing forward the increase in State Pension Age to 66 from 2026 to 2020.
- New Deal replaced by the Work Programme.
- Universal Credit: the design and build of Universal Credit begins. The aim is that Universal Credit would start with all new out of work claims from October 2013, all new in-work claims from April 2014 thereafter, all benefit claims would be moved over to Universal Credit by October 2017. Testing would begin in pathfinder areas and new technology used to support the new benefit will be developed by external contractors
- Two Major Projects Authority reviews are carried out in 2011.
- 9 December 2011: Equality Impact Assessment about Universal Credit introduced under the Welfare Reform Act 2012.

2012

- The Welfare Reform Act 2012 introduced several welfare changes, notably the introduction of Universal Credit, replacement of Disability Living Allowance by Personal Independence Payment, reform of Employment Support Allowance, and Housing Benefit reform including introduction of an under-occupancy penalty (so-called “bedroom tax”),
- 23 July: A collection of equality impact assessments relating to Welfare Reform Act 2012.
- 10 December: Universal Credit Impact Assessment by the DWP
- 10 December The Social Security Advisory Committee (SSAC) reports on the draft Universal Credit and related regulations.

2013

- The Major Projects Review Group review Universal Credit and raise concerns about the programme’s progress. The Universal Credit programme is paused and ‘reset’. New plans for the project includes a proposal to run a “live service” in the pathfinder areas using the technology developed so far alongside a new digital system (“full service”) using technology developed in-house.
- The focus is switched from a national roll out to getting the pathfinders to work.
- In April 2013 Universal Credit is rolled out to Ashton-under-Lyne jobcentre to test Universal Credit in a live environment. It is the first of four pathfinders with Warrington, Wigan and Oldham jobcentres joining later in the year. It is tested using benefit claims from single, childless, out-of-work claimants who would otherwise be eligible for Jobseeker’s Allowance. This is the Live Service.
- By December 150 people had been signed up to Universal Credit in the four Live Service pilot areas.
- Council Tax Benefit replaced by local Council Tax Reduction schemes. (WR Act 2012)
- Household benefit cap introduced, initially set at £26000. (WR Act 2012)
- Personal Independence Payment (PIP) introduced, starts to replace Disability Living Allowance.

2014

- Pensions Act 2014 reforms state pension provision, introducing a simplified new State Pension.
- Universal Credit: A very limited number of new claims from couples are added to the Live Service.
- Announcement in November 2014 that the transfer of claimant to Universal Credit would not start until January 2018, the aim is to complete it by the end of 2019.
- From 16 June 2014, ‘gateway conditions’ are introduced. These conditions set out whether or not a person living in a designated live service postcode area is able to make a claim for Universal Credit. If the person met the gateway conditions and lived in a postcode that was accepting Universal Credit claims, they were able to submit a claim.

2015

- The roll-out of the live service to jobcentres continues, mainly for single people and for new claims only but with some complex cases gradually added.
- Summer Budget announces reductions in the “work allowances” for most Universal Credit claimants, commencing April 2016, and a benefits freeze.
- By December 2015, 530 out of the 700 jobcentres are using Live Service, although the number of live cases remained small. Universal Credit full service trials start in Croydon, Southwark and Sutton.

2016

- New State Pension introduced.
- Three-year benefits freeze from April.
- Universal Credit: By Spring 2016, 700 jobcentres are on the Live Service for single unemployed people (or people with very low earnings) satisfying the gateway conditions.
- In May 2016 the Department for Work and Pensions began rolling out the Universal Credit Full Service. Full Service would then roll out to 5 jobcentres a month increasing to 50 jobcentres a month from 2017 concluding with the final jobcentres in September 2018.
- In November 2016, to encourage incentives to work, the government announced a reduction in the Universal Credit post-tax taper rate, which controls the reduction of Universal Credit as employment income grows, from 65% to 63% of post-tax income.
- In December 2016 claimants can apply for New Style Job Seeker's Allowance and New Style Employment and Support Allowance separately to Universal Credit. New Style Employment Support Allowance is a contributory benefit that can be claimed by people who have paid or been credited with enough National Insurance contributions in the 2 full tax years before the year their claiming in. New Style Jobseeker's Allowance can be claimed with, or instead of, Universal Credit, depending on a claimants' national insurance record.

2017

- Autumn: in response to evidence of problems experienced by people moving onto Universal Credit measures are introduced with the aim of easing claimant's transition to Universal Credit. These included abolishing the 7-day "waiting period", increasing the amount of the advance payment people can get at the start of their claim and extending the repayment period for advances, and allowing people moving onto Universal Credit to continue to receive Housing Benefit for two weeks.
- Universal Credit roll out in Northern Ireland started in September 2017.
- Work Programme discontinued.

2018

- Universal Credit Live Service closed to new claims from 1 January 2018.
- The 2018 Budget increases the Work Allowance – the amount claimants can earn before Universal Credit begins to be withdrawn – by £1,000 a year. Extra transitional support for claimants moving to Universal Credit also announced
- April 2018: Universal Credit Full Service rolled out to 258 jobcentres with rollout completion planned for December 2018, when it will be available to the full range of applicants in every jobcentre.

2019

- By March all remaining claimants on the Universal Credit Live Service are moved to the online Universal Credit Full Service
- A "managed migration" pilot project starts in Harrogate in July 2019 with the aim to gradually move people in receipt of existing benefits over to Universal Credit. The pilot was set up to involve up to 10,000 existing claimants in Harrogate and was due to conclude in July 2020. Transitional protection is put in place to ensure that most claimants are not worse off as a result of the managed migration from their previous benefits to Universal Credit.

2020

- A marked increase in the number of claims for Universal Credit due to the COVID-19 Pandemic. Temporary changes are made to Universal Credit in response. Universal Credit continues to be claimed online but claimants are not expected to attend the jobcentre for the initial interview; claimants are not expected to accept claimant commitments to be entitled to Universal Credit. As a response to the Pandemic, requirements to attend appointments, undertake work preparation, undertake work search and be available for work are temporarily suspended. Conditionality requirements are gradually reintroduced from 1 July 2020.
- The April 2020 Budget arrangements included a £20 increase in weekly standard allowance of £20 a week above planned uprating for 1 year to support households during the pandemic; support to the self-employed by temporary suspension of the Minimum Income Floor.
- Due to the Covid-19 Pandemic, the managed migration pilot is suspended.
- Kickstart Scheme introduced to create new jobs for 16–24-year-olds on Universal Credit.

2021

- Amongst other Budget announcements Universal Credit claimants will continue to get the £20 per week uplift until the end of September. Additionally, Universal Credit advances won't need to be repaid for 24 months from April 2021.
- Universal Credit surplus earnings threshold extended. Universal Credit claimants will continue to get the higher surplus earnings threshold of £2,500 until April 2022.
- Full roll out of Universal Credit is now set for September 2024.

The Health Contribution

Chapter One: The Process

The Health contribution to the Significant Case Review was led by the Public Protection Medical Lead in the Child Protection Service at Greater Glasgow and Clyde Health Board and the Chief Nurse for East Renfrewshire Health and Social Care Partnership who previously held the post of Chief Nurse in Inverclyde. It has involved the development of a Chronology of relevant legislation and policy to review alongside the existing multi-agency Chronology coupled with a deep dive into the available Health case files. This component includes an overview of the search for Health case files; a comprehensive overview of legislative and policy from Margaret`s birth to date; consideration of Margaret`s diagnosis in the absence of a recorded learning disability diagnosis as evidenced within available Health files; an analysis of the case from a Health perspective including the reflections of the General Practitioners interview transcripts with the Independent Reviewer concluding with a summary of what would be anticipated for a Margaret of today from a Health perspective with some recommendations for the future.

There were only two ex-staff members, both GPs, who were in a position to provide detailed knowledge of Margaret and her situation. This section also includes some observations from the Clinical Psychologist who was the last professional to see Margaret alive in late 1999.

Health Records Search

The available Health Records that could be reviewed were:

- GP records- including medical record card (3).
- Inverclyde Royal Hospital - previously had paediatric services, includes letters and clinical recordings.
- Royal Hospital for Sick Children.
- One photocopied Health Visiting Pre School Assessment Form dated 11/02/85 when Margaret was 4 years and 3 months old (contained within the medical files).

A further check for Health Records was undertaken following discussion with Clinical Director and Head of Adult Services: Learning Disability and Recovery on 8 March 2022, by the then Health Records Manager (Mental Health).

A thorough check of the indexes was undertaken to find any additional notes for Margaret. No notes were found. This search included old Merchiston Hospital Records and notes held offsite at Iron Mountain. The Records Manager also checked with Inverclyde Child and Adolescent Mental Health Service to see if Margaret had been referred to them as a child. No records were found. It is possible that Margaret was seen at Elizabeth Martin Clinic and that no proper records were created on the system.

From a review of the Chronology, a GP referral to the Community Learning Disability team was noted in November 1999 requesting a psychology assessment. From a review of the patient case file it also looks like there was a home visit on 25/11/99. Subsequent visits to Elizabeth Martin Clinic were cancelled by EC and AJ.

A request for the old Psychology Alpha boxes covering letter “F” from Iron Mountain was made. No additional records for Margaret were identified.

We noted significant gaps in the case files specifically in relation to letters of communication between professionals and reports from other agencies which were requested by Psychologists.

Policy and Legislative Context

All people with learning disabilities require access to Health and social care services to enable equality of Health outcomes. As highlighted in, “People with Learning Disabilities in Scotland: 2017 Health Needs Assessment Update Report”, action is therefore required in two key areas.

“First, all people with learning disabilities are to be included in and have access to universal Health services available for the general population. Second is to ensure that there is access to specialist Health services with practitioners with advanced knowledge, skills and expertise to undertake assessments, treatments and interventions and provide support and education to people with learning disabilities and their families, and practitioners in Health social care and independent sector providers.”

In relation to Margaret, it is important to acknowledge the complexities of Health, Social Work and educational pathways and interfaces at the time and the availability of accepted practice to support children and young people with additional support needs, learning disabilities and learning difficulties.

Chapter Two: Learning Difficulty / Learning Disability Diagnosis

Following a review of the available Health Records there was no evidence of a learning disability diagnosis having been made in relation to Margaret with the exception of a single reference to “learning disability” in a referral letter dated 04 November 1995 by the General Practitioner to Psychology Adult Learning Disability Team. The first reference to 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. This diagnosis was not confirmed and later disregarded. However, it is noted that Sotos syndrome is recorded in the Employment and Support Allowance Form ESA113 on 18/12/11 and 21/11/15.

The following extracts from the Health Records provide an example of the lack of a definitive diagnosis which arguably impacts Margaret`s access to appropriate clinical pathways and sign posting to relevant supports:

[Redacted]

Chapter Three: Analysis of Content within Health Case Files

The focus from a Health perspective appears to initially centre on obesity and strategies to reduce Margaret's weight including inpatient admissions. Carers request genetic testing and investigations due to the obesity and other developmental concerns. Within the preschool assessment form completed by the Health Visitor there is no reference to Margaret having a learning disability.

Of particular note there is acknowledgement within medical case files of previous psychological trauma, various psychological problems and behavioural disturbances. There is reference to major social and emotional problems within the family and that Margaret had a problematic childhood where she was caught in the middle of parental conflict. Margaret's parents are observed and reported to be not pulling well together with a tendency to score points of one another. There is no evidence that these observations and reports are correlated with wider social circumstances and how they were impacting on Margaret's health and wellbeing not least in relation to her behaviour which was reported to be challenging. Based on the academic evidence it is likely that Margaret's exposure to adverse childhood experiences impacts her health and wellbeing including her obesity, developmental and behavioural issues.

The review of the case files indicated some clinical verbal communication between professionals involved which were not documented within the case files. This included reference to the Health Visitor having "a lot" of contact with the family but no detail around this contact. Similarly, in the Psychology file, the Psychologist stated in a discharge letter to the GP in March 2000 that he had 'several concerns which I expressed to you on the phone several weeks ago.' No Health Visitor or school nursing case files are available to review having been destroyed in line with extant policy.

It is important to set out the differences and diagnostic implications when referring to 'learning disability' and 'learning difficulty' which are often confused as being one in the same thing. In practice it is accepted that there is a close correlation between learning disability and learning difficulty, particularly when an individual is thought to have borderline learning disability. By its very nature learning disability describes (in diagnostic terms) the overlap between diagnostic criteria in the context of intelligence quota with the individual scoring in the upper scale indicating a lesser impact on intellectual functioning.

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 now 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.

In many respects this is relevant in the pathways children and young people will follow and is relevant in the case of Margaret. At the time of Margaret`s birth children with more moderate to severe or profound learning disability, which may have been evident from birth or in the early developmental milestones with other Health problems would typically be known to community paediatricians throughout their childhood

with liaison between primary care and the community paediatric service. This arrangement may for some cases continue into adulthood with relevant transition arrangements in place.

However in children similar to Margaret where the 'diagnosis' is less clear there would be less of a focus for paediatric services and, for the majority, all care would be provided within the community with limited role for acute or community medical paediatric services. There is no evidence of communication or triangulation of information from any other agencies including education within the existing heath records for Margaret. A few letters seem to reflect an awareness of involvement of other services but limited in terms of care planning and expectations.

The involvement of specialist learning disability services would likely commence around the period of transition from child to adult services. In some areas, children may also have been seen by nurses in the adult learning disability team and this was certainly the case in the Renfrewshire area (also known as Renfrewshire and Inverclyde Primary Care Trust) when Margaret was a young person in the area. Records indicate Margaret is referred to psychology community adult Learning Disability service by the General Practitioner. An initial home visit is made by the Psychologist on 25/11/99. A second appointment results in a DNA followed by several phone calls and a written letter to contact the clinic for further appointment. Unfortunately there is no engagement. A typical pathway at this time would have been for a member of the Adult Learning Disability team to attend the local specialist school transition planning meetings for children with learning disability from the age of sixteen years and to provide any Learning Disability specialist Health input needed from then on. Margaret, however, had attended a mainstream school followed by attendance at a local College. In the absence of detail and intelligence from Education it is difficult to provide any comment on the multi-agency response to Margaret`s identified needs at this time and on her transition.

Typically, for children where the presence of learning disability or difficulty was more subtle and had a lesser impact on broader functioning they would not have required the specialist intervention of community paediatrics and would not necessarily enter education with a record of needs (although that might emerge later). The primary care input would be similar to that for children without learning disability or learning difficulties.

Some children that are not diagnosed with a learning disability may, depending on the social circumstances and the presence of any other mental Health, behavioural or other emerging Health needs, be referred to the Adult Learning Disability team around the time of transition. But as highlighted above, it is believed that there were also occasions where children would be seen by the Adult Learning Disability team nurses before transition if an appropriate referral was made. The involvement of learning disability teams would by and large be requested by Social Work or primary care, and in a small number of cases children's mental Health services may also request the involvement of learning disability teams.

Margaret`s voice

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 plans. Margaret is always accompanied to her appointments by her mother and father in early years and latterly by her EC and AJ. It is noted that on 26/08/82 during a home visit by a senior Psychologist during the assessment of behaviour and attention control assessment that Margaret (aged 2 years)

'…was distracted often by her parents` presence and contributions to the assessment. A fuller and more accurate assessment of her ability would require her to be seen on her own'.

During a home visit on 25/11/99 Margaret was interviewed with EC and AJ present. It was highlighted EC and AJ were also interviewed alone. Although the written record does not make clear that Margaret was seen alone, it was made clear some time was spent alone with her. The assessment is incomplete and further work required. The concerns noted at the visit result in recommendations that Margaret would benefit from the involvement of the Community Learning Disability Team and should have a Social Worker and a community care assessment.

Chapter Four: GP Reflections

Having had access to the notes from the interviews with the External Independent Reviewer and the GPs involved in Margaret's care, it is clear the General Practitioners played a key role in addressing routine Health issues. Both GPs recognised and emphasised the benefits of multidisciplinary and multi-agency working and continuity of care giving in the early years. The GPs note the level of social deprivation and in the context of the Margaret of today there would likely be a greater understanding of the impact that this has on her Health and wellbeing.

When Margaret was born GPs used brief handwritten records and read coding, alerts and follow up were less organised and structured than it is today. They would often only reflect critical physical symptoms and limited information relating to social history or family functioning. Patients with certain diagnoses now are appropriately coded and called for review or follow up. GP electronic records also have the ability to flag children or young people who may be more vulnerable as a trigger when they contact the practice. For example, if a child was on the child protection register a read code would be added to their record.

Language used to describe children or young people with a learning difficulty or disability has changed and support making them 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. Of particular note the Scottish Government recently announced both in the press and via a circular received 20th May 2022 from the Interim Director of Mental Health, the implementation of annual Health checks for people with a learning disability to be undertaken by Health Boards or persons with whom Boards enter into agreements with.

Annual Health Checks for people with learning disabilities is a not a new concept in Scotland or indeed the UK. These are already provided in England and Wales and have been in place since 2008. There has never been a national roll out of Health checks in Scotland; plans to do so will be the first in Scotland. That said, annual Health checks were in place in NHS Greater Glasgow & Clyde through the delivery of a Local Enhanced Service between 2002 and 2016. NHS Greater Glasgow and Clyde was at the forefront of this programme and was the only Board in Scotland to run an incentivised scheme with GP practices. The scheme was provided on an opt in basis with payments made to each practice per item of service. GP uptake in the area was high and this extended to the old NHS Lanarkshire Camglen corridor.

NHS Greater Glasgow and Clyde operated a team known as the Learning Disability Primary Care Liaison Team during the life of the Local Enhanced Service. This team maintained support for GPs, administered payments, created a register of people with learning disability, developed clinical decision trees and information on the GP IT systems and carried out a small number of Health Checks each year.

The Local Enhanced Service was retired in 2016, at the time the new arrangements being proposed by SPIRE planned to include Learning Disability Health Checks in this. Locally, a decision was taken to redesign the Primary Care Liaison Team when the Local Enhanced Service stopped and transfer the Scottish Enhanced Services Programme funding to local Health and Social care Partnerships to maintain a degree of support for GPs whilst new arrangements were made at a national level. The small staff team of nurses, team lead and business support were redeployed into the wider Learning Disability Community teams.

The information, research and known benefits in addressing the number of Health inequalities faced by people with learning disability is largely available as a result of NHS Greater Glasgow and Clyde work during the life of the Primary Care Liaison Team / Local Enhanced Service.

Since 2016 the Scottish Government has engaged in further exploration of the benefit of Health checks and have run a pilot programme in NHS Grampian. It is understood that this work was delayed somewhat by the pandemic but has now concluded, with internal discussions about a nationwide scheme leading to the plans now published by the Scottish Government. For this initiative to be successful it would be important that those eligible for review had an appropriate diagnosis and read code on their GP record. This would require close working between Education and Health.

Primary care has seen a shift 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 benefit from improved communication between GPs and Health Visitors and a greater understanding of emotional development and the impact of trauma on child development. 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 within that child or young person'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 or what her transition or support arrangements were.

Reflections would suggest limited awareness of Social Worker involvement within Margaret's life and this is similar to reviewed Health records. Today greater inter-disciplinary and inter-agency communication, assessments and planning would be expected to meet the needs of any child, young person or adult with diagnosis or disability that impacted on daily functioning.

Registering with a GP is a universal right and patients have the right to choose. Patients are in part protected by the GP contract. There are only two main reasons why a patient would be de-registered actively by a GP practice. One is a break down in a relationship often cited or following behaviour from a patient that a practice finds threatening. The other is when a patient moves out of the practice catchment area. However, with children and vulnerable adults practices may be less active in this situation. In fact, in NHS Greater Glasgow and Clyde GPs would hardly ever actively de-register a child or young person because they were out of area.

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. There was no record of any formal care arrangements for Margaret within the Health records. This remains the case today.

The records and reflections suggest a potential pattern of disguised compliance and not being brought to appointments by her parents or 'carers'. Throughout her life her weight was a recorded issue yet assessments and subsequent plans to address were rarely followed or resulted in any meaningful change. There is also a potential disparity in our approach to children and young people with obesity as a proxy measure of potential neglect issue in contrast to children and young people who are weight faltering.

Critically there was no follow up for her Psychology appointment. This was also perceived by the GPs to be the route into Social Work and additional support. Social Work practitioners strongly asserted that this perception was flawed and that clear systems did exist.

In 1995 / 96 Margaret had been living with her father and paternal grandparents. Her father then died, her mother seemed to struggle to meet Margaret's needs and she eventually resided with EC and AJ. Margaret no doubt would have experienced loss and interrupted relationships. 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. Margaret did present with episodes of self-harm and behavioural change which resulted in a psychology referral but as previously stated there was no engagement with this service.

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 within a Getting It Right for Every Child model to assess and support. Health records today will contain regular inputs from Education and reference to Third Sector support. As an older child with no complex Health issues her main care would be provided by her GP. This would be a similar pattern today. It is not clear from Health Records what her difficulties were in school or what her transition or support arrangements were.

Chapter Five: What Would Margaret of Today Expect from a Health Perspective?

Baby Margaret of today would have access to universal Health services. However, within the organisational, cultural, political landscape coupled with policy changes, this would enable a greater focus on integrated working in comparison to when Margaret was born. For example, policy developments and legislation had significant implications for the Public Health Nursing workforce, specifically those engaged with the nought to five years population. Policy initiatives included a range of measures crucial to improving children's rights across Scotland and added momentum to implementation of the Scottish Government's Getting It Right for Every Child approach. As a result there was recognition of the need to make explicit the respective roles of the Health Visitor and School Nurse, alongside the respective education and training requirements. As outlined in CEL 13(2013) Public Health Nursing Services – Future Focus Health Visitors would focus on the population pre-birth to age five years with School Nurses focusing on the five - eleven years and eleven-nineteen years respectively. Today all children will have a comprehensive assessment of their needs using the Getting It Right for Every Child National Practice Development model.

The Health Visiting universal service offers a minimum of eleven visits including a pre-birth visit. Throughout the universal pathway, and in line with the National Parenting Strategy, the terms 'family' and 'parent/ carer' are used to refer to a much broader range of primary caregivers. Essentially, mothers, fathers and all carers involved in the lives of children and young people are considered in the unique family/Health Visitor relationship. The holistic approach adopted by the Health Visitors enables the parent/ carers to get to know their Health Visitor and develop a therapeutic relationship. The pathway is based on the best available evidence which indicates that all visits should be undertaken by a Health Visitor in the home. This should also include parents/ carers where there are documented vulnerabilities which impact on the health and wellbeing of the child.

Children and families have diverse needs. The level of support which they require will be dependent on the comprehensive Getting It Right for Every Child assessment undertaken in partnership with parents and carers. The Health Plan Indicator should be allocated by six months. However, the Health Plan Indicator may, where appropriate, be allocated ante-natally, in consultation with the family, midwife and other key professionals. The Health Plan Indicator may also be re-assessed following changes within the child's life including the emergence of new risk factors. In the context of Margaret`s life it is anticipated that the Health Visitor would have allocated an additional Health Plan Indicator (either low or high depending on Getting It Right for Every Child National Practice Model assessment) and would therefore have had access to more support with sign posting to other agencies and services.

Supporting Early Years Nutrition Across NHS Greater Glasgow and Clyde

The need to promote early intervention for Healthy weight gain in infants is a significant public health priority. Whilst this includes faltering growth it predominately relates to overweight and obesity.

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. Successful interventions will require to be 'poverty proofed' in development to meet the needs of the most vulnerable families.

The Maternal and Infant feeding Review completed in 2019 outlined a discreet work stream relating to Early Years Nutrition which included:

- A mainstream approach to faltering growth support for Health Visitors etc. based on learning from the current Growth and Nutrition service.
- Comprehensive training and practice development to support growth and nutrition as part of the implementation of the Universal Pathway.
- Development of approach to include support for overweight children building on the MDT support role of child and family teams and learning provided by national /local evidence.

Margaret of today would have been monitored carefully in relation to her weight and the focus of support would have been within the community setting involving a range of professionals including infant feeding advisors, community paediatricians and paediatric dietician with oversight from Health Visitor up to five years or until entry to school.

Child Healthy Weight Programme

The focus on Child Healthy Weight started in 2008 with a specific Child Health Weight Health Improvement, Efficiency and Governance, Access and Treatment target. The national direction required intervention delivery from five to fifteen years from 2008. Locally Greater Glasgow and Clyde operated a Board wide programme called Active Children Eating Smart in all Health and Social Care Partnerships delivered in conjunction with Schools and School Nursing teams.

The overall strategy for Child Healthy Weight was agreed with the Board in 2016 and still remains the direction. Further direction by the publication of the Child Healthy Weight standards and ring fenced funding from 2019 requires NHS Greater Glasgow and Clyde to provide Healthy weight intervention for all age groups in line with standards.

The Weigh to Go 24 Week Programme

Weigh to Go for young people is well established and Weigh to go families was operating pre pandemic. The key aims are:

- To engage young people who are overweight or concerned about their weight and provide support for them to reduce their BMI and increase their physical activity levels.
- As part of the package of support, provide access to commercial weight management services.
- Ensure that programme delivery is targeted.
- To provide wrap-around support to those young people who are identified as requiring additional support, e.g. self- esteem, resilience, employability etc.
- To ensure that the programme is flexible and meets the needs of young people.

Margaret of today would therefore have had access to the support as outlined above.

School Nursing (5 - 11 years and 11- 19 years)

The school nursing contribution is 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. The national Review of the School Nursing role in Scotland 2016 refocused the role to outline school nurses' contribution within a wider inter-agency setting. In response NHS Greater Glasgow and Clyde School Nursing Review Group was established in January 2017. It was acknowledged that the task for the review group had been challenging not least because of the financial challenges for Greater Glasgow and Clyde Health Board at that time. The key intent was to ensure the ongoing delivery of the core school nursing role in supporting improved outcomes for school aged children and young people and the need for Health and Social Care Partnerships to respond to local needs based on their community and strategic planning objectives.

In moving this work forward the review of the current school nursing activity considered the following key objectives:

- Make visible the range of services being provided for school age children in relation to the ten national pathways with specific focus on locally agreed priority pathways (due to School Nursing workforce capacity) i.e. emotional Health and wellbeing, child protection and transitions pathways.
- Ensure that school nurses are able to fulfil their role in each Health and Social Care Partnership area.
- Ensure core services are being delivered.
- Review the resilience of the local services.

Legislation and Key Dates Chronology

YEAR	POLICY	POLICY OVERVIEW
01/11/80		Margaret Fleming`s Birthday
1984 4 Years	Mental Health (Scotland) Act	The Act placed duties on local councils to provide care and support services for people with mental disorders. It introduced changes to develop community-based mental Health services, involvement of service users and unpaid carers in decisions concerning treatment, and respect for the human rights of people with mental disorders.
1986 6 Years	Disabled Persons (Services, Consultation and Representation) Act	The Disabled Persons Act 1986 sought to improve services for people with disabilities, by strengthening their voice through making provision for representation and placing additional duties on local authorities. Section 2 of the Act enabled the appointment of representatives for people with physical and learning disabilities, as well as those with mental illnesses.
1990 10 years	National Health Service and Community Care Act	First major reform of the NHS since 1948. The National Health Service and Community Care Act made provisions to split the provision and commissioning (i.e. purchasing) of Healthcare. It marked the start of an internal market within the NHS, with the creation of NHS trusts and changes to the way in which local authorities carried out their social care functions. These proposals had been outlined in the Department of Health white paper Working for patients in January 1989. The 1990 Act gave the secretary of state powers to establish NHS trusts by order. These trusts were to assume responsibility for the ownership and management of hospitals or other facilities previously managed or provided by regional, district or special Health authorities. These 'self-governing' trusts had greater freedoms to borrow money, generate income and raise revenue directly from providing services. The Act also gave authorised GP practices the opportunity to manage their own budget for practice expenses, drugs and some hospital services, giving GPs the freedom to choose where to purchase services. Fundholding was voluntary, but many GPs who were competitive, independent contractors took to it with enthusiasm. Fundholding was originally restricted to practices with a list size greater than 11,000. The restrictions on list sizes were later relaxed, to allow practices with a registered population of over 5,000 to become standard fund holders. Those with a list size of under 3,000 were able to purchase community services and outpatient care (community fundholding). Family Health services authorities were established, replacing the role of family practitioner committees (FPCs) in the planning and delivery of primary care. Family Health services authorities were themselves replaced in 1995 by Health authorities. **Changes to local authorities' social care functions** In parallel, the Act made changes to the way in which local authorities carried out their social care functions by: • giving them an obligation to carry out a needs assessment of older people and people with disabilities for community care services allocating funding for places in residential homes as well as domiciliary care services. Such services were mainly covered by existing legislation, such as the National Assistance Act 1948, and included:▪ home assistance ▪ respite services ▪ day care ▪ provision of adaptations ▪ rehabilitation and prevention services ▪ home delivered meals. Section 47 obliged local authorities to carry out a needs assessment if someone appeared to need community care services, or if they had disabilities. However, in urgent situations, local authorities had the discretion to provide services before undertaking an assessment. Assessments were to include other services a person might need, such as housing and Healthcare. The responsibility for funding, planning and means testing community care services was transferred to local authorities from the Department of Social Security. Local authorities became responsible for allocating funding for places in residential homes, as well as domiciliary care services (e.g. home assistance and care). The Audit Commission's role was to appoint auditors to secure high quality audits of public sector spending. Before 1990, the commission's role focused on local government. Increasingly, the commission looked at value for money and carried out national thematic studies into cross-cutting issues such as spending on young people and crime. The Act also gave authorised GP practices the opportunity to manage their own budget for practice expenses, drugs and some hospital services, giving GPs the freedom to choose where to purchase services. Fundholding was voluntary, but many GPs who were competitive, independent contractors took to it with enthusiasm. Fundholding was originally restricted to practices with a list size greater than 11,000. The restrictions on list sizes were later relaxed, to allow practices with a registered population of over 5,000 to become standard fund holders. Those with a list size of under 3,000 were able to purchase community services and outpatient care (community fundholding). Family Health services authorities were established, replacing the role of family practitioner committees (FPCs) in the planning and delivery of primary care. Family Health services authorities were themselves replaced in 1995 by Health authorities.

YEAR	POLICY	POLICY OVERVIEW
1995 15 Years	Children (Scotland) Act	This Act outlines the legislative framework for Scotland's child protection system. It covers parental responsibilities and rights, and the duties and powers local public authorities have for supporting and promoting the safety and welfare of children.
1995 15 Years	Disability Discrimination Act	The Disability Discrimination Act was introduced in 1995 to end discrimination against people with disabilities. It has been continually expanded and revised over the years. It covers a number of areas, these include: ▪ Employment ▪ Education ▪ Access to Goods, facilities and services ▪ Buying or renting land/property ▪ Functions of public bodies
1998 18 Years	Human Rights Act	This lets individuals defend their rights in the UK and compels public organisations, including the Government, Police and local authorities, to treat everyone equally.
1998 18 Years	Data Protection Act	Introduced the right of the individual to privacy with respect to the processing of personal data.
2000 20 Years	Adults with Incapacity (Scotland) Act	Scottish legislation that provides a legal framework to safeguard the welfare and manage the finances of adults, aged 16 and over, who lack capacity due to mental illness, learning disability or a related condition, or due to an inability to communicate. The main care groups covered by the Act include people with dementia, people with a learning disability, people with an acquired brain injury, people with severe and long-term mental illness, and people with a severe sensory impairment. Part 5 of the Act is important in relation to medical treatment and allows treatment to be given that safeguards or promotes the physical or mental Health of an adult who is unable to consent. Part 5 of the Act gives a general authority to treat a patient who is incapable of consenting to the treatment in question, on the issuing of a certificate of incapacity. The general principles of the Act must be applied by the practitioner who issues such a certificate and giving treatment under it. The common law authority to treat a patient in an emergency situation remains in place.
2000 20 Years	The same as you? Adults with Incapacity (Scotland) Act passed.	The review began by looking at services, especially in social and Healthcare, and their relationship with education, housing, employment and other areas. However, its focus changed to include people's lifestyles as that is what matters. Services are there to support people in their daily lives. Same as You review was committed to improving the quality of life for people with disabilities. The review reflected our wider policies including social inclusion, equality and fairness, and the opportunity for people to improve themselves through continuous learning. The focus of the report was consistent with existing policies on community care. 'Modernising Community Care' which aimed at ensuring better results for people through quicker and better decision-making, greater emphasis on care at home and agencies working more closely together. The desire to improve the general Health of people with learning disabilities was also directly related to the aims in 'Towards a Healthier Scotland'. People with learning disabilities should be able to lead normal lives. They should: ▪ be included, better understood and supported by the communities in which they live; ▪ have information about their needs and the 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 wherever possible and special services if they need them. Review of services for people with learning disabilities and ASD. **Note on language** Throughout this report we use the term 'learning disability'. We recognise that some people prefer the term 'learning difficulty' and this is the term used by People First (Scotland), the national self-advocacy organisation. We have used the term 'people on the autism spectrum' but recognise that some people will prefer a different term. Some people with learning disabilities are also on the autism spectrum. However, people on the autism spectrum do not necessarily have a learning disability.
2001 21 Years	Protection From Abuse (Scotland) Act	This Act of Scottish Parliament came into force after a report in November 2000, by the then Justice and Home Affairs Committee, which concluded that the law afforded inadequate protection to individuals at risk of abuse from other individuals and the desire to give the police more powers to protect such individuals.
2001 21 Years	Regulation of Care (Scotland) Act	Regulation of Care Act (Scotland) 2001. Key legislation-principles and provisions. This Act established both the Scottish Commission for the Regulation of Care (Care Commission), which regulates and inspects care services in Scotland and the Scottish Social Services Council, which regulates the workforce. Improve standards of social care services

YEAR	POLICY	POLICY OVERVIEW
2002 22 Years	Community Care and Health (Scotland) Act	The Community Care and Health (Scotland) Act introduced two new changes: ▪ the introduction of free personal care for older people, regardless of income or whether they live at home or in residential care ▪ the creation of rights for informal or unpaid carers, with the intention of providing adequate support services to ensure the continuation of care-giving in the community. The Act created the right to a separate carers assessment and the responsibility of Health boards to produce carer information strategies which must be submitted free of charge to carers.
2003 23 Years	Mental Health (Care and Treatment) (Scotland) Act	The Mental Health (Care and Treatment) (Scotland) Act came into force in 2005. It increases the rights and protection of people with mental disorders, which is a term than encompasses: mental illness; learning disability; personality disorder; The act places duties on local councils to provide care and support services for people with mental disorders.
2005 25 Years	Establishment of Child Protection Service for NHSGGC	Allows all Health professionals in NHSGGC access to advice and support, child protection learning/ training and central corporate service to ensure Health board meets its child protection requirements/ responsibilities. Would include GPs, HVs, school Health and all community based staff as well as acute, maternity and disability/specialist children's services.
2007 27 Years	Adult Support and Protection (Scotland) Act	Adult Support and Protection (Scotland) Act 2007 is legislation that enables the protection of adults who may be at risk of harm. The Act requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights. Central to the legislation is that any intervention in the affairs of an individual must provide benefit and be the least restrictive option as the means to meet the purpose of the intervention.
2008 28 Years	Early Years Framework	This framework at its simplest is about giving all our children the best start in life and the steps the Scottish Government, local partners and practitioners in early year's services need to take to start us on that journey. At the heart of this framework is an approach which recognises the right of all young children to high quality relationships, environments and services which offer a holistic approach to meeting their needs. ▪ we want all to have the same outcomes and the same opportunities; ▪ we identify those at risk of not achieving those outcomes and take steps to prevent that risk materialising; ▪ where the risk has materialised, we take effective action; ▪ we work to help parents, families and communities to develop their own solutions, using accessible, high quality public services as required.
2009 29 Years	Child Protection and Wellbeing NHS Greater Glasgow and Clyde	NHS Greater Glasgow and Clyde vision for children's services NHS Greater Glasgow and Clyde seeks to embrace the Scottish Government's vision for children- that they are safe, Healthy, active, nurtured, achieving included, respected and responsible. These key objectives are detailed in the children's service planning process. Overall objectives for NHS Greater Glasgow and Clyde are: ▪ Improve resource utilisation ▪ Shift the balance of care ▪ Focus resources on greatest need ▪ Improve accessibility ▪ Modernise services ▪ Improve Health ▪ An effective organisation. So our vision is to make sure that we manage our resources effectively to protect children and young people and ensure that their needs are met.
2009 29 Years	Family Nurse Partnership programme	The Family Nurse Partnership was introduced to Scotland in 2009. Focused on addressing the individual, social and economic challenges faced by young, first time mothers and providing a licensed, evaluated programme, and monitored for quality and fidelity. The Family Nurse Partnership is a licensed, intensive, preventative home-visiting programme, developed over 40 years ago in the United States of America by Professor David Olds and the University of Colorado). The programme aims to improve outcomes for young, first time, mothers and their children. It has been developed specifically for these mothers and their children due to their increased risk of disadvantage and associated poor outcomes across a range of domains. It focuses on helping first-time mothers to engage in preventative Health practices, supporting parents to provide responsive, sensitive, and positive parenting, and helping them to develop self-efficacy to both identify and achieve their future goals. A structured programme of tailored visits is delivered by specially trained Family Nurses. This begins early in pregnancy and continues until the child's second birthday. The three key goals are: ▪ to improve pregnancy and birth outcomes, through improved prenatal Health behaviours; ▪ to improve child Health and development, through positive, responsive caregiving; and ▪ to improve the economic self-sufficiency of the family, through developing a vision and plans for the future. It currently has a Level 4+ evidence rating from the Early Intervention Foundation (EIF). This is the highest rating given to programmes with evidence of a long-term positive impact established through multiple rigorous evaluations. Outcomes highlighted include; supporting children's mental Health and wellbeing, preventing child maltreatment, enhancing school achievement and employment, preventing crime, violence and antisocial behaviour, preventing substance abuse, preventing obesity and promoting Healthy physical development.

YEAR	POLICY	POLICY OVERVIEW
2010 30 Years	Equality Act	The Equality Act 2010 and the Public Sector Equality Duty is UK-wide legislation that provides the legal framework to protect the rights of individuals and advance equality of opportunity for all, including those with disabilities. Under the legislation, people are protected from discrimination based on their protected characteristics in employment, education, access to goods and services and membership of clubs and associations. The characteristics specified in the Act are, age, race, religion or belief, disability, sex, sexual orientation, gender reassignment, pregnancy and maternity and marriage and civil partnerships. There is a specific requirement for public bodies to make 'reasonable adjustments' for people with a disability. The Public Sector Equality Duty in the Equality Act 2010 came into force in April 2011 and places an obligation on public authorities, including Health services, to act to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between different groups and foster good relations between different groups.
2011 31 Years	Children's Hearings (Scotland) Act 2011	The Children's Hearings (Scotland) Act 2011 (the 2011 Act) established a new national body for the Children's Panel, under the Leadership of the National Convener. This represented an opportunity to establish common practice across Scotland between the Children's Panel, Local Authorities and the Children's Reporter.
2011 31 Years	A New Look at Hall 4- the Early Years	A New Look at Hall 4 – the Early Years – Good Health for Every Child Published 18 January 2011. Health for All Children (Hall 4) in the early years – a time where children's futures can be shaped by appropriate levels of support and intervention. It supplements the 2005 guidance – Health for All Children 4: Guidance on Implementation in Scotland1 – and addresses key issues identified as requiring further clarification. This guidance focuses on 3 main aspects of Health service delivery to children and their families in the early years: ▪ The allocation of the Health Plan Indicator ▪ The 24-30 month review ▪ The delivery of Health improvement information and advice. **The Health Plan Indicator** The Health Plan Indicator (HPI) was developed following the publication of the 2005 guidance, for use by Health practitioners to enable them to allocate to a core, additional or intensive programme of support, depending on a child's assessed level of need. Although the timescale for allocation of the HPI was not defined, as the 2005 guidance was implemented the default milestone for allocation became part of the 6-8 week review in the majority of cases. This has been attributed mainly to the changing role of the Public Health Nurse - Health Visitor in the years following the publication of the 2005 guidance. The use of the HPI has varied across Scotland with some areas using it as a corporate tool to measure workforce requirements or levels of deprivation within communities. It should be clear that the HPI is a tool to reflect the child's needs in their family, community or wider context. The allocation of the HPI requires to be flexible and should reflect the changing needs of the child and family as situations and circumstances change. These changes happen throughout a child's life but, for the purpose of this guidance, are particular to the early years. The HPI is a snapshot of a moment in a child's life but is an appropriate indicator for use by practitioners as a measure of the mutually agreed support for the child and his or her family. Applying a Getting it Right for Every Child approach means that an assessment of needs should determine whether proper access to universal services and the core support they provide are sufficient for the family or whether additional input is required to help the child reach its full potential. In line with Getting it Right for Every Child, there will now be 2 categories of HPI - 'Core' and 'Additional'. **Timescale for Allocation** Children and families have diverse needs. The level of support which they require will be dependent on a comprehensive assessment undertaken in partnership with parents/carers. The HPI should be allocated by 6 months. However, the HPI may, where appropriate, be allocated ante-natally, in consultation with the family, midwife and other key professionals. The period prior to the allocation of the HPI should be a period of support and assessment, using the Getting it Right for Every Child National Practice Model, the Pathway of Care for Vulnerable Families (0-3) and supported by local tools to ensure a full assessment is carried out and appropriate, proportionate and timely levels of support are provided. Core means that a universal health visiting service will be provided. Additional means that additional health visiting support and/or support from other disciplines or Agencies will be provided. **Key Recommendations** ▪ The HPI should be allocated in response to the assessed level of support required by the child and family. ▪ All children should have an HPI by age 6 months. ▪ There are 2 categories of HPI - 'Core' (receiving the universal Health visiting service) and 'Additional' (receiving additional Health visiting support and/or support from other disciplines/agencies). ▪ Assessment should be carried out using the Getting it Right for Every Child National Practice Model, the Pathway of Care for Vulnerable Families (0-3) and supported by local tools.

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		24-30 Month Review The 24-30 month review for all children is the appropriate time to review the child's parameters of development identifying and addressing areas where additional support is required. Needs identified should be addressed using evidence-based interventions with subsequent monitoring to ensure that agreed outcomes are achieved. It is important that contact is made with all families with children at this stage and no child misses out on the opportunity for a review. NHS Boards must ensure there are protocols in place to deal with non-responders. The review should be carried out in partnership with parents and carers, ensuring that they understand the expected developmental progress of their child at this stage. The Personal Child Health Record (The Red Book 3) contains a number of developmental firsts and this should be used as a proactive tool to work with parents to help them understand, and take the lead on, discussions regarding any concerns they may have. Where there are concerns about a child's development or growth patterns, Health visitors should ensure that the necessary follow-up action is taken. For example, where a parent expresses concern about a child's weight or if the Health visitor, during the review, is concerned regarding the child's weight, the child's height and weight should be measured and recorded on the WHO growth chart 4. If there are further concerns following this measurement, the Public Health Nurse - Health Visitor should ensure appropriate advice is provided. In cases where a more detailed clinical assessment is necessary, the Public Health Nurse - Health Visitor should refer the child to the appropriate local resource, informing the GP of their action. In order to protect children, core principles, values and shared standards of practice and communication form the foundation for effective, collaborative child protection activity. While different agencies will have differing codes of practice and responsibilities, a shared approach to values and standards will bring clarity and purpose to single-agency, multi-agency and inter-agency working. The 24-30 month review should cover the following as a minimum and may require to be expanded, depending on child and family circumstances and professional concerns: ▪ Speech, language and communication ▪ Personal, social and emotional development (including behavioural issues) ▪ Nutrition, growth and weight ▪ Immunisations ▪ Parental concerns and issues ▪ Vision, hearing and oral Health ▪ Physical activity and play. **Key Recommendations** ▪ 24-30 month review to be carried out for all children. ▪ NHS Boards should ensure that needs identified are addressed using evidence-based interventions to achieve agreed outcomes. ▪ NHS Boards should agree the format and approach to the review. ▪ The review should be carried out in partnership with parents/carers and the Red Book should be used as a tool to assist this. ▪ NHS Boards should ensure protocols are in place for non-responders. ▪ Where there are specific concerns, appropriate referrals should be made to other services. ▪ NHS Boards should develop clear pathways of care to ensure that referrals for support are appropriately managed.
2011	Maternity and Infant Feeding Framework	Improving Maternal and Infant Nutrition: A Framework for Action was launched by the Scottish Government in January 2011, alongside a raft of policies and frameworks aimed at improving the Health and wellbeing of parents, children and families across Scotland. The Scottish Government recognises the vital importance of good nutrition before conception, throughout pregnancy and in the early years of a child's life. The vision includes the following: ▪ Women entering pregnancy are a Healthy weight, in good nutritional Health and that this continues throughout their pregnancy and beyond. ▪ All parents receive full information they can understand on infant feeding to enable them to make an informed choice on how they will feed their infant ▪ All women receive the support they need to initiate and continue breastfeeding for as long as they wish. ▪ Infants are given appropriate and timely complementary foods and continue to have a wide and varied Healthy diet throughout early childhood. The Framework clearly underlined the fact that these ambitions cannot be delivered by any Agency or organisation in isolation. The challenge of improving nutrition for mothers and young children in Scotland will need every organisation to work together. As well as providing up to date information on the diet and nutrition of mothers and young children in Scotland, and research based recommendations for improvement, the framework document set out actions to be taken by the Scottish Government, NHS Boards, local authorities, community groups and others to help improve the nutrition of pregnant women, babies and young children. These actions included activities designed to improve the knowledge and skills of staff working to support families, improve communication of crucial messages on nutrition, and provide practical support for families to encourage good nutrition.

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		Progress on the Framework is being monitored by the Implementation Group. Reports have demonstrated that Health Boards and other organisations across Scotland have been working together to deliver nutrition information to parents in the antenatal period, help to initiate and maintain breastfeeding, and provide support for parents to access and use Healthier food for their young children. The involvement of community food initiatives and third sector organisations in many areas of Scotland is vital to the success of this work. Further partnership work is strongly encouraged. Education and training resources needed to improve the skills and knowledge of the diverse workforce supporting parents and children in Scotland have been developed led by NHS Education Scotland. Implementation of UNICEF UK Baby Friendly status. Achievement of Baby Friendly Awards is a key part of the Maternal and Infant Nutrition Framework, and every NHS Board in Scotland is working toward achieving and maintaining Baby Friendly status in both hospital and community settings. NHS Greater Glasgow and Clyde were the first Health authority in the United Kingdom to have achieved full accreditation throughout all maternity units as well as across every community Health partnership. Improving maternal and infant nutrition across Scotland will require effective and sustained partnership working to deliver for parents and children.
2013 33 Years	Universal HV Pathway in Scotland	It is well known that prevention, early identification and intervention throughout the early years of life are crucial to people's future experience of Health and wellbeing. It is also recognised that continuing preventative approaches and holistic assessment of children after they reach the age of five, particularly focusing on vulnerable children and families and those who have experienced, or are at risk of, adverse childhood experiences (ACEs), [1] are equally vital. The roles of Health visitors and school nurses, with their wider teams, have been refocused to reflect this evidence. The aim is to ensure a preventative foundation throughout the early years by providing critical support and interventions to children under five and their families, complemented by a stepped-skill approach to universal and targeted services for all children of school age. **Health Improvement** Positive Health improvement information and support are key to the success of achieving a Healthy nation. In modern times, these messages are provided through a range of media from internet sites and national TV advertising campaigns to national and locally produced materials, aimed at serving the local population. Public Health Nurses - Health Visitors are key to the delivery of these messages and to ensuring that the right messages are getting through. As part of the primary Healthcare team, Public Health Nurses - Health Visitors should ensure that positive Health improvement messages are provided as part of all universal contacts with children and their families. Such information and support should be accessible to individual families and tailored to their needs to ensure improvements in Health and wellbeing also contribute to reducing the current inequalities in outcomes for children. By adopting an "asset-based" approach, Public Health Nurses - Health Visitors can build on the existing knowledge and skills of families. Public Health Nurses - Health Visitors should ensure that they promote the use of materials such as Ready Steady Baby! and Ready Steady Toddler! as a regular reference point for Health improvement information and advocate the use of Ready Steady Baby! and Ready Steady Toddler! websites to obtain additional information and support. **Key Recommendations** ▪ Public Health Nurses - Health Visitors should promote materials such as Ready Steady Baby! and Ready Steady Toddler! play@home, Breastfeeding Off to a Good Start, and Fun First Foods to provide parents with information. ▪ Public Health Nurses - Health Visitors should ensure that information, resources and support provided are accessible and tailored to meet the needs of individual families. ▪ Health improvement messages can be provided through a range of sources and NHS Boards should ensure that accessible positive messages and guidance are given to parents/carers. Public Health Nurses - Health Visitors should use the 24-30 month review as a key point for the provision of Health improvement information and support.
2013 33 Years	Keys to Life strategy (Scottish Government)	Launched in 2013, it is a joint commitment with COSLA and builds on the success of 'The same as you?' the previous strategy which was published in 2000 following a review of services for people with learning disabilities. The keys to life strategy recognises that people who have a learning disability have the same aspirations and expectations as everyone else and is guided by a vision shaped by the Scottish Government's ambition for all citizens. Everyone – including people with learning disabilities - should be able to contribute to a fairer Scotland where we tackle inequalities and people are supported to flourish and succeed. People with learning disabilities should be treated with dignity, respect and understanding. They should be able to play a full part in their communities and live independent lives free from bullying, fear and harassment.

YEAR	POLICY	POLICY OVERVIEW
2013 33 Years	Introduction of Electronic Management Information for Children and Families	NHS Greater Glasgow and Clyde utilise the Electronic Management Information System which is a clinical information system for all community services; children and mental Health adults. NHS GG&C operate a single shared record for community based children's services which enables seamless transitions between and within services; improved communication between disciplines and across services; streamlines data entry; provides improved statistics and new data sets; ceases the creation of paper records (Children); supports access to clinical information at site of care delivery; supports agile working on 3g/4g laptops and tablets; improves coordination of services and service user satisfaction and communication to primary care, acute and partner agencies. The Record is used by: ▪ NHS Greater Glasgow and Clyde Public Protection Unit ▪ Child and Adolescent Mental Health Services • Community Paediatrics ▪ Family Nurse Partnership ▪ Heath Visiting ▪ Speech and Language Therapists. This means all community children and young people's services information is stored in one place. Clinicians can instantly update and share information. It has led to improved coordination and communication between disciplines the creation of multi- disciplinary significant event chronologies, a single record of non- attendance, ability to issue organisation wide alerts. It also supports a single care planning structure. Record sharing has been transformational in allowing clinicians to make informed decisions more quickly. Clinical colleagues in acute services can see a summary from the Record and community clinical staff can access clinical portal via the Record to view case records relating to acute episodes of care that the child has undergone. Health Visitors have access to Badgernet system to enable inputting of information following antenatal contact. Some Health and Social Care Partnerships have adopted tests of change to give Health visitors read only access to Social Work care first records – this requires further exploration. General Practitioners do not currently have access to the child's community Health record. NHS Greater Glasgow and Clyde has information sharing agreements with all six local authority areas and staff are well acquainted with inter-agency information sharing duties and guidance to support this and within legislative framework and the principles underpinning the Getting It Right for Every Child National Practice Model.
2014 34 Years	The Public Bodies (Joint Working) (Scotland) Act 2014	The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislation that provides the framework for integrating adult Health and social care. Bringing together adult Health and social care services aims to provide a consistent level of quality and sustainable care services for the aging and increasing Scottish population, many of whom will require care and support from both Health and social care services due to their multiple, complex, long-term conditions. A major policy initiative, the integration of adult Health and social care services brings together budgets for care services to create a single commissioning budget. This enables the partner Health and social care organisations to commission services that will improve outcomes for adults requiring assessment, treatment, care and support.
2014 34 Years	Children and Young People (Scotland) Act Key elements of Getting it Right for Every Child	**Maternal and Child Public Health** The role of the maternity, children and public Health team is to reduce inequalities and improve the Health and wellbeing of children, young people and pregnant women by providing strategic, evidence based advice and guidance enabling the delivery of high quality services. https://www.gov.scot/policies/maternal-and-child-Health Works with NHS Scotland to promote and support good child and maternal Health, so that all children in Scotland can have the best possible start in life. SG policies support maternal and child Health are part of Getting It Right For Every Child (GETTING IT RIGHT FOR EVERY CHILD) - our national approach to improving outcomes and supporting the wellbeing of children and young people. The Children and Young People (Scotland) Act 2014
10/2016 36 Years		**31/10/2016: Two Police Officers present at Port Glasgow Social Work Office requesting MF's records**
2018	People with Learning Disabilities in Scotland: 2017 Health Needs Assessment Update Report	People with Learning Disabilities: 2017 Health Needs Assessment Update Report Research report First published on 07 December 2017 Description This Health needs assessment provides a broad overview of the current research evidence of the Health needs of adults with learning disabilities. It is an update of the 2004 Health needs assessment. The evidence and recommendations provided in the 2017 update of the Health needs assessment report was to enable service and workforce to review their existing provision and initiate and plan developments, necessary to ensure that the care and support needs were provided now and for the future.
2018	General Data Protection Regulation (GDPR)	The General Data Protection Regulation is a regulation in EU law on data protection and privacy in the European Union and the European Economic Area.

YEAR	POLICY	POLICY OVERVIEW
April 2018	Transforming nursing, midwifery and Health professions roles: the school nursing role in integrated community nursing team. The attached link provides access to Paper 4 in the transforming roles programme and outlines the school nurse's contribution within wider Health and educational wellbeing teams in schools.	The Chief Nursing Officer is committed to maximising the contribution of the nursing, midwifery and Health professions (NMaHP) workforce and pushing the traditional boundaries of professional roles. The Transforming Roles programme aims to provide strategic oversight, direction and governance to: ▪ develop and transform NMaHP roles to meet the current and future needs of Scotland's Health and care system ▪ ensure nationally consistent, sustainable and progressive roles, education and career pathways. The attached paper (Transforming Nursing, Midwifery and Health Professions' (NMaHP) Roles: pushing the boundaries to meet Health and social care needs in Scotland: Paper 4 - The school nursing role in integrated community nursing teams (qnis.org.uk)) outlines the school nurse contribution within wider Health and educational wellbeing teams in schools. Wider teams may include education staff, allied Health professionals, community children's nurses, staff nurses, clinical support workers and Health improvement staff, all of whom play a vital role in schools. This will enhance the perception of schools as an important portal for universal access to Health services for children. The school nursing contribution will be critical within this wider 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. With this very much in mind, the school nursing role in Scotland has been reviewed and refocused to outline school nurses' contribution within a wider inter-agency setting.
2020	Children (Scotland) Act 2020; what will the new legislation mean for children in Scotland.	The 2020 Act: Replaced the presumption that only children aged 12 and over are mature enough to have their views heard in courts and children's hearings; ▪ Places an obligation on the courts to explain their decisions to children in a way they will understand; ▪ Abandons the outdated Form F9 in favour of free expression for children in Courts; and ▪ Places a duty on Local Authorities to consider how to maintain contact between siblings should they be placed outside the family home. The current presumption in the Children (Scotland) 1995 Act, that only children aged 12 and over are mature enough to give their views will be replaced with the presumption that all children are capable of giving their views, except in exceptional circumstances. Judges will retain a sufficient degree of discretion in this regard, having to consider the views of the child, taking into account their age and maturity. The 2020 Act also abandons the one-size fits all approach of gathering the views of children via the completion of the court-approved Form F9, which children can do so with the help of a parent, teacher or other trusted adult. Instead, children will be invited to give their views in whichever manner the child prefers, this could be via drawings, video presentation, letter writing or play therapy - the possibilities are endless. Courts have been encouraged to get creative with the means by which children communicate their views. Numerous children's charities have applauded this change; noting the courts will now have the opportunity to gain a more honest and nuanced view and in-turn can make a better-informed decision. Once the court has made a decision in relation to contact, residence or other section 11 orders, it will now be obliged to communicate its decision to the child in a way they can understand. The Judge may explain the decision face-to-face, electronically, in writing or they may also request that Child Welfare Reporter to explain the decision. When this was initially proposed, it received backlash from Court of Session Judges who suggested that it would be unworkable due to the volume of orders made; they also cited that the primary responsibility to explain decisions to the child should remain with parents. It has been argued, however, that the outcome of court proceedings often leave children feeling anxious about whether they have said the right thing or how their views may impact a parent. The new legislation intends to give the child the opportunity to hear why a certain decision has been made from a neutral source, in language the child can understand. Section 13 of the Children (Scotland) Act places a legal obligation on Local Authorities to "promote relations with siblings where appropriate". This means that Local Authorities will be required to support and facilitate sibling relationships where children are not able to live together. Children's hearings and Judges will also have a duty to consider contact with siblings and other relevant persons who are not living with the child, when making, changing or continuing compulsory supervision orders. Judges will be required to consider the impact of an order on i) the child's parents in bringing up the child; and ii) the child's important relationships with other people. In addition to this, section 25 of the act grants eligible siblings and relatives the right to participate in a children's hearing when there was previously no such right. This is an important change which aims to give grandparents and siblings more protection. The Children (Scotland) Act 2020 aims to put children and children's views at the heart of the decision-making process; to ensure the fair treatment of children and families by Scotland's civil courts. The 2020 Act gives children in Scotland a level of certainty that their views, and the views of important people in their lives, will be heard and, in-turn valued by the civil courts.

YEAR	POLICY	POLICY OVERVIEW
2021	National Guidance] for Child Protection (2021)	Following the commencement of the provisions of the Children and Young People (Scotland) Act 20141, the Scottish Government published non-statutory National Child Protection Guidance in Scotland in the same year 2, to offer encouragement and support to the changes in procedure and process to ensure readiness for the new duties. The current version of the National Guidance for Child Protection in Scotland was published in May 2014, updating a comprehensive 2010 rewrite of a 1998 version. In 2017 the Child Protection Improvement Programme3 (CPIP) recommended updating aspects of the 2014 Guidance. Subsequently the Government committed in their 2019/20 Programme for Government that revised National Guidance for Child Protection in Scotland will be published to ensure it is consistent with the legislative and policy framework as well as current practice developments. This revision takes full account of policy and legislative developments and reflects thinking across a range of areas. It incorporates our understanding of best practice from various sources, including practitioner and stakeholder experience, inspections, research, and learning from Significant Case Reviews (SCRs). The broad objectives of this revision are to: ▪ ensure children's rights and voices are central to child protection ▪ underline the need to engage with families to offer support and reduce risk of harm ▪ support consistency in understanding about key processes when agencies must work together to prevent and respond to significant harm to reduce unwarranted variation ▪ integrate essential changes in legislation and national Guidance ▪ reference key policy, research and practice developments and sources The intended outcomes of this revision are to: ▪ support a reduction in the incidence of significant harm to children and of child death in Scotland ▪ improve professional inter-agency practice, supervision, management, training and development ▪ promote a shared, rights-based inter-agency ethos and philosophy of care and protection, as experienced by children, families and communities ▪ support a context in which children and young people receive a more consistent approach to care and protection
May 2022	The annual Health checks for people with learning disabilities (Scotland) Directions	The Circular encloses The Annual Health Check for People with Learning Disabilities (Scotland) Directions 2022 ("the Directions"), which provide a duty on Health Boards to provide Annual Health Checks to all people in Scotland aged 16 and over who have learning disabilities, using the Scottish Health Check for Adults with Learning Disabilities.

The Education Contribution

Chapter One: The Process

Given that Margaret's education consisted of pre-school, primary, secondary and further education elements, no one official could lead on all of these dimensions. Data retention rules also mean that there are few available individual records.

However, the Education Steering Group representative produced a high level legislative and policy piece and liaised with relevant colleagues to identify and engage those who had a contribution to offer. They also prepared a paper on ongoing good practice in Inverclyde in relation to children and young people with additional support needs to illustrate what is being achieved today.

We have limited knowledge of her nursery and primary experience. Margaret's mother has described her perspective on this. There is also some psychological services material that provides some insights and these are covered in the Health component of the Review.

Secondary teachers that knew Margaret at Port Glasgow High School were interviewed. They were able to describe the learning environment, Margaret's ability, appearance, personality and behaviours as well as aspects of her upbringing.

The Corporate Director for Education, Communities and Organisational Development was instrumental in initiating contact with the current Chief Executive and Principal of West College to get their support in developing understanding of further education then and now in terms of opportunities and safeguarding.

Although the Principal had no direct knowledge of Margaret, they lead an Institution which is made up of three predecessor bodies, one of which was James Watt College in Greenock where Margaret undertook a Step Course. As a result, it was possible to interview the Assistant Principal from that time as well as the appropriate Head of School. Further information was obtained from one of the College lecturers who taught Margaret. They each gave their perspective on the purpose and objectives of learning, student welfare, safeguarding expectations then, incidents that would trigger concern and how they would be followed up.

Margaret's College classmates were interviewed who recalled her personality and interests, her contribution to the Course and what the experience had entailed overall.

In addition, an interview took place with the current Assistant Principal (Student Life and Skills) who leads on present day safeguarding policies and who provided the relevant documentation.

The assistance of Police Scotland was also needed to understand its investigation of allegations that Margaret had been raped whilst a student, of which the College was unaware at the time.

What follows concentrates on Margaret's secondary education and beyond as it during this period that her circumstances alter and deteriorate.

Chapter Two: What we Know of School Life

Early years and Primary Education

In contributing her thoughts to the Review, Margaret's mother has made clear that she needed support to manage her from an early age. She recalled that her first known contact with the Social Work Department was to ask for their assistance in securing a nursery place. A place was provided at Barmoss Nursery which would be her first exposure to support, play and informal learning. Margaret's mother's understanding of the benefits of the nursery placement were that she could be prepared to move to primary school by getting to know other children at nursery who would be moving at the same time as her to the same school.

Records from that time have been destroyed. One contributor to the website that Inverclyde Council set up for sharing any knowledge of Margaret recalls that she missed a lot of nursery.

Margaret then attended the local mainstream school which was Slaemuir Primary. She was classed as a child with moderate needs and it is thought likely that if she had been born a decade earlier she would most likely have gone to Glenburn School which was a school specifically for children with learning difficulties.

Although it is no longer available, High School staff think that Margaret already had a Record of Needs at this point. Margaret's mother also believes that her father pushed for there to be such a Record. This would mean that an Educational Psychologist would have been involved. One teacher thinks that there was 'some form of Support Plan' although was unsure how well this would have been shared with staff. Another believes that a Record existing could be largely attributable to her father being very involved in her educational progress and someone who was assertive about ensuring that she was well understood and supported. Other teaching staff commented that some records had been destroyed when Strathclyde Regional Council ceased and was replaced by Inverclyde.

During this period, Margaret attended a variety of health related appointments to better understand challenges she faced, principally obesity and behavioural issues. The former is covered in the Health section of the Report. Its relevance here is that it was an issue for most of her life and may have singled her out.

Secondary Education

Her secondary school was Port Glasgow High School which was a relatively small school with between 500 and 750 pupils at the time she was there. Margaret left at the end of her fourth year in the summer of 1996.

One teacher advised that they had a policy of visiting all the Primary 7 classes prior to them making the transition to secondary school to get to know the children who would be in remedial classes. They would then write up reports about the needs of each child and disseminate these to the staff to ensure that there was a consistent approach to teaching and an atmosphere that promoted understanding and empathy in encouraging young people to be all that they could be. They are clear that they would have visited Margaret's class in 1992 but have no direct memory of seeing her at this time.

Margaret was observed in the various classes which she shared with a range of pupils with from mild to moderate difficulties, pupils with dyslexia, children with hearing impairments and pupils whose second language was English. There was also outside and specialist input. Although they were integrated into a mainstream school, special needs students would have been segregated for these subjects. Remedial classes were half size classes and would have up to fifteen children with a different ability range.

Academically, she had difficulty with reading, numeracy and needed to further develop her social skills. This was a general foundation class for a mixture of youngsters who had significant additional support needs in terms of numeracy and literacy. The class contained 'quite a mixture of students with a number whose behaviour was poor.'

She did not appear to enjoy the subjects on offer e.g. English, Maths, Geography and History and was said to have particularly avoided sport and exercise. It is thought that the latter may have been related to embarrassment in changing in front of others. She drew no attention to herself, have needing considerable encouragement to do her school work.

An exception was that she became the person responsible for the Class Register which involved her collecting and returning it to the Office. This was a task that she loved for which she received a recommendation which was sent home.

One reflection, shared by more than one of Margaret's teachers, was that she may have been happier going

to Glenburn School because 'she would have been a star' academically amongst some of the pupils and there would not have been as many pupils with a high staff/pupil ratio that is not thought to be available today.

Margaret did not progress greatly academically. There was not a huge advance in her reading or writing age. In terms of grades, Margaret was in the bottom section and got a 5 for reading and 6 for writing which is the very bottom end of the scale. In order to get a 6 for writing you needed to be able to write 100 words unaided that largely communicates a thought or an idea on first reading. She would struggle to put pen to paper, constantly sought reassurance and required a lot of prompting to produce that type of work. Her reading and writing age was assessed as being 'about eight years.'

Her writing ability was discussed in Court in an attempt to assess whether Margaret would have been capable of writing a letter to EC and AJ that indicated that she was still alive and well. Margaret was not competent enough to have composed this.

It would have been recommended that Margaret undertake the Step Link Course in College but not necessarily with a view to getting a job. This would have been for her to acquire some daily living skills such as going shopping as she would have always needed a degree of support. Teaching staff would have assisted Margaret with this transition.

The school had good relationships and regular contact with Child Psychology and with Social Work services, usually knowing which young people had Social Work support. One staff member was clear that her work with Social Work colleagues 'did keep people safe'. The staff did not know that there was Social Work involvement with Margaret's family and had not seen a need for this. Only one of the three staff had undertaken annual child care or child protection training.

Two of the three teaching staff were unaware of Margaret's mother although the third had had a brief discussion with Margaret's father where he described his relationship with Margaret's mother as 'acrimonious.' Her grandmother attended a parents' evening in third year with Margaret's father. One teacher indicated that 'there was no sense then that they found her difficult at home.' There was a sense 'they both cared for Margaret and were worried and concerned about her.'

Margaret never mentioned her mother but was never asked about her because they were unaware of Margaret's mother until the trial. She never mentioned staying elsewhere other than with her family.

Margaret let staff know that her dad had died and they understood that her grandmother had died shortly thereafter. After the exams in fourth year the English teacher recalled Margaret coming into school with a younger woman whom she assumed was her mother. She was more animated than usual and advised she was now living with her mother. Margaret was dressed in a pink hooded sweatshirt or jacket; her nails were painted and her hair had been permed.

Teaching staff thought that Margaret would have completed her College course if her father had lived. There was also a belief that, with appropriate support, Margaret 'would have been able to have a productive life' and was capable of living in supported accommodation.

Policy Perspectives

One of the teaching staff still works in a senior role in another educational setting and was able to provide their reflections on how educational policy and practice has evolved.

Back in 1994 they believe that there was not such a clear understanding of the different profiles or types of additional support needs. 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 perceptions about children's finite capacity for learning but our understanding of that has now changed considerably.

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. However, she may have flourished with a different pathway that allowed her to build skills incrementally.

They believe there probably are other Margaret's out there and that parents should be encouraged to fight for resources for their children backed by a professional perspective. Children are placed into nurseries that specialise in Autism Spectrum Disorder type profiles and once children are in that sector they tend to stay there regardless of how their profile develops. In other more deprived areas parents may not know how to fight for these resources and sometimes their children are left behind. For example, a child with a lot of issues may enter mainstream school and the school will do its best to manage challenging behaviour, but a specialist placement would really support the child for a few years before they return to mainstream school. However, because resources are not evenly spread, these specialist placements are taken by youngsters locked into a pathway they may not necessarily need.

It can happen that if a child does not fit a certain type of profile they do not attend that school or unit, rather than considering how best to support that child. What can also happen is that a child with issues will attend mainstream school with a Classroom Assistant allocated to them but they will not engage and in some cases will be excluded.

Another of the staff believed that joined up working could have been better with more information sharing across the disciplines.

Observations/Findings

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

Margaret made limited academic progress in school and 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.

The secondary teaching staff made clear that the learning environment had a strong ethos of kindness from which all the pupils benefitted.

There were some procedures and processes in place for transition from both primary to secondary and from secondary to College and Margaret would have participated these.

Teaching staff 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. There was some general evidence of effective inter-agency working with Social Work and with psychological services although it was thought that there was room for further improvement in terms of joint working.

Chapter Three: What we Know about College Life

College Life

Margaret attended James Watt College Step Course from the summer of 1996, completing all of the first year and leaving before the end of the second one.

The former staff members who were interviewed cannot recall Margaret although it has been possible to speak to two fellow students who do remember her.

The Staff Perspective

The College Principal at the time was recognised as being innovative and very committed to providing opportunities for young people that had additional needs. This meant that there was a dedicated Department known as the Faculty of Special Education Needs which then became the Faculty of Inclusion. The Faculty comprised of three Schools, the one Margaret attended being for young people who had mild or moderate learning difficulties. Whilst there were similar initiatives in other Colleges, these tended to be tied into Health and Social Care Departments, the Faculty of Special Education Needs is said to have regarded itself as being particularly innovative and inclusive.

The majority of students came from mainstream schools although there was a cohort from Glenburn School which was for children with learning difficulties. Part of the requirement for attending the Step Course was that you were able to travel independently. A large number of students who attended the College came from all over the country, some staying in residences which were adapted for their needs. There were Outreach Centres too such as one in Argyll.

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 'good' with their Head of Learning Support always inviting College staff to Future Needs Assessments. Port Glasgow High School was also 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 described 'as a comfort for parents'. Parents were worried their child would be finishing school and they needed some reassurance about their options once it was finished. What was involved in the Step Course would be covered at the Future Needs Assessment meeting.

The Course itself consisted of Scottish Vocational Qualification Units which aimed to develop academic, social, practical and vocational skills, with an emphasis on the latter in the second year. Communications, numeracy, IT and computing were also covered.

Confidence building, skills acquisition and making friendships were core aspirations.

The students were invited to attend a Link Course in March or April as a no obligation trial for them to experience College. It was made clear to prospective students that they had to earn their place and at the point the student was accepted they felt they had really achieved something.

The cohort of first year Step Link students were in the School almost all of that time except for computing until they were well settled in. In second year, they stayed within the School for core skills like communications and numeracy but also spent more time in different areas to try out vocational skills but stayed within their own group. Options included child care, car mechanics, construction, painting and decorating. The School still had responsibility for guidance and links with parents.

In terms of outcome, very few students were ready for employment although a small number would move on to mainstream courses. Some of the young people who attended missed a lot of school through illness and the Course filled in gaps in terms of core skills for these students so they could then move on to other things.

The majority of the students were not ready to leave after two years. The College Bursary Department recognised this and so provided four years of funding. A new course was developed called Transitions so these students went from Step to Transitions for a year. A further course was developed called Careerwise which was about finding jobs, employability and placements. The Bursary Department then decided that one year was insufficient for Careerwise and funded another year. So some students were there for five years, at the end of which many students secured part time or voluntary jobs.

Parents liked the fact they could phone or come into the College to discuss their young person. Some parents regularly phoned or came into the College. Students were also reviewed twice a year and parents were invited to attend these reviews.

Staff would also contact parents if they believed there was an issue with a student. All students had a Personal Learning Support Plan where everything was documented – incidents, phone calls etc. If there had been a disagreement between students that would also be addressed.

Those records no longer exist but were kept as they were audited. Funding was linked to additional support needs – 1 student with additional needs was funded to the amount of 1.8 mainstream students so it was almost double funding. It had to be documented that these students were receiving that extra support.

The Student Perspective

The former students confirmed that they both transitioned to College directly from school and were supported in doing so by visits prior to beginning. They each remembered their first day as concentrating on familiarising themselves with the physical environment and with each other. They also recalled that they were explicitly told that if they ever had any concerns that they were to share these with the staff. This had created a supportive and trusting environment where the students shared difficulties that they had over the course of their studies. They both spoke about kindnesses shown to them by several staff members.

The learning programme was described in some detail, with an acknowledgement that Margaret had particularly enjoyed leisure and recreation. Both students commented that they benefitted from the experience, feeling that they had grown in confidence and had learned to socialise more with peers as well as learning new skills. They both had positive outcomes from their time in James Watt – one being in full time employment and one living an independent life.

They were also consistent in their recall of Margaret as a shy person who stayed in the background and who was reticent about coming forward at times when she was struggling with what was being asked of her academically. She did have a sense of humour and enjoyed laughing and giggling with her peers.

A couple of trips were part of the curriculum which were highlights – to Dunoon and to Holland and Margaret had been on both of these. One student said that she had really come out of herself on these occasions, being visibly more relaxed and outgoing. They also said that Margaret had had a couple of short-term relationships with other students. One was sceptical that these were of a sexual nature and neither was aware that there had been an allegation of rape.

It was also noticed by one that Margaret was tense at the graduation at the end of Year 1 which he thought should be the highlight of the year and remembers her constantly looking over to EC and AJ.

Both students said that she stopped attending in Year 2. One thought this was not unusual as another student had left with their family to live elsewhere. The other had asked staff and was advised that they had tried to ascertain the reasons for the withdrawal but their attempts had come to nothing. Neither of the students saw Margaret again and are both affected by her passing.

College Safeguarding Then and Now

I Interviews took place with both the relevant past and present Assistant Principals responsible for safeguarding which were supplemented by further information from the Head of School in Margaret's time. Access was also given to the current College Safeguarding policies which are presently being revised and updated.

The past Assistant Principal who started at the College in 1985 and retired in 2010 described the College safeguarding policy as just evolving at that stage. Strathclyde Regional Council was abolished at the end of March 1996 and they recalled that some of what had been Strathclyde systems were adopted by Inverclyde including Guidance and Student Support Policy and Practice. Over subsequent years, the Authority developed its own policies and practice.

The arrangements for safeguarding became more formalised, too, when Scottish Government guidance being introduced.

They were clear that there was what they termed a 'vertical escalation process' within the College for any issues – whether they were financial or other. So concerns would go from Lecturer to Senior Lecturer to Head of Section to Head of the Faculty. Referrals to other agencies could be made at any point with any member of staff being able to refer and to escalate concerns immediately. Sometimes referrals would be made externally to the Police. At other times it would be for support for an individual such as Student Counselling.

Key staff were not aware of a rape allegation that Margaret was alleged to have made but

had then withdrawn. Safeguarding at that time was not formalised in the way it is now, but this type of allegation would have been investigated. Conversations would have taken place with the person who made the allegation and anyone else involved. It would then be reported to the Police.

Similarly, if a student left the Course, this would be followed up. Retention levels were very high and it was unusual for a student to leave unless they were moving away. If a student was absent or not attending, even for a day or two, staff would contact their home to ensure everything was fine. Links with the student's parents were really strong linking back to the Future Needs Assessment meetings.

There could be very simple explanations for non-attendance that the College could help to resolve such as transport problems, but if there was no response, then 'there was a limit to what could be done.'

The current Assistant Principal (Student Life and Skills) at West College leads on wellbeing and safeguarding which encompasses a range of individuals including children in care, young carers, children estranged from their families, children from the armed forces and other individuals perceived as vulnerable.

They confirmed that there was no surviving written records relating to Margaret as they would have been destroyed after seven years. Now it is sometimes possible to retrieve digital records after they have been destroyed. They questioned whether General Data Protection Regulations may be an obstacle to receiving the best information about a student prior to starting College as it is possible that key information may not be shared.

Distinctions are made at College between wellbeing and safeguarding with staff being very clear that safeguarding is a priority that is dealt with immediately, whereas wellbeing is a longer term support mechanism. The present policy is based on what was referred to as the 'Yellow Book' i.e. the National Guidance for Child Protection published in 2014. The local College policy was in the process of being reviewed.

The College has a Wellbeing and Safeguarding team which historically consisted of safeguarding volunteers to which wellbeing functions were added three years ago. Three full time equivalent dedicated staff are now employed on fixed term contracts - one based in each of the three campuses – to fulfil these roles. The team has various qualifications linked to mental health and wellbeing and come with different experience including an ex school teacher, someone who worked with the Prince's Trust who worked with vulnerable young people, and someone from a counselling background.

The team meets regularly to discuss casework as it arises and senior managers will chair these when required. Much depends on the perceived complexity of the situation and the duty of care that may emerge. The number of cases and referrals goes on an annual basis to the Learning Teaching Committee to demonstrate the volume of activity the team supports.

It was noted that there can be issues getting an appropriate response from Social Work when referring someone for support. The College sometimes has to be assertive with some local authorities to provide a young person with support as they have a duty of care to ensure that person is safe, particularly if they are vulnerable. Two examples of student homelessness were cited.

Bearing in mind the principal function of further education, collaboration with Health colleagues is not something that happens routinely but would if it were considered to be beneficial to a specific student.

The Police will always respond when asked to do so.

It is made clear from the very beginning that everyone in the organisation has a responsibility for safeguarding and not just one person. Safeguarding is part of the College Induction programme and staff are given constant reminders about it. Staff are also asked to retrain every three years. It is recognised that not everyone comes from a traditional background and staff need to ensure everyone is given the same opportunities.

In addition, there is a Student's Charter which does not use the word 'safeguarding' as the term would not mean anything to a large number of students. The College does encourage students to seek support. All the support that is available is advertised and promoted through the student intranet. Prior to the pandemic there were a lot of leaflets around the support that was available, one of these being a booklet entitled 'It's okay not to be okay'.

All employees of West College, no matter their role, have to complete mandatory safeguarding training. This consists of an online module which takes approximately an hour to complete. The course is managed by the College's Organisational Development team who record who has completed it and remind people to undertake a refresher every three years. All staff in the college are PVG checked.

It is understood that there are boundaries to safeguarding that it would not be appropriate for staff to overstep so College staff do not undertake investigations. They consider the facts that they have been given and decide whether the situation should be passed to Police, Social Work or the person's parents or carers. Whist every effort will be made to respect confidentiality, this will be waived if an individual is considered to be at risk and this is made explicit at the outset. The College would end its involvement when a referral is made to another organisation in that other services are regarded as being better equipped to manage these situations. This process is defined as Listen, Respond, Report.

National College Safeguarding Group

This is managed via the College Development Network and all twenty-six Colleges in Scotland, including West are represented. The group meets six weekly to discuss activity, learning, updates to processes and to share good practice. Guests from other Agencies are also invited to attend to share information.

College Links to the Local Child Protection and Adult Protection Committees

There were no formal links at the beginning of the Review but this has now changed. There are also other examples of collaboration at a strategic level such as representation on the Inverclyde Alliance Board and close working relationships with Community Learning and Development. They were not in receipt of the appropriate Protection Annual Reports which may be beneficial in describing trends that could be taken into account.

The College has been trying to urge Police Scotland to provide a physical presence around campuses as there believe that there are benefits for students to be comfortable around authority figures as this may help with community cohesion and avoiding situations like Margaret disappearing.

Present Policy and Practice in Relation to Rape Allegations, Non-attendance and Contact with Carers

The one occasion it would be different in terms of College response is a rape allegation with the Safeguarding and Wellbeing team in the lead and with all staff having undertaken an eight-week rape crisis training programme led by Rape Crisis Scotland. Original practice was to report the rape allegation to the Police regardless of what the person was looking for. After taking advice from Rape Crisis Scotland, if a student is in that situation they will be asked if they are willing to report it to the Police first. If not, the College puts the person in contact with one of the women's support charities in the area who will support them to report the allegation to the Police. The College will always refer the person to an expert.

Non-attendance also triggers staff intervention as part of a Retention Strategy. There is a process the College undertakes with three different touchpoints for mainstream students. The College would continue to contact the person if they drop out as it has implications for funding or other allowances linked to attendance. For students within the Learner Development Team there is good dialogue with the main points of contact at home. Each student has a Learning Support Plan which has key contacts. Staff within the Learner Development Team would make contact with a person's closest relative or carer to find out why they had not been attending and see if there was any support they could provide. There would be a direct response from that team rather than general retention support. It would be noticed quickly if someone was not attending as classes are small with a maximum of 12 students.

Someone referred to as a carer or who describes themselves as such will be accepted as such without any formal check. Staff would only question this status if they observed the student with the carer and found cause for concern. The effect of this acceptance makes it possible that someone in Margaret's position today would not have their circumstances fully understood or exposed.

Police Investigation of Alleged Rape

When Margaret was found to be missing in October 2017, EC said that she claimed to have been raped by a fellow student on a trip away. This allegation was then extensively investigated by the Police. They found that there was no recorded record of any sexual offence against Margaret. This incident only came to the attention of the Police through statements obtained, during the initial stage of the investigation, from EC and AJ.

Further enquiries conducted with James Watt College failed to provide any further information regarding any incident apart from a student who recalled Margaret saying that she had sex with another student.

A review of medical records also failed to provide any evidence. While this confirmed Margaret's mother's statement that she took her daughter to the GP to enable the contraceptive pill prescribed, the reason for this prescription was recorded as irregular periods and the prescription was never renewed.

They concluded that 'there is no record of why Margaret left College and the statements provided by the adults in her life at that time provide differing versions of events so it is unclear exactly what led Margaret to leave College in 1997. However, the notes within her medical record suggest that something may have happened at College or connected to her College life that caused her to stop attending although we cannot confirm or prove that this is potentially a made up story by EC and AJ to get Margaret under their control and away from others, while still obtaining welfare benefits.'

Chapter Four: Findings

There is sufficient evidence to suggest that Margaret would have been supported by staff in school and in College in transitioning to secondary school and to further education.

Margaret attended a Further Education College recognised for its innovative approach at that time to students with additional support needs where she was offered both academic and pastoral opportunities to develop.

Ex –students and staff alike recall that James Watt College built trust and kindness that enabled students to share and resolve concerns.

Margaret does not appear to have maximised those opportunities, choosing to sit back. She did not progress much academically although she benefitted from socialising with others – particularly on excursions away from home where she was visibly more at ease, brighter and upbeat.

The retrospective rape allegation made by EC was something that College staff were unaware of at the time and it is unlikely, although not conclusively so, that a rape took place. Margaret did have a couple of short lived relationships with two fellow students which were not considered serious by her peers.

Practice in respect of investigating alleged rape in College is now rigorous and robust.

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 recalls asking about her absence and staff saying that they had tried unsuccessfully to contact her.

There has been considerable progress in safeguarding policy, procedures and practice in Scottish Further Education Colleges since Margaret was a student.

Safeguarding procedures in West College are based on National Child Protection Guidance and would benefit from an adult protection perspective and input.

Safeguarding in Inverclyde could be further developed if the College was an active member of both the Child and Adult Protection Committees and progress is ongoing with this.

Anyone presenting as a carer would not be questioned about their status then or now. It would be helpful to add a further check at Registration to ascertain that carers are authentic.

Safeguarding in University is not currently subject to the same checks and balances and this aspect requires further exploration, analysis and action as people with learning disabilities are part of that environment.

Margaret's allegation of rape would be treated very seriously today with staff trained both in their generalist and specialist functions to recognise the sensitivity with which to ensure that appropriate support and investigations take place using external expertise.

Although there is a National Safeguarding Forum with representatives from all Colleges, there are no formal links with Child and Adult Protection Committees. Such collaboration should be explored and scoped.

It needs to be acknowledged that the primary role of Further Education is to educate and develop young people with additional needs to be all that they can be. There is a limit to this activity that must also be recognised as safeguarding is the core duty of other Agencies.

Chapter Five: Good Practice Now – The Inverclyde Offer

For the last decade and more Inverclyde Council has prioritised its work to ensure that its young people achieve positive and sustained post school destinations, the success of which has been recognised nationally. Planning for this starts when pupils enter their Senior Phase within the Curriculum for Excellence and Inverclyde's More Choices, More Chances Team plays a central role in working alongside partners in this area. This work does not cease when young people leave school.

On a weekly basis More Choices More Chances meets with partners from the West College Scotland, Skills Development Scotland and providers such as the Inverclyde Community Development Trust in a forum titled the Inverclyde Offer. As part of the Inverclyde Offer information is held on all young people post school through the sixteen plus Data Hub, which is a portal hosted by Skills Development Scotland that contains information that allows for tracking young people's destinations. In Inverclyde all young people who are sixteen to twenty-four are recorded on the sixteen plus Data Hub and, the rigour with which this information has been gathered has ensured that there are no young people in this age range who are resident in Inverclyde who are not known.

In addition to this the Inverclyde Offer, an Additional Support Need meeting takes place approximately every six weeks to support young people who are care experienced or who have a specific Additional Support Need. Partners involved are More Choices, More Chances, Health and Social Care Partnership and Skills Development Scotland.

Part of the work of the Inverclyde Offer group involves following up with those young people who are not actively known to post-school education, training and employers. Information from the sixteen plus Data Hub is used to target support to young people who are not active. This can involve telephone calls and face to face meetings. If it is not possible to make contact, their information continues to be held and they are followed up periodically and offered support again through the Inverclyde Offer.

Evolution of Legislation and Policy 1978 Onwards

YEAR	TITLE	IMPLICATIONS
1978	Department of Education and Science Special Educational Needs: Report of the Committee of Enquiry into Education and Handicapped Children and Young People (The Warnock Report). London: HMSO.	Introduced the concept of 'special educational needs' which, at the time, was seen as conveying a more positive understanding of children than the previous 'handicap' and deficit based language.
1978	The Education of Children and Young People with Learning Difficulties in Primary and Secondary Schools in Scotland. Scottish Education Department. Edinburgh: HMSO.	The driver for this report came from His Majesty's Inspectorate, who desired a move from a narrow approach, focused on remedial education, into one that encouraged change in classroom practice to meet need.
1980	Education (Scotland) (Act)	Recognised that there was a growing requirement to educate children and young people with Special Educational Needs in mainstream education settings. It thus brought forward the notion of integration over segregation. It also defined Special Educational Need as being brought about where a child or young person has 'greater difficulty in learning than most other children their own age.' It also brought forward the Record of Needs, a legal planning document requiring local authorities to plan for those pupils who were assessed to have pronounced, specific or complex special educational needs which require continuing review.
1994	Effective Provision for Special Educational Needs. Scottish Office Education Department.	This policy document produced by Her Majesty's Inspectors concluded that meeting SEN could not be considered as peripheral to the teaching profession. It had 10 specific recommendations: 1. Teachers must understand the continuum of special needs. 2. They must have effective assessment and identification procedures. 3. All pupils must experience an appropriate curriculum. 4. Local authorities must have forms of provision to meet needs. 5. There should be effective approaches to teaching and learning. 6. Clear goals should be set for pupils with SEN. 7. There should be increased parental involvement. 8. There must be inter-professional cooperation where appropriate. 9. There should be effective management of provision. 10. Young people should be fully involved in decision making processes.
1998	A manual of Good Practice in Meeting Special Educational Needs. Scottish Executive Education Department	Three key areas were focused on: • Working together in partnerships. • Providing an appropriate curriculum. • Involving young people in the decision making process. The manual also asked education establishments to engage in self-evaluation processes in these areas by asking the questions: • How are you doing? • How do you know? • What are you going to do now?
2000	Standards in Scotland's Schools (Act)	This legislation reflected the growing movement away from segregation and integration and towards inclusion. It placed a legal duty on local authorities to provide mainstream education for pupils except in certain circumstances. It, therefore, brought forward the philosophy of presumption of mainstream.
2001	For Scotland's Children (SEED)	Recommended that there should be a consistent assessment framework across Scotland's schools.
2003	Moving Forward! Additional Support for Learning (SEED)	For the first time there was a challenge to the term Special Educational Need with the promotion of Additional Support Need. This is a wider definition of need and recognises that it can be transitory and fluid and/or based on social and emotional factors.

YEAR	TITLE	IMPLICATIONS
2004	Education (Additional Support for Learning (Scotland) (Act)	This legislation ended the notion of Special Educational Need and the Record of Needs planning framework. It brought forward the term additional support needs and widened the understanding to involve any additional need. Furthermore, it replaced the Record of Needs with the Coordinated Support Plan, a legal planning document with strict criteria, recognising the increasing need for cooperation across agencies to plan for pupils. It also placed into law legal expectations around transition for all pupils who have additional support needs: • Early years-primary – 6-month period of transition. • Primary-secondary – 12-month period of transition. • Secondary-post school – 12-month period of transition. The legislation also created means by which disputes between parents and local authorities could be resolved in law by bringing forward the Additional Support Needs Tribunal system.
2009	Education (Additional Support for Learning (Scotland) (Act)	The amendment to the previous Act concentrated on the status of looked after children and young people. In particular it brought forward the notion that all looked after children are presumed to have additional support needs. In practical terms this means that it is the duty of local authorities to test all looked after pupils against the criteria for a Coordinated Support Plan on a yearly basis.
2014	Children and Young People (Scotland) (Act)	This Act is not specifically related to education matters. It places emphasis on ensuring that Ministers are making progress in relation to their commitment to reporting on their response to the implementation of the United Nations Commission on the Rights of the Child. It places the Getting it Right for Every Child assessment and planning framework at the centre of integrated public service work. It also brought into law the role of the Named Person ensuring that all children and young people have a single point in order to access supports.

Children and Families Contribution

The Process

Children and Families staff adopted the same approach to the Significant Case Review as other participating agencies with Margaret and her family having contact with this service between 1995 and 1998. This part of the review begins with a resume of what can be gleaned from Social Work records and is followed by a short listing of steps that could have been taken. This is followed by a summary of relevant child care policy and practice dating back to prior to Margaret's birth to the present. It concludes with some thoughts on how Margaret, or someone with similar needs to Margaret, could be supported today.

Section A: Social Work Records

It should be noted that at this time there was a generic Duty system in place which consisted of a rota of both front line and managerial operational staff from across Social Work covering Port Glasgow, Strone and Greenock Central. The conversations below took place under this system where members of the public would make or would be offered appointments.

Extract of Social Work Records

There is no paper casefile in relation to Margaret as a child. The case file was destroyed on 20.10.03 as per recording and retention policy. The case file is where details of assessments, intervention, reports and correspondence would have been contained. There are limited electronic records migrated from SWIS electronic system to SWIFT in 1999. Electronic records contained limited contact note information at that period and information pertaining to Margaret was sourced by cross referencing with electronic records for her mother and grandparents.

18.10.95 Social Work SWIFT record on Margaret's file

[Redacted]

18.10.95 Visit to Social Work office

[Redacted]

20.10.95 From Margaret's mother's SWIFT record. Margaret's mother and Margaret attended the Social Work Office with another individual

[Redacted]

25.10.95

Margaret's father died.

26.10.95 Margaret's mother's SWIFT record

[Redacted]

23.11.95 Margaret's mother and another individual attend the Social Work office

[Redacted]

24.11.95 SWIFT record – Margaret allocated to Social Worker

08.03.96	Paper case file transferred to Social Worker, Special Needs in Ravenscraig Hospital, and recorded on SWIFT as case closed

[Redacted]

03.02.97	Margaret's mother at Social Work office seeking referral to Children with Special Needs Team

[Redacted]

14.03.97	Margaret Fleming's SWIFT record

[Redacted]

20.10.1998	Margaret Fleming's SWIFT record

[Redacted]

22.10.1998	Margaret's SWIFT record

[Redacted]

02.11.98	

[Redacted]

05.11.1997	Standby referral received logged in Margaret's paternal grandmother's SWIFT record

[Redacted]

Missed Opportunities

October 1995 - In the lead up to Margaret's father's death and just beyond both Margaret and her mother had contact via the Duty Social Work arrangements in place at the time. During the second of these two contacts Margaret alleges that her mother hit her in the kidneys, and she was fearful she would do this again. 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 workers thinking regarding thresholds being met for formal investigation under Child Protection Procedures and/or a referral to the Children's Reporter under Section 32 of the Social Work (Scotland) Act 1968 on the grounds that Margaret was out with parental control. What the records do show 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. The subsequent available records would also suggest that Margaret's mother viewed this intervention as being impactful in improving relations with her daughter.

February 1997 –Margaret's mother has further contact with Duty Social Work. She advises relations with her daughter have deteriorated and is requesting the previous social worker is reallocated to the family to offer support. Although Margaret is 16 years of age and unaware of her mother seeking such assistance, there is agreement by Social Work to further assess the family's circumstances. This however does not happen, and available records provide no insight into why this was the case. Had this been followed through this could have provided an opportunity to clarify Margaret's living arrangements and any support needed.

October 1998 – Margaret's mother is again in contact with Duty Social Work. On this occasion she advises her daughter, who is now 17 years of age, is living out with the family home. Margaret's mother states she is being prevented from seeing Margaret by the couple (EC and AJ) she is living with and is concerned about Margaret's wellbeing. Margaret's mother also alleges being assaulted by EC and more recently Margaret's paternal grandfather allegedly being assaulted by the same individual and money and bankbooks being removed from the paternal grandfather's home. With Margaret's mother's agreement these details are passed to a named officer at the Police Female and Child Unit. Given Margaret's age, the allegations of assaults and possible theft this action would have been reflective of practice at the time. The investigative framework offered by the Adult Support and Protection Act 2007 was not yet available to staff and was indeed some years away from being passed into statute. Notably, this referral was closed off without Social Work establishing the outcome of the Police investigation. Whilst efforts were made by Social Work in this regard, they had been unsuccessful. This combined with no further contact from Margaret's relatives informed the decision to close the referral. Had this been followed up more definitively this could have offered independent clarity on Margaret's living arrangements and any supports needed.

Section D: Consider the Policy, practice, and Expectations of that time and whether these were met at that time:

Policy and legislation in Scotland for protecting children is complex. This reflects the complexity of children's lives and because throughout their childhood their lives involve interaction with a range of different agencies and systems.

DATE	POLICY CHANGE	WHAT DID THE POLICY/GUIDANCE STATE?	POLICY, PRACTICE, EXPECTATIONS MET?
1968	Social Work (Scotland) Act 1968	The Social Work (Scotland) Act 1968 provides the primary legislative framework for Social Work intervention in Scotland. This legislation created the duty under section 12 to promote 'social welfare' Under the 1968 Social Work (Scotland) Act, local authority Social Work departments replaced children, welfare, Health and probation committees. Local authorities also took over responsibility for investigating child abuse.	The allegation made by Margaret that her mother had hit her should have been investigated under this Act. 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 workers thinking regarding thresholds being met for formal investigation under Child Protection Procedures and/or a referral to the Children's Reporter under Section 32 of the Social Work (Scotland) Act 1968 on the grounds that Margaret was out with parental control. What the records do show is that the workers assessed tensions in the mother and daughter relationship and sought to address this though the allocation of a social worker which both agreed to. The subsequent available records would also suggest that Margaret's mother viewed this intervention as being impactful in improving relations with her daughter.
1974	Inquiry into the death of Maria Caldwell	The inquiry into the death of Maria Caldwell at the hands of her stepfather highlighted a serious lack of coordination among services responsible for child welfare. Its report led to the development of Area Child Protection Committees in England and Wales, which coordinate local efforts to safeguard children at risk.	The inquiry highlighted the need for continuous recording of accumulation of concerns by all involved agencies. Without the case file and limited electronic records is difficult to assess communication and engagement.
1980-83	Divisional Review Committees	These produced their own child protection procedures. These are no longer available having been cited for destruction in an office move.	Not possible to say as we do not have access to these. However, they are likely to be precursors of the document below
1983-1996	Strathclyde Regional Council `Child Abuse: The Manual of Procedures for staff'		Use of this guidance ends a year prior to Margaret attending the Social Work office. However, it is likely that, what replaced it observed many of the same remits.
1991	Establishment of Child Protection Committees within Scotland	Sets the standards for operational response to child protection concerns	There is record of Margaret being spoken with on her own. However, further exploration into allegations and record of enquiry would have been helpful to understand extent of the assessment.
1995	Children (Scotland) Act 1995	The Children (Scotland) Act 1995 marks a significant stage in the development of legislation on the care of children in Scotland. It is centred on the needs of children and their families and defines both parental responsibilities and rights in relation to children. It sets out the duties and powers available to public authorities to support children and their families and to intervene when the child's welfare requires it.	This was enacted but unlikely to have been fully implemented within Inverclyde in 1997. However, its definition of parental responsibilities is relevant to the choices and decisions for Margaret's care and also her view about where and with whom she wanted to live. Margaret had been spoken with directly but current records do not allow for full exploration of this.
1996-2000	Inverclyde Policies and guidance	These no longer exist as the Social Work digest was deleted in a move to new offices	While we no longer have access to this guidance it is likely to have been based on the previous Strathclyde model.
1988 onwards			Margaret would by now have reached adulthood therefore the policies listed below, and the associated expectations would not been relevant to her situation. They are included for completeness and to highlight how policy in this area has continued to evolve.

DATE	POLICY CHANGE	WHAT DID THE POLICY/GUIDANCE STATE?	POLICY, PRACTICE, EXPECTATIONS MET?
1998	Scottish Office: Protecting Children – a shared responsibility.	Guidance on inter-agency cooperation. The principle of inter-agency co-operation is now embedded in children and families Social Work practice via Getting It Right for Every Child.	
Circa 2000	Circa 2000 Glasgow City Council Child Protection Procedures	These procedures introduce chronologies and the premise that accumulative concerns should be recorded on one system. It is thought Inverclyde procedures followed these	
2002	Scottish Executive: It's Everyone's Job to Make Sure I'm Alright	Audit and review of child protection practice across Scotland.	
2003	Inquiry into the death of Caleb Ness	Highlighted the need for more integrated services and better information sharing.	
2003	Scottish Executive, Protecting Children and Young People Framework for standards	The Scottish Executive's Child Protection Reform Programme (2003-2006) resulted in several guidance documents following the Audit and Review (2002).	
2005	Protecting Children and Young People: Child Protection Committees	Established new standards for Child Protection Committees	
2008	Scottish Government: Getting It Right for Every Child National Practice Model	The National Practice model (Wellbeing Wheel, the My World Triangle and the Resilience Matrix), provides a holistic understanding of the child's developmental needs and how these can be met.	
2009	HMIE How well do we protect children	Findings from the first national programme of joint inspections to protect children. This establishes inspection of child protection services. Inverclyde inspections in 2011 summarises children are listened to and respected and are kept safe. 2017 Inspection reported families benefit from joined services which has a positive impact on improving the lives of children and young people. Improvement in how staff assess and respond to risk and need informed the changes to duty service with the establishment of the Request for Assistance Team in 2018.	
2011	Children's Hearing (Scotland) Act	In January 2008, the Scottish Government announced plans to strengthen the Children's Hearings System, which was followed by a nationwide consultation process throughout 2008 and into 2009. The Scottish Government then published the Children's Hearings (Scotland) Bill in 2010. After receiving Royal Assent on 6th January 2011, the new Children's Hearings (Scotland) Act 2011 came into force on Monday 24th June 2013. The most notable change of the new Act was the creation of Children's Hearings Scotland. Led by the National Convener, it has responsibility for recruitment, appointment, monitoring and training of Panel Members, as well as the setting of consistent national standards of practice.	
2012	National Risk Framework to Support the Assessment of Children and Young People www.gov.scot/resource/004/00408604.pdf	Provides an assessment model where there may be child protection concerns. This holistic approach builds on the Getting It Right for Every Child National Practice Model for practitioners to approach the task of risk identification, assessment, analysis and management with confidence and competence.	
2013	How Well do we Protect Children and Meet Their Needs?	Findings from the second national programme of joint inspections of services to protect children 2009-2012	
2013	Private Fostering in Scotland: practice guidance for local authority children's services	Guidance for local authorities in Scotland on how to manage notifications of private fostering. Highlights the vulnerability of children and young people in unknown private fostering arrangements. Children in private fostering arrangements are not deemed looked after children.	

DATE	POLICY CHANGE	WHAT DID THE POLICY/GUIDANCE STATE?	POLICY, PRACTICE, EXPECTATIONS MET?
2014	Scottish Government: National Guidance for Child Protection in Scotland	Provides a national framework for agencies and practitioners at a local level to understand and agree processes for working together to safeguard and promote the wellbeing of children. It also sets out expectations for strategic planning of services to protect children and young people and highlights key responsibilities for services and organisations, both individual and shared. This guidance incorporated the Framework for Standards and Child Protection Committee Guidance.	
2014	A report on the effectiveness of Child Protection Arrangements across Scotland	The Care Inspectorate reported on the effectiveness of adult and child protection arrangements to Scottish Ministers following the inspection year 2013/14.	
2014	Children and Young People (Scotland) Act	The Children and Young People (Scotland) Act 2014 put the United Nations Convention on the Rights of the Child into a Scottish statute for the first time. It encourages Scottish Ministers and public bodies to consider children's rights and requires them to prepare reports on what they are doing to progress children's rights. The Act also gives more powers to the Children and Young People's Commissioner in Scotland. This legislation focuses on the whole child and their journey. The Act shift public services towards early years of child's life and towards early intervention whenever a child or their family need help. The Act introduces the concept of Children's Rights and that the voice of the child should be listened to. Advocacy service introduced in Inverclyde for children.	
2014	Inquiry into the death of Declan Hainey	Recommendations on improved inter-agency working, sharing and review of information.	
2019	2019 Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities	Update to previous guidance. Reinforces the duty of Chief Officers to ensure Child Protection Committees are able to perform their key functions.	
2019	Children Equal Protection from Assault (Scotland) Act 2019	The purpose of this legislation is to bring an end to the physical punishment of children by parents and others caring for or in charge of children by abolishing the common law defence of "reasonable chastisement" The legislation is a step in ending the harm caused by physical chastisement but must be supported by non-stigmatising parenting support and promotion of positive parenting.	
2020	The Independent Care Review: The Promise	Sets out recommendations to ensure that all children in Scotland grow up in a loving environment whether they live with their family or not.	
2021	Scottish Government: National Guidance for Child Protection in Scotland 2021	Significant refresh of the 2014 guidance with best practice examples. Advocates for care and protection measures up to eighteen.	
2021	National Guidance for Child Protection Committees Conducting Learning Reviews	Supports reflection, learning and improvements in systems and practice by reviewing events where children or young people have been harmed, placed at risk of harm, or where effective practice has prevented harm or risk of harm.	
2022	Scottish Government: Getting It Right for Every Child	Refresh of the 2008 approach. Getting It Right for Every Child is embedded in practice of all children who require a child's planning meeting and multi-agency support are supported to do this through education.	

Section E: What would Happen now with an Individual who Presents with Similar Needs to those of Margaret?

Consideration now turns to understanding the improvements in service design and delivery over the years and, how these changes in Children's HSCP Services now may impact on the service offer to Margaret today.

In the present day, we have comprehensive communication and multi-agency working in place for those families and children that may need additional support over and above universal services. The guiding principle for care, support and protection of vulnerable children is that it is 'everyone's job to make sure I am alright'. This National Guidance has now developed to Getting It Right for Every Child and indeed is moving to Getting It Right for Everyone, which considers the whole journey of a person in need of support. Getting It Right for Every Child embodies a number of principals that highlight the importance of children's' rights, wishes and views.

Within Children's Social Work Services, although this is not a universal offer to every individual in the community, the accessibility of additional support and care is co-ordinated and communicated with our partners, children and families and communities. This now is available at the earliest point of care, in the pre-natal offer of support. Now we provide Special Needs in Pregnancy support. This is a co-ordinated, shared, multi-agency support with Health, including Family Nurse Partnership, midwifery, Alcohol and Drug Partnership representatives, thirds sector and local authority partners.

At this point any mother to be, who may have particular vulnerabilities or indeed her partner, has access to additional assessment, care planning and support prior to the birth of their child. This can include early help and intervention, through the Getting It Right for Every Child practice model to Child Protection support. The National Child Protection Guidance 2021 is currently being reviewed and implemented through Inverclyde's Child Protection Committee.

The current Special Needs in Pregnancy also links together with our Parenting Strategy and ensuring community, family and parents have the earliest opportunity for support, either from universal, targeted or specialist services, getting the right help, from the right people at the right time.

As a baby and young child in Inverclyde, the Health and Social Care Partnership (HSCP) has strong links with third sector and local communities and infants have access to universal Health care offer, which includes regular assessment of development, parenting, advice and guidance. Inverclyde Child Poverty Action Group has also provided additionality to vulnerable families, through Homestart further expanding since 2021, providing group support, parenting support and individual emotional and practical support. Furthermore, the HSCP works closely together for routine 27-30 month assessment of development for all young children and have access to referral points for further specialist assessment, care and support for those children who may not be meeting their milestones and understanding why this might be. This provides an early opportunity for parents, carers, and children to access additional services if needed including specialist children's Health services.

For all children, should there be a concern raised within universal services regarding the care, protection, or additional needs support the family and other agencies can now refer directly to Children's Services through the Request for Assistance Team. This Team has been established to ensure early, prompt, and consistent assessment and response to all requests for assistance to Children's Social Work Services. This includes a family, individual or Agency referring a request for further assessment of support for a child considered under s23 of the Children (Scotland) Act 1995, children aged under 18 with disabilities have the right to an assessment of need.

Whether Margaret, today, was considered to meet the additional needs for s23, or if she was a child in need, a request for assistance could be made to Children's Social Work Services. Her circumstances may be initially assessed, and family, child and other agencies involved contacted to determine appropriate advice, guidance and assessment of need and support. She may be allocated a children's Social Worker, or a worker may attend on a consultative basis to a Team Around the Child meeting.

Inverclyde HSCP currently offers specialist support for children with additional needs with a dedicated Additional Support Needs Team, who link closely with families, education, third sector and Health colleagues. Disability and additional support needs would include children and young people who have a formal diagnosis of a learning disability and/or children and young people who have diagnosis that could

broadly be termed neuro-diverse. Children and young people involved with Children's Social Work Services in relation to their disability may have an additional package of support, this could include access to recreational services, community or residential short breaks and may also include payments made under the principles of self-directed support.

This ensures a collegiate response to assessment and need of the child and access to Additional Needs Social Worker, resources, and close links with psychological services within education and community young people and adolescent mental Health team, through Specialist Children's Health services.

Getting It Right for Every Child offers a national practice model for service provision to children in Scotland. The United Nations Convention on the Rights of the Child is used as a framework to ensure that we consider children's rights, whenever we take decisions, and to help provide every child with a good start in life and a safe, Healthy, and happy childhood. This forms the basis of Getting It Right for Every Child. This is a tiered approach involving universal services through to complex multi-agency packages of support that remain child-centred, rights respecting and highlights the importance of the views of the child.

Integral to service support in the present, is Team Around the Child meetings. This may be supported by a professional that knows the child and family. When this is an allocated case to Children's Social Work Services, the lead professional and co-ordinator of the meeting, may be the Social Worker. Together, with the child, family and other partners, the Child's Plan would be designed to identify the needs of the child and what needs to happen to improve their particular outcomes. For Margaret, today, this may include education and Health support, family relationship, and parenting support.

Furthermore, Inverclyde HSCP and Children's Services are developing their offer to families at the point of Request for Assistance by building closer links with our third sector partners, including Children 1st and improving family group decision making support. This is a strength-based support service, keeping the child and family at the centre and supporting the family to identify and co-create their solutions and build service support to promote the child's needs and improve outcomes.

In Margaret's life-story, after her parents separated, further concerns around care, sleeping arrangements, relationships, or support, could have continued to be addressed through the Team Around the Child support embedded with the principles of Getting It Right for Every Child with a clear referral pathway to Children's Services.

Margaret's main carer was her father and she and her father lived with her grandparents after an incident at their home. When her father was admitted to hospital the Margaret of today may have been referred to Children's Services for additional support and the family could have access to additional support, assessment and service should another family member need to be considered to provide her fulltime care.

This would be assessed through a kinship assessment, which provides further identification of need for care, supervision and service if a child or young person cannot be looked after by the person with parental rights and responsibilities, and a more formal offer and assessment of support is required around who needs to look after the child and what additional service input may be required to meet their needs, to grow up, loved, safe and secure. This would provide a kinship worker to work alongside and support the carers of the child.

Also, if there is not a suitable, safe, and supportive family member to look after the Margaret of today, further consideration would be available in terms of a child becoming looked after and accommodated. Given the Independent Care Review and The Promise to children in Scotland, Margaret's view about where she wanted to live and who she wanted to care for her would be listened too and she would be appropriately involved in decision making around her care.

If her grandparents were unable to care for the Margaret of today, then alternative places may be explored. If Margaret was with her mother, and she was involved with Children's Services at that time, the allocated worker would continue to identify her safe care needs and if her needs could be met with ongoing support on a voluntary basis, or indeed through the Reporter to the Children's Hearing.

When Margaret's father died support may be available to the Margaret of today through Inverclyde's Health and well-being service, including Action for Children which is open to self-referrals and referrals across agencies. Young people have access to trauma informed support, sometimes co-ordinated at school, if that is helpful for them. Specialist Children's Services and some Health practitioners also have additional training in child emotional Health and well-being and can provide additional support. The early help

Hub for emotional Health and well-being is currently available across Inverclyde to signpost children to the right emotional Health and wellbeing support for their needs. Inverclyde HSCP also has close links with community supports to access grief and loss counselling for children and young people.

Today, there is more awareness now of the impact of trauma and adverse childhood experiences. An intervention would likely be more trauma informed. This may now provide a more holistic approach to bereavement and loss. Furthermore, Inverclyde HSPC and partners, have a Trauma Informed Champion to support training, learning and implementation of trauma-aware to trauma informed practice, with the aspiration to become trauma responsive. This will continue to grow and develop across practitioners, managers and continue to improve our offer to the most vulnerable children and families.

If the Margaret of today made a disclosure that may have indicated an offence or serious risk presented to her care and welfare, Children's Services could consider an Inter-agency Referral Discussion (IRD). As part of the Child Protection procedures, anyone can refer to the Request for Assistance Team and this would be assessed and allocated for ongoing Social Work involvement. When a young person discloses something that may present a significant risk of harm to them or indeed others, an IRD could be considered and within this a joint discussion, with Health, Police and sometimes Education as to next steps, including if a joint interview was required with Police and Social Work services.

Inverclyde is part of the North Strathclyde Partnership of four local authorities and two Police divisions, leading the way in practicing the Scottish Child Interview Model. This is considered best practice with highly trained staff, trauma informed, planned, and supported interviews for child witnesses and those children reporting a possible offence or an event/s of significant harm. Should the Margaret of today be consenting to speak to Police and Social Work, she would also now, be offered recovery work and support from the point of interview. This partnership and multi-agency collaboration continues to promote good communication and information-sharing at the most vulnerable moments through a child's life to provide the support, protection, and care, when they need it.

Through the child protection process, the investigation would identify what was required to meet the child's needs and improve outcomes for the young person, including child protection registration or not. Whichever course of action should there be ongoing Children's Service involvement, this should include regular reviews of the plan, the child's voice and family and partner Agency involvement.

Depending, on the circumstances for children, the offer of support from Children's Services could now be available up to 18, or beyond for some with additional needs and including care experienced young people. If required, young people can continue to access support through the Children's Hearing system until 18.

Margaret was over 16 when she went to live with EC and AJ and apparently did so with her mother's agreement. Parents may have legitimate reasons for involving someone else in caring for their child over an extended period. However, should a young person have capacity to make decisions around where they want to live, but there are significant risks of harmful behaviour, now the young person could still be supported through an Initial Referral Discussion and joint sharing of information as to whether there required further Child Protection investigation. This now includes vulnerable 16 and 17 year olds and in some cases further risk assessment through Inverclyde's HSCP care and risk management process soon to be implemented.

Also, if there is a reported concern to Children's Services regarding risk of exploitation, there is now a Vulnerable Young Persons pathway that involves a multi-agency discussion, led by Police and partners and involves consideration of the harmful behaviour, harmful others, potential concerns and what actions need to be taken to reduce the risk of exploitation. This will continue to develop through a contextual safeguarding lens.

In Inverclyde now, there is More Choice More Chances service, offering opportunities for young people and adults with learning disabilities, offering support to young people between 14 and 19 years who are either in their senior phase at school or who are in transition from school to post school learning. This may now support a young person, like Margaret, with additional support needs to ensure a transition plan between school and college. Young people with a learning disability would have a supported transition to the Community Learning Disability Team (CLDT) with the transition completed by the end of their final year at school. Young people with physical disabilities, or neuro-diverse conditions can also be supported into an adult service best fitting their needs. This can include the Assessment and Care Management Team or the

Community Mental Health Team. There is ongoing service improvement and tests of change relating to the transitions of young people who have a diagnosed Autistic Spectrum Disorder but do not have a learning disability.

Where such a young person was also supported by Children's Services, the transition plan would further embrace collaborative planning and reduce the risk of leaving education without additional support around the young person or family. A young person now would much more likely be eligible and accessible for services under Children Service within the HSCP up to 18 and in some circumstances beyond and inclusive of care experienced young people to 26, which identifies the importance of decisions, choices and views being heard beyond the legal age of being an Adult to identify with a young person's journey and their individual needs.

Adult Social Work Services

Chapter One: The Process

Referrals made to Adult Social Work Services were reviewed as was guidance that was in place at the time. Consideration was given as to whether there were any potential missed opportunities, as well as the learning and changes made since Margaret was alive. This section also explains how these changes might impact on an individual who presents with similar needs to those of Margaret today.

In addition, there is a comprehensive summary, in chronological order, of the legislative framework and the Inverclyde policies and guidance. Consideration is given to how these were applied and whether or not they were met in Margaret's case. There is detail on what Social Work would do now to support an individual who presents with similar needs to those of Margaret, and descriptions of both the individual processes and the broader measures in place to support vulnerable service users.

Potential Missed Opportunity - Referral to Adult Services by Children's Services at Transition

Margaret could have been considered for transfer or referral to Adult Services at the time of her transition from School to College and to adult life. There is no record that this was considered at the time of the closure of the case file.

Given the lack of a formal diagnosis for Margaret, and that she had capacity to take decisions around her life, it could be that she would not have met the threshold for Adult Learning Disability Services or another adult service when she left school. There is a potential missed opportunity to have a discussion around potential support Margaret could have received, especially in light of the later referral to Psychological services by the GP.

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.

In Margaret's case, a College place was identified with some additional support (the Step Link Course), but no Social Work support was requested to facilitate that.

Further work on Transitions guidance is planned and there is currently transitions training out to tender to specialist Third Sector organisations such as the Scottish Transitions Forum. Inverclyde is signed up to the Principles of Good Transitions guidance and is carrying out a test of change around this process.

Potential Missed Opportunity - Referrals made to Adult Social Work Services 2012

18.06.2012 - 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 and only saw AJ. The request was for a Community Care assessment for Margaret as they were concerned for her in general, about living conditions and the condition of house. The Department for Work and Pensions Visiting Officer did not tell AJ that this request to Social Work was being made. This was not flagged at the time by the referrer as either an adult protection or an adult welfare concern.

11.09.2012 – A staff member closed the referral dated 18/06/2012 on this day. This was on the basis the Department for Work and Pension Visiting Officer did not obtain Margaret's permission to make a referral to Social Work and therefore no further action could be taken.

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 the Department for Work and Pensions Visiting Officer. There was, however, a practice in the service at the time where consent to proceed was highlighted as key. Today we always seek consent and agreement in the first instance. Failing this, consideration is given as to whether there are safeguarding or welfare issues that would mean contact would be made in a measured and proportionate way. This would mean efforts being made to contact the individual who was subject of the referral.

It is clear that 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. These were the 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 outwith 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 would likely have been made in June 2012 if procedures and legislation had been followed.

Social Work visit to trigger referral to Police Scotland 2016

The changes in practice can be evidenced by the response to the 28.10.2016 referral when the 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 was available at the time.

The same staff member 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 and to engage with AJ, the staff member instigated the referral to Police Scotland. This made clear the significant concern for Margaret's Health and wellbeing and resulted in a visit by Police Scotland that day.

Practice, Policy and expectations of the time met - Social Work visit, assessment and analysis of all available information triggers the referral to Police Scotland

Chapter Two: Learning and Changes Made

Duty Service

A review of the Adult Duty System was undertaken in 2014 following the appointment of an experienced Service Manager who was a qualified Social Worker. This was incorporated as part of an internal review which looked to 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 clear focus to roles, remit and responsibility.

In context of the Significant Case Review there are two key elements;

- There was a comprehensive revision of guidance and management of the Duty System to bring it into line with common practice around Scotland. 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 the volume of referrals meant delay in any response. The designation of a Duty Social Worker meant a fair distribution of these tasks across the workforce allowing for screening action and escalation to the Duty Team Leader for an appropriate decision and action. This resulted in all staff working to their role and remit and 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.

This freed up the Community Learning Disability Team to focus on adults with a learning disability concerns and welfare. This was implemented in 2015 with the proviso that Assessment and Care Management would support on Adult Welfare concerns.

Following on from the revision to the Duty System, 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. Access 1st was developed to reduce the number of points of access to the Health and Social Care Partnership for members of the public, stakeholders and partners.

Inverclyde Access 1st is the single point of contact for Adult Support and Protection Referrals and Welfare Concerns. The Adult Support and Protection procedure for the processing of referrals and concerns was reviewed. Access 1st staff screen, triage and direct Adult Support and Protection referrals to the appropriate Officer (and their Team Leader) in order for the correct decision to be made. This means progressing under Adult Support and Protection where the criteria for an adult at risk of harm is met or, where not, as to how will be progressed under the auspices of other legislation. Each Assessment Team or service has a Duty System with direct access to Council Officers.

Access 1st operates an open referral policy and encourages other professionals or members of the public with concerns over the welfare and safety of an adult to contact the service. Access 1st covers all referrals to Health & Community Care. A full review of the implementation in 2020 identified the key benefits of having a bespoke Referral Service for both service users, 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 resources or can be provided with the appropriate advice to maintain their independence. As a single point of contact, Access 1st has created stronger links with Community based services to support service users, their carers and relatives.

Access 1st has provided referrals to Home 1st (Hospitals discharge) and Health and Community Care Services as well as partner agencies. Referrals from this pathway provide consistent information, making it easier to determine priority for allocations. The performance review demonstrates that 77% of referrals were screened and completed within 0 to 3 days in line with service specification. Access 1st took over the screening of adult welfare concerns in April 2019. This resulted in an 80% reduction of the number of referrals going to Assessment and Care Management.

In addition to Assessment and Care Management and Homecare services, Access 1st received and processed 4121 NHS Greater Glasgow and Clyde acute hospital discharge referrals for patients living in Inverclyde and an additional 513 referrals were out of area discharges.

Review of all referrals across Adult community care services suggest 20,000 individual contacts across a 12-month period. Some of these will be duplicate referrals going to different services and some repeated about the same individual. Channelling through on Access 1st contact point 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'.

Quality Assurance Framework for Adult Support and Protection

The Quality Assurance Framework for Adult Support and Protection) was reviewed under the governance of the Adult Support and Protection Quality and Policy Sub Group of the Adult Protection Committee. A programme of Self-Evaluation is in place to determine how effective the Authority are at fulfilling respective legislative duties and functions 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 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 has implemented a supervision policy for staff in 2015 and updated in 2018. It is for all staff and focusses on supporting staff to make safe and evidenced based decisions. This is a generic supervision policy for Social Work Service staff in the Health and Social Care Partnership. It has been developed with a view to achieving high level outcomes through an outcome focussed framework. It sets a minimum standard of professional development that promotes consistency, giving opportunity for each service to individualise their strategic goals and plans.

Supervision within Inverclyde HSCP is based on the following principles:

- Supervision should be centred on achieving better outcomes for service users and carers
- Supervision should promote and evidence accountable practice by supporting staff to reflect on, analyse and evaluate their practice
- Supervision should establish clear practice roles and responsibilities to manage the emotional impact of their work
- Supervision should build capacity for development and improvement

Margaret would not have met the threshold for Adult Learning Disability service or another adult service at the time when she left school. 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. In Margaret's case, a College place was identified with some additional support (the Step Link Course), but no Social Work support was requested to facilitate that. Further work on Transitions guidance is planned and there is currently Transitions training out to tender to specialist Third Sector organisations such as the Scottish Transitions Forum. Inverclyde is signed up to the Principles of Good Transitions guidance and is carrying out a test of change around this process.

The Scottish Government has decided to make annual Health Checks available to all adults affected by learning disability, a piece of work that will be supported by Inverclyde Community Learning Disability Service in identifying eligible adults and informing them of this right. Where adults are not known to the service or their diagnosis is unclear, there are arrangements for consultation and initial visits being carried out jointly between the Learning Disability service and Assessment and Care Management teams.

Section B: Consider the Policy, Practice, and Expectations of that Time and Whether these were Met at that Time

DATE	LEGISLATION / MARGARET CASE SCENARIO	WHAT DID THE LEGISLATION STATE?	LEGISLATION, PRACTICE, EXPECTATIONS MET?
It is believed that Section 12 came into force on 17 November 1969	Social Work (Scotland) Act 1968 In response to the request of the Department for Work and Pensions Visiting Officer a visit to Margaret could have been undertaken on the basis of the Local Authority's duty of care to her and to ascertain her views and consent. Decision made not to progress referral in 2012 on basis of no consent.	Section 12 contains a general duty to promote social welfare by making available advice, guidance and assistance to those in need. As there are only two case notes on SWIFT from 2012, there is no evidence if further discussion took place or efforts to obtain information or contact Margaret were made.	No for 18/6/2012
Came into force 1993	National Health Service and Community Care Act 1990 The request of the Department for Work and Pensions Visiting Officer was for a Community Care assessment for Margaret as were concerned for her in general and about living conditions and condition of house Decision made not to progress referral in 2012 on basis of not having Margaret's consent.	Section 47 obliges local authorities to carry out a needs assessment if someone appears to need community care services, or if they had disabilities. However, in urgent situations, local authorities have the discretion to provide services before undertaking an assessment. Concern referrals should be discussed with the Team Leader on duty. People referred to Social Work are not always seen – some background checks would be made on the electronic system (SWIFT) and phone contact made first. Situations where a home visit would be expected would be in cases of Adult Protection concerns, or if there were a family or placement breakdown or request for admission to a care home. If the main presenting need was a Health issue, Social Work staff may request a Health visit.	No for 18/6/2012
This legislation did not come into force until after Margaret died. It is believed that Sections of the Act came into force in stages between 2 April 2001 and 1 October 2003.	Adults with Incapacity (Scotland) Act 2000 An adult for the purpose of this act is someone over the age of 16. Prior to this legislation being introduced, it is understood that the most similar predecessors were the legal appointments of curator bonis, Tutor-Dative, Tutor-At-Law and Guardianship under the Mental Health (Scotland) Act 1984.	Act defines Capacity and puts in place measures that can be utilised on application to Sheriff court to safeguard individuals Welfare and Financial Guardianship.	Not applicable during Margaret's life

DATE	LEGISLATION / MARGARET CASE SCENARIO	WHAT DID THE LEGISLATION STATE?	LEGISLATION, PRACTICE, EXPECTATIONS MET?
Human Rights Act 1998	Human rights is a subject devolved to Scotland by the Scotland Act 1998. The Scottish Parliament also has competence to observe and implement international human rights treaties. We work within that legal framework. In Scotland, civil and political rights are protected by provisions in the Scotland Act 1998. These rights come from the European Convention on Human Rights (ECHR).	Public authorities must follow the Human Rights Act in everything they do. They must respect and protect your human rights when they make individual decisions about you. They must also follow the Human Rights Act when they plan services and make policies.	General legislation that covers Actions or actions by omission that were detrimental to Margaret's Human Rights Was this over applied in 2012 - the right to life the right to respect for private and family life?
Came into force October 2008	The Adult Support and Protection (Scotland) Act 2007 Accompanying Code of Practice 2007/Revised 2014/ Revised 2022 Department for Work and Pensions Visiting Officer (18/6/12) and Department for Work and Pension Practice Nurse (28/10/2016) both had available to them detailed information that raised concern with regard to Margaret as to her safety and wellbeing and in respect of living conditions within the house and the condition of the property. Margaret had not been seen. Referral to SW in June 2012 was made by telephone and referrer asked for a community care assessment. Phone call was not followed up by written referral which would be expected if an ASP concern. Decision made not to progress referral in 2012 on basis of no consent. Decision made to progress referral in 2016	The Act is designed to protect those adults who are unable to safeguard their own interests and are at risk of harm because they are affected by: disability, mental disorder, illness, physical or mental infirmity. Harm means all harm including self-harm and neglect. Referred to as the three-point criteria or test (all three parts must be satisfied). For Part 1 of the Act, measures include placing a duty on councils to make the necessary inquiries and investigations to establish whether or not further action is required to stop or prevent harm occurring and a requirement for specified public bodies to co-operate with local councils and each other about adult protection investigations. Police are contacted where there is concern that an offence may have been committed. The inquiry stage of the Adult Protection Policy, Practice Standards and Operational Procedure is about gathering all known and relevant information in order for a decision to be made regarding what further action is required. This can under the auspices of the Act or under the auspices of other legislation, policy and procedure where the decision based on the application of principles of the Act and evaluation of all available information is that this will fulfil the object of the intervention. Information can come from a variety of sources.	**No** for 18.6.2012 There were no further inquiries made by Social Work in response to the referral with the Department for Work and Pensions Visiting Officer and other agencies, professionals and services that potentially Margaret could have been known to in order to inform defensible decision making and the recording of such. The decision and the recording of this was not timeous. **YES** for 28/10/2016 Expectations were met for Adult Support and Protection in terms of policy, procedural and practice expectations by all Social Work and Health and Social care Partnership staff involved. Inquiries/information gathering undertaken on this day informed decision making and rational for the decision to contact the Police regarding concerns identified and Margaret not being seen.

Section C: Current and Future Margaret

This section details how many of the improvements, changes and learning implemented would be applied if Margaret were to be referred today and as a current user of services.

Current Margaret

Operational Teams

- Role of Access 1st – This team screen, triage and direct referrals. Where there are Adult Support and Protection concerns they direct referrals to the appropriate Officer (and their Team Leader) in order for the correct decision to be made.
- Access 1st is supported by the Assessment Teams Council Officers who take on Adult Support and Protection and Adult Welfare concerns.
- Role of Health and Social Care Partnership Community Learning Disability Team and services for people with a learning disability – on a multi-professional basis would assess and identify the needs of an adult with learning disability referred. If the diagnosis or referral criteria were unclear, the Community Learning Disability Team would carry out a screening visit, or visit jointly, with staff from the Assessment and Care Management team to establish information.
- As necessary, and supported by partner agencies, Social Work staff operate within a statutory framework designed to support and protect adults at risk of harm such as the:
- Adult with Incapacity (Scotland) Act 2000;
- Mental Health (Care & Treatment) (Scotland) Act 2003;
- Adult Support and Protection (Scotland) Act 2007.

Processes, Systems and Documentation

- Electronic Information Management System with a specific module for Adult Support and Protection in respect of case recording and pathway outcomes recorded for each stage of the process that can be completed where required within the individual case record.
- Existing Adult Support and Protection reporting templates have been revised as part of continuous improvement to better evidence assessment, analysis, risk assessment, decision making and recording across all stages.
- Electronic Filing System in place with specific section for Adult Support and Protection documents. Reports in respect of adults referred or known under the auspices of Adult Support and Protection are readily accessible across operational Social Work teams with adult protection responsibilities. All Adult Support and Protection templates for each document type are available within the system to allow Social Work staff to type directly into the system with right template in the right place.
- Multi- Agency Chronologies held on the CIVICA system so can be accessed and added to.

Consultation and Feedback

- Public Engagement /Service User and Carer consultation and evaluation
- Complaints Process

Provision of Independent Advice

- Advocacy Services Circles Advocacy, Your Voice.

Public Information

- Inverclyde Council Website Professional pages and access to relevant documentation and procedures.
- Access to Public information and where to contact when concerned for an adult: Adult Support and Protection Videos Inverclyde You Tube, Inverclyde Council Adult Support and Protection specific webpages for public information including range of public information leaflets. All leaflets and videos developed in conjunction with focus groups comprising of members of the community who have experience of being an adult at risk, been a carer for/ family member of an adult who has been an adult at risk or are interested and supportive of ensuring that vulnerable adults are safe and supported.
- Dedicated Margaret Fleming website / referral processes, management information systems.

Section D: Legislation Timeline

Because this Significant Case Review may require to consider a period spanning almost thirty-six years, for ease of reference, this document details legal obligations relating to adults and children (who meet specific legal criteria) which may be relevant to consider. This list may not be exhaustive.

Depending on the legal obligation being looked at, the age of the service user at the date in question and circumstances at that time would determine whether the statutory provision being looked at was applicable.

Adult Support and Protection (Scotland) Act 2007

This legislation did not come into force until after Margaret is believed to have died, although the agencies working with her did not suspect that she had died until late October 2016 at the earliest.

Had she been alive, she would have been over 16 when the Act came into force.

Social Work (Scotland) Act 1968

Section 12 - This contains a general duty to promote social welfare by making available advice, guidance and assistance to those in need. It is believed that Section 12 came into force on 17 November 1969, and was amended on 12 December 1996, 11 August 1998, 1 March, 2000 and 1 July 2002.

Section 12A - This contains a duty to make a formal assessment of needs of people appearing to require community care services. This came into force on 1 April 1993, and was amended on 1 April 1996, 1 September 2002, 1 April 2015, and 1 April 2018. Relevant to Section 12A is the **Social Care (Self-Directed Support) (Scotland) Act 2013** which contains obligations to provide options to people in need of care and support. It is understood that sections of this act came into force between 11 January 2013 and 1 April 2014.

Chronically Sick and Disabled Person's Act 1970

In terms of this legislation, where it appears to the local authority that a disabled person in their area requires specific services which are detailed in the Act, it has a duty to provide these. It is believed that sections of this Act came into force between 29 August 1970 and 1972. Only some of the provisions apply to Scotland.

Adults with Incapacity (Scotland) Act 2000

This legislation is not believed to have come into force until after Margaret died. It is believed that sections of the Act came into force in stages between 2 April 2001 and 1 October 2003. An adult for the purpose of this Act is someone over the age of 16.

Prior to this legislation being introduced, the most similar predecessors were the legal appointments of curator bonis, Tutor-Dative, Tutor-At-Law and Guardianship under the Mental Health (Scotland) Act 1984.

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

It is believed that sections of this Act came into force between 1 July 2003 and 1 May 2006. The legislation which this replaced was the Mental Health (Scotland) Act 1984, which came into force on 30 September 1984. The most similar legislation in force prior to then was the Mental Health (Scotland) Act 1960, which was amended by the Mental Health (Amendment) (Scotland) Act 1983.

Housing (Scotland) Act 1987

This contains a legal duty to provide housing and has particular duties to people who are homeless. It is believed that the Act came into force on 15 August 1987.

Protection of Vulnerable Groups (Scotland) Act 2007

Sections of this Act came into force between 18 April 2007 and 28 February 2011.

Children (Scotland) Act 1995

It is believed that this came into force between 1 November 1995 and 1 April 1997. It is believed that the most relevant sections would be Sections 17, 22, 23, 24, 25, 52 and 53, all of which came into force on 1 April 1997.

Section 17 was amended on 28 September 2009 and 24 June 2013. Section 22 was amended on 6 April 2003, 27 October 2008 and 29 April 2013. Section 23 was amended on 1 September 2002, 5 October 2005 and 1 April 2018. Section 24 was amended on 1 September 2002, then repealed on 1 April 2018. Section 52 was amended on 28 October 2004, 27 January 2010, and repealed on 24 June 2013. Section 53 was amended on 1 April 2013, then repealed on 24 June 2013.

Prior to 1 April 1997, the provisions applicable to children would have been contained within the Social Work (Scotland) Act 1968. It is believed that the most relevant sections would have been likely to have been Sections 12, 12A (detailed above), 15, 16, 17 and 18. Some of that Act is not yet in force, although it is believed that sections of this act came into force between 1 April 1969 and 17 November 1974. Sections 15 to 18 came into force on 19 November 1969. Sections 16 and 18 were amended on 25 September 1991.

National Assistance Act 1948

Section 29 of the National Assistance Act 1948 commenced on July 5, 1948. This Section was repealed by Part 1 of Schedule 9 to the Social Work (Scotland) Act 1968. It is not believed to have been applicable to Margaret given that she was not born until November 1980.

Section 47 of the NA Act 1948 was repealed, by paragraph 1 of Schedule 2 to the Adult Support and Protection (Scotland) Act 2007, on 29 October 2008. This Section covered the removal to suitable premises of persons in need of care and attention.

The Police contribution

Chapter One: Incidents and Outcomes

When it became clear that Margaret's whereabouts were unknown, this led to a comprehensive Police investigation which culminated in the trial and successful prosecution of EC and AJ.

The Police, like all other Agency partners, have co-operated fully with the Review by offering senior representatives to sit on the Steering Group and by committing to the Appreciative Inquiry approach.

They have also enabled access to critical documentation, negotiated access to Margaret's mother and provided their perspective on the one relevant incident in which they were involved in 1997.

The Senior Investigating Officer in the missing person and murder investigation, gave a presentation to the Steering Group at the outset and has made themself available to the External Independent Reviewer prior to the Review being published in order to revisit what has become known and to offer thoughts on maximising learning and change.

Chapter Two: An Incident

The Police involvement In Margaret's life prior to this focuses on one incident which took place on 26th November 1997, the only formal record of which is an Initial Crime Report.

In this, AJ states that Margaret's mother came to Seacroft and was in 'an uncontrollable fit of rage and that she attacked EC, who tried to restrain her.' She is said to have been swearing and 'making accusations against EC.' When he was interviewed, he confirmed AJ's account.

Margaret was interviewed too and made clear that 'she is perfectly happy living at Seacroft with EC and AJ and does not wish to return to her mother's house or to communicate with her in any way.'

Margaret's mother differs in her recall saying that her first contact with the Police during her daughter's lifetime was when she reported to them that she had been assaulted by EC. Margaret's mother states that the catalyst for the visit was that she had received a letter purporting to be from Margaret in which she was saying she did not want to be with her. Margaret's mother alleged that when she had visited Seacroft, EC had thrown her against a wardrobe, hitting her head. He had then pushed her over a chair before he had spat on her. She accepts that she did not behave well when challenged in this way and that she attempted to retaliate to some extent.

When she left she went directly to a friend's house. She said her friend had since died. It was upon his insistence that he called the Police on her behalf. In addition to reporting this assault, she asked that the Police check with Margaret if she was alright and said that she had asked them to speak with her daughter on her own. She was worried that if EC could do this to her as to what he could do to Margaret. She confirmed this was the first time she had seen any violence exhibited by him.

Margaret's mother alleges that she was barred from visiting Seacroft after this, having previously welcomed the support that was offered there, and that presents she sent to Margaret via others were also rejected by EC.

The Police chronology indicates that EC had summoned Margaret's mother. She said EC was interested in her/their financial situation. She said EC was 'pumping' Margaret for information on Margaret's mother's financial position as to what benefits and other monies they had. Discussion at the trial would also indicate that this may have been the case and that the purpose was to discuss Margaret's benefits.

Chapter Three: The Outcome

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 view of this is that it was 'their word against mine.'

The officers who visited are now retired, were interviewed as part of the murder investigation and have 'very little memory' of what took place.

The Police indicate that 'from the time of the incident to the investigation being concluded was about six weeks which [would be considered] reasonable although that would depend on the complexity of the enquiry, the investigating officers' other commitments and witness availability', none of which are documented in the existing records.

Chapter Four: Practice Today

If the same circumstances presented today, the Police expect that there would be multi-agency discussions as to Margaret's suitability to be interviewed by the Police, a Concern Report recorded which would document Margaret's vulnerabilities and this would be shared with partner agencies to discuss and make decisions to support Margaret's welfare.

Chapter Five: Findings

The Police make clear that they consider their assessment and intervention in relation to the incident to be proportionate, timely and appropriate in terms of practice at that time. This is yet another pivotal moment when Margaret's situation was accepted at face value. Given there was no crime that could be pursued, and that the Police role was not principally about safeguarding as we would now understand this, this reflects the attitudes that prevailed then. A referral to Social Work given the circumstances may have revealed concerns that could have been acted on and ultimately protected Margaret from harm.

REMEMBER MY NAME

A SIGNIFICANT CASE REVIEW INTO THE LIFE OF

MARGARET FLEMING

MARGARET'S ENDURING VOICE