# REMEMBER MY NAME

A SIGNIFICANT CASE REVIEW INTO THE LIFE OF

**MARGARET FLEMING**

EXECUTIVE SUMMARY

This report was prepared by independent reviewer,
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# EXECUTIVE SUMMARY

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# Executive Summary

## Context and Approach

The expectations of what a conventional Significant Case Review should contain are fulfilled in Parts 1-3 of the full Report with Part 4, the chronology adding substance. They focus on understanding the circumstances of Margaret's death and some systemic issues as well as service review and development. However, Margaret's situation was unique in that it was nearly seventeen years before anyone realised that she was missing - a discovery that resulted in those she lived with being convicted of her murder. So this Review has gone further and extended its remit as described below to reflect the fact that it is unlike any other.

The time lapse meant that key people had died in the intervening years. Documentation retention policy meant that many records pertaining to Margaret's life had long since been destroyed. Significant changes have taken place in national and local policy that impact on how individuals, similar to Margaret in needs and wishes, are now supported and protected.

Equally, there was a willingness and a determination to find out as much as possible about the circumstances of Margaret's life and death.

For these reasons, Inverclyde Chief Officers Group and the local Child and Adult Protection Committees approved the Significant Case Review Steering Group and the External Independent Reviewer adopting a broad Appreciative Inquiry approach as the means of fulfilling agreed Terms of Reference.

Appreciative Inquiry is not an easy option, but one which requires all the key Agencies to invest in individual and collective in-depth analysis of documents as well as policy, procedures and processes and to openly and honestly assess practice, recognise potential missed opportunities, what has changed and what is still required. Everyone is held to account and poor practice is called out when it is found. Colleagues in the Department for Work and Pensions, Education, Health, Children and Families, Adult Care and the Police all agreed to work in this way.

The role of the External Independent Reviewer was to undertake research into policy and practice, to conduct extensive interviews with key individuals and to collaborate with the Agencies in delivering a Report with clear findings and recommendations. Considerable thought was given to honouring Margaret's memory and creating a legacy. This led to the Reviewer gaining the views of approximately 100 people with learning disabilities and carers on what life is like in Scotland today through a series of extended workshops.

The Report is a culmination of these collective efforts. It is not a beginning where the Reviewer recommends future action. It is the embodiment of honest, sometimes painful reflection, where there has been holding to account and acceptance of shortcomings as well as commitment to ongoing practice improvements. In fairness, there is evidence of good practice, some of which has come about in response to Margaret's death.

The hope is to retrieve something positive from a uniquely tragic death. There is no doubt that Inverclyde residents were deeply affected by what happened to Margaret in their community. This Report acknowledges this and the wider impact on the whole of Scotland and beyond. It asks difficult questions about how we support and protect the marginalised and the role of all citizens to contribute as we move forward. It is a clarion call to us all.

## Report Layout and Versions

The full Report consists of several parts:

**Part 1:** Context, Methodology, Margaret's Life

**Part 2:** The Policy Landscape - National and Local

**Part 3:** Findings, Changes since and Recommendations

**Part 4:** The Chronology

It is recognised that different readers will have different requirements. For some, the Executive Summary may be sufficient. For those who would welcome a deeper understanding, but who may not require to immerse themselves in the entire Report, the Findings and Recommendations Part can be read independently of the rest as it summarises the background and main considerations. There is substantial additional content. The work book from each agencies submission will be published on the website to demonstrate the breadth of the work undertaken. A summary of feedback from people with learning disabilities will also be published on the website, and played a significant role in helping us understand what needs to change.

## Who was Margaret?

What follows is a more complete portrayal of Margaret than what was offered during the trial or through associated media coverage. She was not the severely disabled and non-functioning adult described in the application for funding made to the Department for Work and Pensions by Avril Jones (henceforth referred to as AJ). The purpose of this section is to correct these false perceptions, to be her voice, and to convey who she was and where she was at different points in her life. The Findings and Recommendations sections will focus on the service delivery aspects.

Margaret was an only child who was born around four weeks early in November 1980, her parents had been married for several years before her birth and they stayed together for her sake before divorcing some years later. Her mother has indicated that she struggled to bond with her daughter and liked her 'well enough' until she became physically aggressive between the ages of three and seven. Her father is said to have questioned paternity initially but began and sustained a much more active interest in her from the age of four when her additional needs became apparent to him.

Margaret was not formally diagnosed as having a learning disability but was treated as having additional needs throughout her life. A suspicion that she had Sotos syndrome was disregarded in childhood but this continued to appear in her records and was partly the basis for her receiving benefits.

Records of her early development are sometimes contradictory, indicating that she had difficulties and at other times saying her development was within a normal range. She was larger than her chronological age range with obesity being investigated which led to hospital admissions and weight reductions which were not maintained on discharge.

Both parents worked, her father retraining as a lawyer, so there were sufficient finances within the household.

Social Work services arranged a nursery placement at Margaret's mother's request to improve the ability to communicate and to socialise with others.

Both primary and secondary education were in mainstream schools. It was her father who pushed for her to be in the mainstream and who sought to understand her condition and her ability to learn. Some Education staff thought that Margaret's father was bringing up Margaret alone and have suggested that it may have been preferable for her to be in specialist provision because she could have been at the top of the class. This may have motivated her more and given her more confidence. Learning was limited, much was repeated and progress was slow. There was also a sense that Margaret could be unkempt and had minor hygiene issues.

She also attended a Step Link course in College which she did not complete. Fellow students remember her as enjoying the time she spent there which gave

her new experiences including trips away. She was regarded as being funny and up for a laugh.

In terms of personality and behaviour, those who knew her agree that she tended to blend into the background but could also be sullen. She was seen as likeable but could also be needy and unmotivated. She may have been subjected to what has been described as some low-level bullying. She had few friends. Some recall rare outbursts of anger which could be physical, whilst others recall her anger being borne out of frustration, particularly after her father's death. Within it all, she could be reasoned with.

Margaret was two when her mother first filed for divorce on the grounds of her father's unreasonable behaviour. This application was withdrawn with the couple ultimately divorcing in 1993. Her father had custody and her mother had access. She continued to see Margaret throughout this period although the relationship with her ex-husband continued to be strained. Margaret's father was engaged at the time of his death and Margaret appears to have had a good relationship with his fiancée and her extended family.

Margaret and her father moved in with her paternal grandparents when they became homeless due to a fire/explosion in their home. Her paternal grandparents were very fond of her, although Margaret said that she did and did not want to be with them at different points in her life.

Margaret's father was not in the best of health but his death was relatively sudden. This brought her mother more actively back in the picture and she sought Social Work support. Eddie Cairney (henceforth referred to as EC) and AJ offered her support too and Margaret spent more frequent and longer periods with them until she moved on a full time and permanent basis. Margaret had come to know them as friends of her father who ran a local hotel which she and her father frequented. Margaret's mother indicated that she had only met them once before Margaret's father's death and was initially grateful for their assistance. The relationship soured with allegations being made by Margaret's mother that EC had attacked her. Margaret's father's fiancée also indicated that she had been treated aggressively when she visited to try and maintain a relationship with Margaret. The outcome was that both women reluctantly withdrew. Margaret's mother did so when Margaret indicated that she wanted to stay with EC and AJ. Margaret's father's fiancée did so having been advised that she had no enforceable rights.

AJ became the Appointee in respect of Margaret's benefits. Her medical records were not transferred. By now Margaret was totally isolated and invisible. It is thought that she died late in 1999.

# Findings

## Introduction

The scale of change in national policy and practice since Margaret was alive makes what existed then unrecognisable in many respects. Each Agency provides their own in-depth analysis of what these changes are, some of which are summarised below.

The Children (Scotland) Act 1995 was ground-breaking and centred on the needs of children and families, setting out parental responsibilities and those of public authorities. Reorganisation of local government from 1996 onwards created organisational churn for several years to come which was compounded by the computerisation and migration of handwritten documents.

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

Agencies acknowledge that there are aspects of its practice that fell short. There continued to be missed opportunities after Margaret had died but before this became known to the authorities. The Agencies have also accepted that there are elements of performance that can be improved and have been progressing those aspects on an ongoing basis. As with many other Reviews, there is clear evidence of inter- agency communication breakdowns. Collectively they accept that inter- agency, multi- disciplinary information sharing, assessment, delivery and evaluation can and should be progressed further.

## Overarching Findings

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

Had Margaret's father lived, it is highly unlikely that his daughter would have died.

Margaret was invisible at the time of her death. She was gradually and systematically removed from her world little by little and step by step.

EC and AJ exploited Margaret, the primary motivation being financial gain. They also abused Margaret and were found guilty of her murder.

Margaret's right to choose where she lived and the status of EC and AJ in relation to her is complex. There can be no absolute certainty when she moved in with them on a full time and permanent basis. If it was before she was sixteen, then her mother could be viewed as having agreed to a private fostering arrangement. Such direct or explicit permission was never given. The major concerns arise when she is seventeen and she makes clear to her mother and the Police that she wanted to stay with EC and AJ. Whether this was an authentic choice or whether she was coerced can never be fully known.

When EC and AJ assumed 'carer' status, this went unchallenged. In the case of the Department for Work and Pensions, AJ's status was accepted within their policy and procedures at that time. In the case of one of the GPs, their status was accepted positively in that when he saw Margaret when she lived with them she was slim, having had weight management issues throughout her life.

Margaret was observed by individuals who visited Seacroft with tubing on her arms, duct tape on a wrist and calling in distress from a bedroom window. Explanations were variously offered by EC and AJ that Margaret needed to be prevented from skin picking to that she was being punished. The individuals concerned failed to report the harm.

The impact of Margaret's death continues. Whilst her mother has adjusted to some degree with the passage of time, she still grieves for her adult child and the relationship that they have not had - including the prospect of having been a grandmother.

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

Professionals who knew Margaret have been impacted. Some found the trials acutely challenging, citing the lack of any follow up from the Courts system. Others continue to question what they could have done differently and carry that with them in their everyday lives. Yet others have chosen to address shortcomings that they became aware of to mitigate the risks of any reoccurrence. Their dedication is evidenced in ongoing policy and practice developments directed at further improving the lives of clients with learning disabilities living in Inverclyde today.

Citizens of Inverclyde are affected too and are in disbelief that this could happen in their community. Some of those living in Inverkip, where Margaret lived latterly, need to understand what took place and have committed to being part of positive change going forward.

## Findings Relating to the Agencies

The Department for Work and Pensions continued to provide benefits for over a sixteen year period without seeing Margaret. In doing so, they largely followed their stated policies and procedures. This stark fact is difficult to comprehend and accept.

They accepted that Margaret was too scared to see them on several occasions. The Department for Work and Pensions did consider Margaret's medical evidence in accepting good cause and also carried out a home visit based on her continued non-attendance. It was they who made the referral to Social Work.

The Department for Work and Pensions accepted a diagnosis of Sotos syndrome from the GP which had been disregarded in her childhood. Information from GPs in respect of claims was largely accepted at that time.

Margaret almost gets lost in Health services overall as she does not have any complex issues but it is likely that her exposure to adverse childhood experiences impacted on her health and wellbeing, including her obesity, developmental and behavioural issues.

No Health professional ever raised any child protection concerns and no other Agency contacted Health to raise any concerns or to get any further information.

Whilst her mother is clear that Margaret had a learning disability, there is no evidence of a formal diagnosis being made with the exception of a single reference in 1999 by the GP to a Psychologist. The lack of a definitive diagnosis overall may have impacted on Margaret's access to appropriate clinical pathways and signposting to relevant supports.

In terms of the medical practice that she attended for the majority of her life, it is clear that the GPs played a key role in addressing routine health concerns.

Margaret's weight was a lifelong issue yet assessments and subsequent plans to address these were rarely followed and did not result in any meaningful change.

She attended Accident and Emergency on five known occasions between 1988 and 1994 which were not regarded as unusual or concerning at those times.

There is also some acknowledgement within a range of medical files of psychological issues and reference to trauma but these are spread out and so are not collated in a way that may have signalled concern.

Margaret had a Record of Needs and was subject to regular reviews and made limited progress in school. Her transition from Primary to Secondary and from Secondary to College was actively and positively managed within Education but transition planning did not extend to ascertaining the views and participation of other Agencies.

Although her attainment was again limited in College, there is a sense that she enjoyed her time there and was becoming more independent. EC made a retrospective allegation that Margaret has been raped at College which was investigated and no evidence found to substantiate this. Her departure from College was noted and staff are confident that standard practice would have been followed with contact being made to establish reasons for this. A student who was on the same Course confirmed that this follow up did take place as he had missed Margaret and had asked about her.

In late 1995, in the lead up to Margaret's father's death and just beyond it, support was sought by the paternal grandparents' Home Help on their behalf as Margaret has been aggressive towards them. Margaret's mother became involved and Social Work interviews take place in which Margaret alleged that

her mother had hit her in the kidneys. While 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 the thresholds being met under Child Protection procedures and/or a referral could and should have been made to the Children's Reporter under Section 32 of the Social Work (Scotland) Act 1968 on the grounds that Margaret was out of control and whether her mother had caused her harm. What is apparent from the records is that the workers assessed tensions in the mother and daughter relationship and sought to address this through the allocation of a social worker which both agreed to.

In February 1997 Margaret's mother asked for her case to be reopened as her daughter's behaviour had deteriorated. No assessment or allocation appears to have taken place.

The final referral prior to Margaret's death was made in October 1998 by her mother who alleged that she had been assaulted by EC in November 1997 when she had gone to see her daughter and was no longer allowed to see her. She was concerned for her daughter's welfare. The workers involved referred the matter to the Female and Child Unit at Greenock Police Station as they were already dealing with allegations that Margaret's paternal grandfather was being exploited by EC. Some limited efforts were made by Social Work to follow up the referral and the case was closed. Again Margaret's situation could have been referred to the Children's Reporter for consideration under Section 32 of the Social Work (Scotland) Act 1968. As Margaret is a month away from her eighteenth birthday, this may not have been considered appropriate, depending on whether the earlier suggested referral had been reported and acted upon.

In terms of Adult Social Work provision, the Department for Work and Pensions made a referral in June 2012 having paid a home visit and were concerned about the state of the house and that they were unable to see Margaret. The Social Work team are clear that the referral did not explicitly flag up an adult protection or an adult welfare concern. The First Line Manager (Social Work) closed the referral in September having taken no action on the basis that Margaret's permission to refer had not been obtained. Whilst this inaction made no material difference as Margaret had already been dead for several years, it was possible to have inquired under the Adult Support and Protection (Scotland) Act 2007 without Margaret's permission.

Police involvement centred on Margaret's mother's allegation of being assaulted by EC and not being allowed to see her daughter. When they investigated Margaret was viewed as a potential witness and dismissed as being 'obviously mentally handicapped' and that she was 'perfectly happy living at Seacroft'. Margaret's needs and safety were not considered when they should have been.

# Recommendations

## An Inverclyde Implementation Group

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

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

## A National Audit

What happened in Inverclyde could happen in any part of Scotland and so it is recommended that the work undertaken, findings and recommendations are widely disseminated to improve understanding and to instigate necessary changes. When the Borders case was reported in the early 2000s, an audit of each local authority's practice was sought by national Inspection agencies. Much has improved in the intervening years in terms of inspection and continuous improvement but an overarching and specific audit in relation to this unique Report may be valuable in preventing future harm.

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

## Putting Appreciative Inquiry Principles to the Forefront

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

## Diagnosis of Learning Disability

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

## Learning the Lessons from Workflow and Communication Breakdowns

It has been suggested that failings, in part, were attributable to the Duty system of the past, given that it was generic in nature and consisted of a rota involving both front line and managerial staff. So there was no specific Children and Families immediate point of contact. There needed to be a clearer definition of roles and responsibilities in terms of allocation to a social worker. However, the Social Worker's intervention was successful in that she supported both Margaret and her mother, which Margaret's mother acknowledged.

Child care practitioners also indicated that Margaret was over sixteen in two instances and could legitimately have been seen by adult care colleagues. In such circumstances universal services would have been able to make such a referral to adult services.

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

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

Although there have been major positive changes since then, the fundamental errors of failure to evidence whether thresholds are met for further scrutiny within both Child Protection and Children's Reporter frameworks along with poor communication and ineffective follow up could still apply today. It is therefore, recommended that all local authorities consider these failings and ensure that they have steps in place to mitigate the risk of any repetition.

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

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

Some members of society do not report harm when they see evidence of this. Services cannot respond if they are not advised that abuse may be happening.

In updating of the Act the Scottish Government should therefore consider making the failure to report suspected or known harm an offence.

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

## Scrutiny and Developing Learning

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

## The Voice of Families

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

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

## Expanding the Scottish Government Health Checks National Rollout

The Scottish Government should consider the expansion of the annual Health Check for adults with learning disabilities to ensure that no shows should trigger an alert and a subsequent investigation. Inverclyde Community Learning Disability Service is already supporting this by identifying eligible adults and informing them of this right.

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

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

## Transitions

It is recommended that the learning from this review about what constitutes good, multi-disciplinary transitions is shared with those who are currently taking the Disabled Children and Young People (Transitions to Adulthood) (Scotland) Bill through the Scottish Parliament.

## Further and Higher Education Recommendations

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

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

West College should have a Further Education representative on the Inverclyde Adult Protection Committee (which has already been arranged) and all Adult Protection Committees should review their membership to ensure this coverage.

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

## The Benefits System

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

## Information Sharing, Communication and the Place of Interpretation

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

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

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

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

Information sharing across the agencies has improved but could be further strengthened. What is less developed and similar today to Margaret's experience is the communication, relationship and recording between School Health, Education and GPs. Health

services are reliant on other services to let them know about broader concerns. It would have been helpful and relevant to record some of the things described in terms of Margaret's needs in her Health record to allow Health services to understand and triangulate any contact with her. Going forward, there should be strong working relationships between Education and GPs for all children, but in particular those with a learning difficulty, learning disability and other vulnerabilities. Understandings gained through the assessment undertaken by Education should be reflected in the Health records.

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

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

## Mapping and Enhancing Local Support Services

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

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

## Recommendations about Inverclyde as a Community

There is a palpable sorrow and disbelief in Inverclyde about what happened to Margaret and the potential positive power of this needs to be recognised through encouraging citizens to see and understand that they have an active role in preventing further deaths. There needs to be a campaign which encourages societal participation in calling out potential harm that is not vigilante in nature but about being a watchful eye and a supporter of those who may need protection.

The residents of Inverkip have been particularly affected and should be offered a specific session on the Significant Case Review and its findings and recommendations.

A Remembrance event should be held in Inverclyde which should be open to everyone in the community and everyone who has contributed to this Review to acknowledge Margaret's life and to commit to actively seeking to protect others who are alive today in a way that respects their human rights.

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