Significant Case Review on Behalf of Ms L

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Protecting People in Dundee

Contents

Foreword

As Independent Chair of the Dundee Adult Support and Protection Committee, I very much welcome the opportunity for learning and development that receipt of this Significant Case Review report, prepared on behalf of Ms L, has provided. This is a complex and tragic case review and our thoughts continue to be with the family of Ms L who clearly loved and supported their family member during difficult and challenging circumstances.

Ms L had a complex history of domestic abuse, homelessness, substance use, mental health issues, chronic physical health issues and isolation from family/friends. She had a young child who was cared for by her family due to her circumstances. She was also targeted by drug gangs and was subject to various forms of exploitation. In addition, Ms L had experienced racial abuse by neighbours and associates.

Whilst there is no evidence that any one action would have changed the tragic outcome for Ms L, better communication and co-ordination across agencies may have helped to support her more effectively with her complex needs. There are examples of good practice identified in the case review, with third sector agencies developing trusting relationships and showing resilience and perseverance to engage Ms L. However, it has also identified a number of areas for improvement. In the three years since Ms L was supported by services a range of work has progressed in many of the areas highlighted within recommendations. As well as presenting the findings from the case review, this report provides information about some of the most significant changes that have already been made in relation to each recommendation (with further detail provided in Section 6). The report also contains information about some of the further improvement actions that will be undertaken and be closely monitored by the Adult Support and Protection Committee and Chief Officers Group. Progress will be reported to the Adult Support and Protection Committee at least every six months. We recognise that full implementation of these actions is required to improve our protecting people arrangements for adults at risk, women affected by gender-based violence and people who use drugs and alcohol into the future.

In the interests of transparency every effort has been made to disclose as much of the Significant Case Review as is lawfully possible. However, all personal information which is disclosed must be shared lawfully and in accordance with the UK General Data Protection Regulations (UK GDPR) and the Data Protection Act 2018 (DPA). For this reason, details such as names, dates of birth and other personal identifiers have not been included in this report. In addition, other personal information has been redacted as disclosure of this information cannot be justified in law. This means that even though some of the withheld information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot be disclosed because the relevant conditions under data protection legislation have not been met.

The process of redacting this Significant Case Review involved careful consideration of:

- The need for transparency and the overall purpose of the review in identifying learning.
- The provisions of the UK GDPR and the DPA and the statutory bases for sharing information.
- The public interest in disclosure, and in particular the public interest in ensuring that the relevant agencies work together effectively in assessing risks and acting where necessary to manage those risk and protect adults.
- Whether information is special category (sensitive) personal data (for example, because it is information about a person's physical or mental health) and whether inclusion in the review complies with data protection legislation.

The full report of the Significant Case Review follows but with certain text redacted for the reasons set out above. Any redactions are clearly marked. Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions.

Elaine Torrance
Independent Chair
Dundee Adult Support and Protection Committee

1. Introduction

1.1 Aims of the Significant Case Review

1.1.1
The terms of reference of the Significant Case Review were endorsed by the Dundee Adult Support and Protection Committee and agreed by Dundee Chief Officers Group. This Significant Case Review has been conducted with regard to the Adult Support and Protection (Scotland) Act 2007 and with reference to the Tayside Multi-agency Guidance for Adult Support and Protection (updated 2019), the Dundee City Protecting People Significant Case Review Protocol (2018) and the Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (2019). The anticipated outcomes are to:

- Identify areas of good practice that should be developed and replicated in adult support and protection work and wider protecting people, work.
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults at risk of significant harm.
- Identify any actions required by the Dundee Adult Support and Protection Committee or other Dundee Protecting People Committees/Partnerships to promote learning to support and improve systems and practice.
- To determine whether, and if so, what changes in practice are necessary to ensure opportunities are not missed to prevent avoidable tragedies.

1.2 Terms of Reference

1.2.1
The terms of reference posed five specific research questions and the full Terms of Reference are included within **Appendix 1**.

1. In respect of Ms L, to what extent did services hear the voice of the adult?

2. To what extent were pathways of care and transitions of care person centred?

3. Was there a systemic and holistic approach to identification and management of risk?

4. To what extent was there evidence of cultural competence in the context of safeguarding?

5. How did leadership and management oversight support practice in this case?

1.3 Timeframe

1.3.1
The scope of the Significant Case Review covers the period from December 2018 (Ms L moves to Scotland and the start of a significant period of escalation in behaviour/ risk/illness) until October 2020. However, prior to this, a number of agencies did have contact and interaction with Ms L, which the review has given consideration to.

1.3.2
The review team critically analysed all relevant agency records and this informed the development of a detailed chronology as part of the Significant Case Review along with a series of meetings with staff. This helped the reviewers establish a timeline for key events and identify key episodes requiring more in-depth analysis and has facilitated a rounded view of events and practice. The reviewers have been careful to consider the responses in the context of work and inter-agency work at the time of the occurrences and explore what has changed since.

1.4 Methodology

1.4.1
The SCR is conducted in accordance with the Terms of Reference (Appendix 1) and the governance arrangements set out in the Dundee City Protecting People Significant Case Review Protocol (2018).

1.4.2
Part 1 of the NHS Tayside Morbidity and Mortality review process was completed at the time of Ms L's death and at that point, physical health concerns were indicated. The reviewers have considered this review.

1.5 Lead Reviewers

1.5.1
Grace Gilling is the Chief Nurse, Public Protection within NHS Tayside with a 34-year career within NHS Tayside with broad experience as a practitioner and Senior Manager in Mental Health services and adult protection. Grace has experience of undertaking reviews with a particular focus on maximising opportunities for learning and improvement.

1.5.2
At the time of the review, Andrew Beckett was a Lead Officer with the Protecting People Strategic Support Team in Dundee. He has over twenty-five years' experience as a qualified social worker with both children and adults as a practitioner, manager and in senior strategic roles. Andrew has experience in supporting and undertaking investigations and reviews of both an individual and thematic nature.

1.5.3
External scrutiny and support was provided by Mr Ewen West, Independent Chair of Angus Adult Support and Protection Committee. Ewen has been the Independent Chair of Angus Adult Support and Protection Committee for over five years and in this time has overseen the process and implementation of two Significant Case Reviews. He has used this experience to provide some critical but constructive comment to the Lead Reviewers of this report and to the wider Case Review Group to ensure that all key issues have been addressed and responded to.

1.5.4
The reviewers were also supported by a Case Review Group which comprised of individuals with subject matter expertise in key areas such as housing and violence against women, along with contributions from services in the local authority area In England who provided services and supports to Ms L prior to her move to Scotland.

1.6 Views of the Family

1.6.1
Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking case reviews. Dundee Adult Support and Protection Committee are grateful for the involvement of members of Ms L's family who have contributed a great deal to this review.

1.6.2
Three main issues were identified by the family:

1. The family question Ms L's capacity at different stages throughout the timeline. They question her capacity to keep herself safe and make a clear distinction between having capacity to make decision and being able to safeguard. Ms L's family are of the opinion that, due to a combination of poor mental health and the impact of her diabetes, Ms L was unable to keep herself safe.

2. Involvement of family in the assessment and care planning process, along with the ability to share information with carers and family is an area Ms L's family would like the partnership to reflect on. Ms L was keen to ensure that her family were made aware of her compliance with her anti-psychotic medication but this didn't extend to other aspects of her care. The family feel that, had they been more aware of the situation in Dundee, they may have been able to help more.

3. Support for bereaved people following a tragic death. The family are of the opinion that the information and support they received following Ms L's death was inadequate and ask that consideration be given to identifying a single point of contact within the partnership that may be able to help families in similar circumstances in the future. Following on from this review process, Police Scotland has heard further from family members about their experiences of contact with the service with a view to identifying opportunities for learning and improvement.

2. Mrs L's Story

2.1
Ms L is a 29-year-old woman who was born and brought up in England and moved to a city in Scotland at the beginning of December 2018. This was in an attempt to move away from an ex-partner whom she had been with for two years. Ms L reported this had been an abusive relationship both emotionally and physically. Ms L reported that following quite an aggressive attack around the end of November 2018, she contacted the police in England and was advised that this ex-partner had been charged with a Court date set for April 2019. Ms L lived in a homeless hostel before moving to Scotland.

2.2
Ms L felt she needed to move away from England and she came to Scotland as her ex-partner's mum lived here and had been very supportive of her. Ms L stayed with her briefly before moving into a homeless hostel.

2.3
Ms L had two siblings and reported a good relationship with her mum. Ms L attended primary and secondary school and reported that she enjoyed school however experienced bullying. Ms L was expelled from secondary school due to fighting, having achieved three GCSEs.

2.4
Ms L was employed in data/admin on leaving school however stopped working when she was first diagnosed with Schizophrenia. Since then, Ms L had worked in various odd jobs in telesales however these never lasted longer than a week.

2.5
Ms L denied any abuse in childhood however reported that she has been in multiple abusive relationships as an adult, mostly physical and emotional abuse.

2.6
At the time of her death, Ms L had one child. Ms L's mother looks after them as Ms L was not allowed to stay in the same house as them due to a Special Guardianship Order, which confers Parental Rights.

2.7
Ms L was diagnosed with Paranoid Schizophrenia in 2010 when she was 19 years old. At that time, she experienced persecutory delusions and she was extremely paranoid. Ms L was 'sectioned' and spent a year as an in-patient in a mental health hospital and follow-up in place with a Community Psychiatric Nurse.

2.8
In 2013, Ms L was readmitted to hospital for a period of six months. She had not been taking her medication and again was expressing persecutory delusions. During this admission she was commenced on a depot[1] injection. Ms L had been relatively stable on her depot since then and had not required any further hospital admissions whilst in England.

[1] Slow release form of antipsychotic medication given intramuscularly by injection.

2.9
Ms L had one suicide attempt in May 2018. Ms L had self harmed in the past but this was infrequent and Ms L had not done this in a long time.

2.10
Ms L developed Type 1 diabetes [redacted] Ms L had at least ten hospital admissions with Diabetic Keto-Acidosis (DKA) prior to moving to Scotland.

2.11
Ms L received a two-year custodial prison sentence in 2014-2016 for assaulting a nurse.

2.12
Ms L was made subject to a twelve-month Suspended Sentence Order with a requirement that she complete twenty-five rehabilitation activity requirement days for the offence of Assault Police Constable committed in October 2017. This sentence was imposed by a Magistrate's Court in July 2018. On moving to Scotland, Dundee Community Justice Service agreed to 'caretake' on behalf of the National Probation Service for England & Wales. As there was no equivalent under Scottish Legislation, the case could not be transferred at the point of a move to Scotland.

3. Timeline of Significant Events

3.1
The scope of the Significant Case Review covers the period from Ms L arriving in Scotland in December 2018 until her death in October 2020. A detailed chronology was developed to inform the review and a condensed chronology is offered below to provide an overview. A separate timeline for depot[2] administration is included within Appendix 2.

Date	Event
2010	Ms L is diagnosed with Paranoid Schizophrenia. Detained in hospital.
2013	Ms L is detained in hospital for six months.
2014	Ms L is diagnosed with Type 1 Diabetes [redacted]
2014-2016	Ms L receives a custodial prison sentence for assaulting a nurse.
2018	Magistrates Court disposal.
2018 - December	Ms L self refers to Women's Aid on arrival in Scotland.
	'Caretaking' arrangement agreed between The National Probation Service for England & Wales and Dundee Community Justice Service.
2019 - January	Ms L's ex-partner is arrested for racial abuse towards Ms L and breaching restraining order- bail conditions in place.
	Concerns raised regarding relationships within hostel and risks to Ms L.
2019 - February	Ms L is discussed at MARAC[3] in early February
	Ms L is admitted to acute hospital due to Diabetic Keto-Acidosis.
2019 - April	Ms L is admitted to acute hospital due to Diabetic Keto-Acidosis.
	Call to NHS 24-999 with Hyperglycaemia. Ms L is seen in A&E and discharged home.
	Ms L signs for housing tenancy.
	999 call for vomiting - Capillary Blood Glucose monitoring reading high. Ms L is admitted to acute hospital. Discharged against medical advice two days later.

[2] Slow release form of antipsychotic medication given intramuscularly by injection.
[3] Multi-agency Risk Assessment Case Conference for high risk victims of domestic abuse.

Date	Event
2019 - May	Ms L is admitted to acute hospital with high blood sugars (shares this is a result of not eating due to theft of funds).
	Vulnerable Persons Database (VPD) entry by Police Scotland for Abduction and assault (The National Probation Service for England & Wales service identify this was by ex-partner). VPD shared only with MARAC Independent Advocacy (MIA) service.
	The National Probation Service for England & Wales worker expressing concern regarding further hospital admission as a result of diabetes and missed depot. The National Probation Service for England & Wales service also advise Dundee Community Justice Service that Ms L is in a relationship with ex-partner.
	Home visit identifies concerns around self-neglect and living environment.
2019 - June	Ms L is admitted to acute hospital for vomiting and hyperglycaemia. Discharged against medical advice two days later.
	Ms L is discussed at MARAC (4 months after initial MARAC discussion) and concerns regarding financial exploitation from ex-partner noted.
	Ms L is assessed by Scottish Ambulance Service following psychotic episode.
	Ms L reports theft to Police Scotland.
2019 - July	Women's Aid advise services that Ms L has relocated to England. The National Probation Service for England & Wales service are notified.
	Suspended sentence order ends.
2019 - October	999 Call to Police Scotland regarding recreational drug use. Reduction in GCS and attends A&E. Ms L is admitted to Emergency Department Observation Unit then discharged home.
	Police VPD - Ms L reports assault that occurred two days previously in England. VPD not shared.
2019 - November	Ms L is admitted to acute hospital with high blood sugars.
2019 - December	Ms L is admitted to Mental Health In-patient Ward as a result of paranoia and suicidal thinking. Discharged against medical advice as did not meet criteria for detention.
	Ms L attends GP appointment and discloses she has been assaulted.
2020 - January	Ms L is referred to the Women's Rape and Sexual Abuse Centre Vice Versa Service[4] (service for women who have been sexually exploited),
2020 - February	Ms L attends the Women's Rape and Sexual Abuse Centre and discloses further assault.
	Ms L is admitted to acute hospital due to diabetes and discharged four days later.

[4] Project run by Women's Rape and Sexual Abuse Centre providing support to women exploited in commercial sexually exploitation.

Date	Event
2020 - March	Ms L reports attempted break-in to property and has barricaded door.
2020 - June	Police VPD due to Ms L experiencing threatening behaviour with a racial element. VPD not shared.
	Ms L discloses to the Women's Rape and Sexual Abuse Centre that she has been assaulted by two female neighbours.
	Integrated Substance Misuse Service (now known as Dundee Drug and Alcohol Recovery Services) team highlight cuckooing[5] concerns in late June but no action taken.
2020 - July	Ms L is found unresponsive by passers-by - 999 call and admitted to acute hospital with Diabetic Ketoacidosis. Discharged against medical advice the next day.
	NHS 24 call to 999 as a result of hyperglycaemia. Ms L is admitted to acute hospital and discharged against medical advice.
2020 - August	Police Scotland VPD following contact by NHS staff regarding concerns for Ms L's welfare. VPD not shared.
	Ms L admitted informally to Mental Health Inpatient Ward on and discharged three days later.
	Ms L reports assault and robbery to Police Scotland.
	Ms L advises Community Mental Health Team property has been broken into.
2020 - September	Ms L reports theft to Police Scotland.
	Ms L advises Community Mental Health Team that she has been 'mugged'.
	VPD following Theft, Fraud and Robbery and Assault with intent to Rob. VPD shared with adult social work.
	Ms L is admitted to acute hospital following assault with metal bar, head injury, high blood sugar; reports keys/money/phone stolen.
	VPD- Ms L Complainer of Robbery and Assault with intent to rob, threatening and abusive behaviour and assault.
	VPD triggers an adult support and protection Inquiry undertaken by the Integrated Substance Misuse Service.
2020 - October	NHS 24- 999 call for heavy breathing and Diabetic Keto-Acidosis. Ms L is admitted to High Dependency Unit. Discharged against medical advice two days later.
	VPD - Ms L contacted NHS 24 and stated she was suicidal. She was triaged by Crisis Response and Home Treatment Team and was deemed safe and well.
	Police Scotland advise of Ms L's death in late October.

[5] A practice where people take over a person's home and use the property to facilitate exploitation, e.g. drug use.

4. Analysis and Findings

4.1 Research Question One

In respect of Ms L, to what extent did services hear the voice of the adult?

- How did practitioners work to 'find the person', and seek to understand their perspective and to make safeguarding person-centred?
- To what extent did practitioners develop positive and trusting relationships with Ms L?
- To what extent did practitioners recognise and respond to concerns from Ms L that she felt unsafe and at risk of harm?
- To what extent did practitioners understand the challenges and difficulties that Ms L was experiencing and communicating?
- Was Ms L's voice central to assessments and decisions?

4.1.1
Professional curiosity is an important skill that allows practitioners to gain an understanding of an individual and be able to recognise the significance of their history and trauma. There are a number of incidents that would most likely have made Ms L feel powerless including repeated racial abuse; domestic abuse from a perpetrator it appears she could not escape from; assaults and possible cuckooing[6].

4.1.2
It is recognised that the experience of trauma can lead to increased anxiety, which in turn may result in challenging or crisis-driven behaviours and practitioners require shifting their focus away from these behaviours and toward the person that requires their help and consider 'what has happened to you?'

4.1.3
The core principle of ensuring the voice of the adult is central in cases such as Ms L. This was too often missed by some services. Without listening to the adult's wishes and needs, agencies are unable to support and empower adults to resolve circumstances that put them at risk. The focus has to be on the best outcome for the adult themselves and as such all process must be person centred and outcome-focused.

4.1.4
Ms L is described by a number of services as coming across as angry and loud. There are times when she has been assertive and confident in contacting services and making

[6] A practice where people take over a person's home and use the property to facilitate exploitation, e.g. drug use

her needs clear and others whereby she becomes frustrated when she does not receive the response she feels she needs. This behaviour was detailed in the risk assessment that was provided by social work services in the English local authority where she had previously lived, as was an explanation and strategies for managing this.

Good Practice

There was evidence that the Women's Rape and Sexual Abuse Centre worked with Ms L to understand her perspective to develop a rapport with her and staff showed compassion when trying to support her. Ms L would often arrive at the office in crisis or angry and at these times found it difficult to engage but the Women's Rape and Sexual Abuse Centre workers persevered, extending offers of support and recognising the importance of building trust.

4.1.5
Direct contact between Ms L and housing was limited. At the point where the housing options team were involved, services were struggling to meaningfully engage with Ms L. There is some evidence to suggest that the voice of the adult was lost amongst systems and procedures.

4.1.6
There are clear examples where Community Justice Services listened to and heard the voice of Ms L. However, there are other examples whereby she was expected to keep herself safe despite increasing incidents of risk suggesting she was unable to do so.

4.1.7
Acute health services recognised that Ms L's behaviours could be disruptive within an in-patient setting and there were concerns around drug use on the ward, this likely contributed to a swift discharge time compared to other patients.

4.1.8
There are numerous examples of third sector agencies 'partnering' with Ms L and, through the building of relationships, allowing her voice to be heard. However, this does not always translate into actions conducive to safeguarding when Ms L comes into contact with statutory services. Risk was not always recognised and responded to despite clear statements from Ms L indicating that she did not feel safe or able to keep herself safe. Third sector partners also highlighted the difficulties they experienced when attempting to escalate concerns.

4.1.9
Ms L did provide some thoughts around her struggles with managing her diabetes. No evidence was found as to follow-up regarding these particular issues, and whether this thinking was factored into a multi-agency discussion.

4.1.10
On occasion, Ms L made contact with services seeking help. For example, Ms L contacted her GP practice in May 2020 to ask for a change in pharmacy for her prescribed diabetes medication and in February 2019, seeking input of a Community Mental Health Nurse.

Findings

From the outset, there was an absence of multi-agency coordination with an agreed lead coordinator and any risk management or action plan with timescales and regular reviews. This made it more difficult for agencies to jointly listen to Ms L and understand her needs and agree a consistent approach.

The absence of Ms L's voice in the review of documentation indicates a lack of person-centred planning and suggests there are challenges in communication between some services which negatively impacted on progressing in a co-ordinated, multi-agency way.

Ms L found it difficult to commit to structured support and what she possibly needed most was compassion and understanding and timely action when in crisis. Ms L highlighted specifically the impact her housing situation had on her and that she frequently felt unsafe.

A significant amount of work has been progressed across the multiagency partnership in respect of a trauma informed approach but the infrastructure available to implement this is required to be fully utilised to help embed the approach.

The review found limited evidence of professional curiosity in relation to risk assessment, rapidly escalating health needs, recurrent hospital admissions, periods of non-engagement, poor concordance with treatment for both diabetes and mental health, and housing.

Effective professional curiosity is a crucial part of adult protection and the review has reinforced the need for robust communication and information sharing and the need to 'join the dots' and have 'the right conversations and ask the right questions'.

Given Ms L's presentation and history, she would possibly have benefitted from a safe environment for women which had access to a range of professionals to support her needs.

Practitioners were viewing Ms L through an operational lens rather than a person centred and trauma informed lens which had they done so, would have indicated that Ms L was in crisis and needed support, but was struggling to secure the support that she needed; this often led to challenging behaviours that shifted the focus away from a compassionate response.

Recommendation 1

All statutory agencies should review and provide evidence and assurance that trauma informed and person-centred care is accurately understood within their agencies/ services, with a priority focus on those services with substantial contact with children, young people and adults at risk of harm.

What has already happened?

- Dundee Drug and Alcohol Services is implementing a tiered trauma training pathway.

- Community Justice Service teams are in the process of completing Level 1 and 2 trauma-informed practice training.

- Dundee City Council, Dundee Health and Social Care Partnership, Police Scotland and NHS Tayside have worked together through the Trauma Steering Group to develop and launch a range of leadership and practice resources across the full range of their services.

- Trauma Ambassador Network has been established, alongside existing senior Trauma Champions.

- Trauma implementation plan is in place and Trauma Learning and Development Co-ordinator is supporting implementation.

What else is planned?

- Training needs analysis to be completed / refreshed across public sector organisations, and training plans updated. This is to include a focus on Level 3 trauma-informed practice training.

- The link between the Adult Support and Protection Committee and the Trauma Steering Group is to be strengthened.

- Adult protection quality assurance approaches are to be updated to support evaluation of how trauma-informed approaches are being implemented in practice and the impact this is having on vulnerable and at-risk people.

Recommendation 2

All partner agencies should review their approach to delivering gendered services, with a priority focus on those services with substantial contact with children, young people and adults at risk of harm.

What has already happened?

- Dundee City Council Leadership Team has participated in a workshop focused on gendered services provision and leaders from across the Council are working to identify opportunities within their services to apply learning in practice.

- The Gendered Services Project has delivered training to over 300 workforce members, including many staff from Dundee Drug and Alcohol Recovery Service.

- A range of gendered approaches have been developed over the last 3 years, including:

    - Neighbourhood Services – women only temporary accommodation at Honeygreen and development of gender sensitive policies, including a domestic abuse policy.

    - Dundee Drug and Alcohol Service – has ensured availability of a female Specialist Nurse Prescriber.

    - Multi-agency – the Women's Rape and Sexual Abuse Centre has led the development and recent opening of Dundee Women's Hub, providing accessible support for women with multiple and complex needs.

    - Multi-agency – a Women's Triage meeting is supporting a risk assessment and management approach for women impacted by drugs, alcohol and other multiple disadvantages.

What else is planned?

- The link between the Adult Support and Protection Committee and the Trauma Steering Group is to be strengthened.

- A range of public and third sector services are to work towards obtaining the 'Welcoming Women' charter mark.

- Work is to be undertaken to improve the quality of gender information contained within Integrated Impact Assessments that support decision-making by public bodies.

4.2 Research Question Two

To what extent were pathways of care and transitions of care person centred?

- What policies/procedures exist or management of depot[7]/Did Not Attends within the Community health Service and were these followed?
- Were Ms L's health and social care needs understood and assessed in an integrated way?
- How was information from England used to inform health and social care needs? How was knowledge of Ms L's history used to understand behaviour and developing relationships?
- To what extent did health and social care needs inform decisions around accommodation and Housing?
- Was there a negative outcome for Ms L due to the fact that her social work input was via the Community Justice Service rather than adult services?
- Was there evidence of joint working across teams and agencies to achieve a multiagency approach to meet Ms L's complex needs?
- What crisis pathways are available when core pathways are no longer able to meet a person's needs?

4.2.1
Ms L moved from England to Scotland where she had input from a number of services but at the point of this transfer, there was no multiagency meeting and the only formal handover was from The National Probation Service for England & Wales Services to Dundee Community Justice Service.

[7] Slow release form of antipsychotic medication given intramuscularly by injection.

4.2.2 Housing

4.2.2.1
Miss L presented as homeless and fleeing domestic abuse and was offered accommodation at a homeless hostel provided by a third sector organisation. She resided there between December 2018 and April 2019.

4.2.2.2
It is apparent that housing colleagues were not aware of the complex nature of Ms L's needs at the time of allocating homeless accommodation.

4.2.2.3
There is some evidence of involvement with the homeless health outreach team but this appears to have been limited and key information was either not shared or not available.

4.2.2.4
Although Ms L was awarded her own tenancy from late April 2019 until her death, there were further periods of temporary accommodation implemented to mitigate against risks identified in the community.

4.2.2.5
During March 2020, there is evidence to suggest that Ms L may have been a subject of cuckooing[8] by a group who had provided her with drugs in return for access to her flat. This information does not seem to have been shared with housing colleagues or Police Scotland.

4.2.2.6
Housing became more actively involved during the period immediately before Ms L's death when she was engaging with the Housing Options team. Housing Options were contacted by the Hospital Discharge team who advised that Ms L was due to be discharged from hospital but could not return to her tenancy due to having been seriously assaulted there and was frightened to return/could not return and so presented as homeless. Temporary homeless accommodation within a local hotel was provided while inquiries were undertaken but Ms L was asked to leave due to an alleged incident and she was moved to another hotel until alternative temporary accommodation could be identified.

[8] A practice where people take over a person's home and use the property to facilitate exploitation, e.g. drug use.

Findings

There is recognition that some of the timeline for Ms L was during the initial response to the Covid-19 pandemic which resulted in limited availability of housing stock and as soon as suitable alternatives were available, they were provided without delay. The suitability of alternative accommodation for individuals such as Ms L who present with complex needs was limited at the height of Covid-19 and staff found themselves working within the constraints of the system.

The profile of temporary accommodation does not meet the increasingly complex needs of the population and those presenting as homeless and this has been recognised in a number of case reviews in Dundee over recent years.

Opportunities were missed to take a more person-centred approach as part of the homeless assessment. The focus was on the need to move Ms L rather than exploring and addressing why she required to be moved. This approach may have led to the identification of the need to progress an adult concern referral and suggests a lack of awareness in relation to the benefits of adult support and protection.

The extent to which housing colleagues were aware of the complex nature of Ms L's needs at the time of allocating homeless accommodation clearly impacted upon the person-centred nature of intervention and the options made available.

Case notes evidence that there was an assessment of support needs and a decision taken that a referral for further support was not required due to the multiple services already engaged. There was no RAG[9] assessment and therefore no way to identify whether the support in place was adequate or if there needed to be an escalation with other support providers in terms of Ms L's support needs whilst she was homeless accommodation.

This is significant as there was evidence that Ms L's vulnerabilities increased whilst residing in the homeless accommodation and in particular, her drug use increased, resulting in her experiencing exploitation whilst a resident.

[9] Red Amber Green traffic light system used to classify the status or progress against projects or improvement work.

Recommendation 3

Housing, supported by the wider multi-agency partnership should build upon the improvement actions achieved to date to mitigate against the various factors that contribute to vulnerable adults who have complex needs experiencing periods of homelessness to ensure they are able to access the right housing to meet their needs.

What has already happened?

- Neighbourhood Services is providing a drop-in housing support service as part of the Dundee Women's Hub provision.

- The Women's Rape and Sexual Abuse Centre has established an 'Initial Referral Team' to ensure 'here and now' support is available to people in a crisis.

- A new women only temporary accommodation hostel has been established by Neighbourhood Services (Honeygreen).

- Injecting equipment provision is now available in all homeless hostels within Dundee as part of the wider implementation of the Medication Assisted Treatment Standards.

- A Housing Options Social Worker has been piloted to support information sharing and implementation of support plans for vulnerable people presenting to the Housing Options Service.

- The Housing First model has been re-introduced, led by Transform, with a focus on providing intensive support to address complex needs and mental health needs.

What else is planned?

- Neighbourhood Services are in the final stages of developing a new personal housing plan approach, with a clear focus on developing a consistent approach to assessing housing and support needs.

- An audit of crisis homelessness presentations will be undertaken to identify learning in terms of opportunities for earlier intervention and support.

- The provision of earlier support regarding homelessness and involvement of Neighbourhood Services in risk management and protection processes will be further enhanced as part of the development of an Adult at Risk Multi-agency Pathway (see recommendations 8, 11 and 12).

4.2.3 Community Justice

4.2.3.1
Ms L was supported by Dundee Community Justice Women's Team between December 2018 and July 2019. The Dundee service had agreed to 'caretake' on behalf of The National Probation Service for England & Wales as Ms L had received a Suspended Sentence from the Court in England. As there was no equivalent under Scottish legislation, the case could not automatically transfer. Ms L had previously been subject to a custodial sentence for a violent assault. At the point of referral, The National Probation Service for England & Wales services sent a copy of the most recent Pre-sentence Report and forwarded a risk assessment report a week later.

4.2.3.2
The risk assessment, although focused on risk of re-offending, did contain details of Ms L's complex health needs relating to her diagnosis of Paranoid Schizophrenia and the requirement for three weekly depot injections and her medical needs relating to her diabetes. The assessment also detailed Ms L's history of poor management of these health needs and the significant increase of risk and ability to comply when she was not stable on medications. The assessment also highlights the importance of Community Mental Health Services in supporting Ms L and managing risk. The report states that "there is clear evidence to show that Ms L has deficits with her thinking and behaviour" and that Ms L 'is stable when on correct medication but when this is not the case her behaviour deteriorates and her aggression increases and she becomes unpredictable and confrontational."

4.2.3.3
A pattern quickly established of non-compliance with the suspended sentence order requirements (missed Community Justice Service appointments whereby eleven were attended and six were not between December 2018 and July 2019). Often these were due to periods of hospitalisation and poor management of both insulin and anti-psychosis medication. Dundee Community Justice Service were advising colleagues in England of concerns and non-engagement but no action was taken by The National Probation Service for England & Wales and Dundee were asked to continue with monthly visits.

4.2.3.4
Records of correspondence between Dundee Community Justice Service and The National Probation Service for England & Wales raised the issue of who was monitoring Ms L's welfare. Ms L was not engaging with Dundee but seemed to have ongoing contact with The National Probation Service for England & Wales officer in England, (partly due to wanting assurances to be made to her mother in order that she could have contact with her child.) Between the time that Ms L moved to Dundee (in December 2018) and her return to England (in July 2019), Ms L had telephone contact with her Probation Officer on six occasions. There were examples whereby The National Probation Service for England & Wales service was advising Dundee workers that Ms L had been in hospital.

4.2.3.5
There does not appear to have been any direct contact between the Community Justice Service worker and the Social Worker in England supporting Ms L's child and managing the supervision order. Any information was shared with The National Probation Service for England & Wales and it would have been expected they would share with Children's Services in England. The main focus around this particular area appears to be whether or not Ms L was engaging and receiving her depot injection in order that she would be able to have fortnightly contact with her child. The review noted that The National Probation Service for England & Wales was making direct contact with the Community Mental Health Team in Dundee to seek updates on this.

4.2.3.6
The review found that Dundee Community Justice Service did connect with other services in an effort to meet Ms L's welfare needs, including provision of food parcels, providing a form to apply for a bus pass for free travel, provision of keep safe advice, progressing a referral to Dundee Drug and Alcohol Recover Service and the input of the Keep Well Nurse.

Good Practice

An initial joint home visit was undertaken within three days of arriving in Dundee in December 2018 to Ms L within homeless accommodation between the Community Justice Service worker and a Community Justice Service nurse, which highlighted issues relating to missed depot and insulin management. Contact was made with Ms L's GP surgery and arrangements were made to attend a drop-in within a week. Support staff at the homeless accommodation agreed to facilitate attendance. Ms L's GP progressed an urgent referral to the Community Mental Health Team two days later, highlighting Ms L's recent move from England in the context of domestic abuse, longstanding mental health difficulties and that she required continuation of depot antipsychotic medication.

Findings

There was no formal agreement between The National Probation Service for England & Wales and Dundee in respect of the suspended sentence order around roles and responsibilities and there was no legal obligation on Dundee Community Justice Service to progress this for Ms L. This resulted in a lack of attention to offence focused work and an absence of an up to date risk assessment following what was provided in December 2018. Given Ms L remained in Dundee, there was an opportunity to transfer the order to a suitable Scottish equivalent that Dundee had responsibility for once it was clear Ms L was remaining in the area. This would have been beneficial for all parties and would have ensured that non-engagement/breach of order was progressed via courts if required.

There were a number of missed opportunities to initiate a multiagency approach for the duration of the order which ended in July 2019; this could have been at the point of Ms L moving to Dundee; as part of an exit strategy from community justice and following return from England to Dundee in October 2019.

Much of Ms L's support was being provided by third sector organisations. Although there are examples of Ms L being signposted and advised by Community Justice Services about how to access support, much of the involvement was through a community justice lens and focused on compliance with the terms of Ms L's license.

Risks were acknowledged and recorded but not always recognised and responded to. There was no consideration given to Ms L being more vulnerable to harm due to disability; mental disorder or illness despite having previously been detained under mental health legislation in England and the impact of her various conditions being detailed in the risk assessment.

Despite detailing many risk factors and strategies to mitigate against these, the risk assessment was not shared beyond Community Justice Services. Some content was shared with partners relating to aggression and abuse. Housing colleagues report they did not initially know the extent of Ms L's vulnerabilities as she had been referred in relation to domestic abuse concerns.

It is apparent from the contributions made by Community Justice Service staff that the service does not have a consistently accurate understanding of the principles of safeguarding of vulnerable adults, including information governance principles and they would benefit from further input in relation to adult support and protection.

Police reports shared by way of the Vulnerable Persons Database do not seem to be routinely shared with Community Justice Service workers by other Social Work colleagues, or if they are, do not seem to have been recorded in case notes.

Although supervising and supporting adults, Community Justice Service workers are not considered to be Council Officers in terms of adult support and protection legislation. Instead, common practice is for Community Justice Service workers to refer any safeguarding concerns to the relevant Health and Social Care Team to undertake statutory duties. This did not happen in respect of Ms L. Some of the actions arising from the MARAC meetings place the onus on Community Justice Service to address a number of safeguarding issues but these were not considered via the Adult Support and Protection core processes. The Community Justice Service has recognised within the review process that there would be benefit in having some staff trained to become Designated Council Officers, who could then undertake the duties around investigation of adult support and protection for Community Justice Service cases and this is in progress.

Recommendation 4

Dundee City Council should ensure that arrangements are in place across social work and social care services to support the workforce to understand how to seek clarity regarding legal obligations of the local authority and how to ensure clarity of voluntary agreements entered into in the absence of legal obligations where service users are moving across geographical boundaries.

What else is planned?

- The Community Justice Service will implement the use of written agreements in all cases where 'caretaking' is in place on behalf of another local authority.

- An audit of 'caretaking' arrangements will be completed to ensure written agreements are in place, are of good quality and are being utilised to provide effective support to people.

Recommendation 5

Scottish Government should consider the need for guidance to local authorities regarding individuals on Criminal Justice Orders or licences from outwith Scotland moving to Scotland where there is no Scottish equivalent.

What has already happened?

- There is currently guidance available to local authorities which sets out arrangements for cross border transfer of Suspended Sentence Orders. The Scottish Government has recognised that this guidance would benefit from being updated.

What else is planned?

- The Scottish Government will work with partners to identify and make any updates required as a result of the findings of this Significant Case Review.

Recommendation 6

All agencies should ensure their staff understand and adhere to the adult support and protection pathways and referral routes in line with the Code of Practice with an initial focus on Housing, Community Justice Services, Community Mental Health Services and Dundee Drug and Alcohol Recovery Service.

What has already happened?

- NHS Tayside has implemented an Adult Support and Protection Protocol, alongside a range of workforce communication and learning and development materials. Level 1 training has continued to be a priority area for delivery across health services and teams, raising awareness of adult protection responsibilities, legislation and required responses. 90% of Dundee Health and Social Care Partnership workforce has completed the adult support and protection core module.

- The Adult Support and Protection Committee, working in partnership with Dundee City Council Learning and Organisation Development Service, has continued to offer a comprehensive range of learning and development opportunities across the multi-agency workforce.

- A Protecting People Learning Framework has been developed and launched, providing the workforce with a single point of access for learning opportunities relevant to adult protection and wider multiple and complex needs.

- Neighbourhood Services has delivered adult support and protection refresher training for all housing teams.

- Police Scotland has agreed an escalation process for people for whom they receive multiple concern reports within a defined time period.

- Both NHS Tayside and NHS Tayside have invested in additional, specific staff to support enhancements to their adult protection processes and practice.

- The Navigator Service, based within NHS Tayside Emergency Department, is helping to identify vulnerable people and link them to ongoing community-based supports.

What else is planned?

- The revised Dundee Adult Protection Procedures will be finalised and launched before the end of 2023, accompanied by a range of learning sessions and materials for use across all agencies.

- Key services are developing specific training plans against which they will report progress to the Adult Support and Protection Committee twice a year.

- The Community Justice Service is working to train additional Council Officers and Second Workers to support them to able to undertake adult protection work more effectively in the future.

- The revised Adult Support and Protection Committee website will be launched by April 2024, providing information to both the workforce and members of the public about how to identify and refer concerns about adults at risk of harm.

4.2.4 Medication Administration and Mental Health

4.2.4.1
Ms L was prescribed depot medication but was regularly not complying with this. There is evidence throughout Ms L's notes of delay's in administration of depot medication and no evidence that use of the Mental Health (Care and Treatment) (Scotland) Act (2003) was considered to address this.

4.2.4.2
There is little evidence within the notes that consideration was given to the identified risks for Ms L and professionals previously involved in her care when medication for her psychiatric diagnosis was not administered consistently.

4.2.4.3
There was an evident general thought culture at the time within the Community Mental Health Team that patients should hold the responsibility for engaging with appointments without any evidence of analysis as to whether the patient had the ability to engage. From an analysis of Ms L's health notes it is apparent that when depot medication was missed there was a deterioration in her physical health often resulting in acute admissions to hospital along with an increase in instability of daily functioning and vulnerability to harm.

Findings

There is evidence to suggest that most partners viewed Ms L through a service specific lens which, when coupled with a lack of information sharing, led to significant shortcomings in joined up working.

Whilst it was documented that Ms L was non-compliant with her psychiatric medication regime there was no suggestion following acute admissions to hospital that consideration was giving to Ms L's compliance with other medication regimes.

There was no evidence that consideration was given within the community teams for escalation of disengagement including no documented evidence of Ms L's case being escalated to senior nurses, no documented consideration of escalation to a Responsible Medical Officer and there was no standard protocol for missed depot administration for practitioners to follow.

When home visits were introduced for Ms L during her second episode of Community Mental Health Team care in Dundee for depot administration, engagement improved as a result.

The review has identified that there are pockets of assertive practice, evidence of person-centered approaches (identifying barriers and looking at the wider social picture); escalation to Care Programme Approach is now considered but difficult to get people to engage with and probably being utilised instead of adult support and protection. However, there is not a consistent approach within Tayside as a whole with each Community Mental Health Team taking a different approach to referrals, assessment, treatment and disengagement.

Discussions within the review identified that multidisciplinary working is usually undertaken for complex cases but there is a barrier in sharing due to differences in documentation used. The reviewers were not assured that care would be co-ordinated to prevent double booked appointments or offering joint appointments to support a coordinated approach or information sharing and discussion of a significant event unless within a planned professionals meeting and again highlights the need for greater awareness in relation to adult support and protection pathways.

Recommendation 7

The Community Mental Health Service across Tayside should ensure that there is clear and consistent guidance on the management of missed doses of antipsychotic depot injection medication (or other relevant medications) which include a clear escalation process.

What has already happened?

- There has been additional investment in the pharmacy workforce within Community Mental Health Teams to support safe and effective use of long-acting injectable antipsychotics.

- The Community Mental Health Service in Dundee has introduced disengagement plans in 2021 to support those who have difficulty engaging and is reflective of an individual's needs and supported by assertive follow up and escalation of concerns activity where appropriate.

What else is planned?

- NHS Tayside Mental Health and Learning Disabilities Medicines Management Group has commissioned the development of guidance to support clinical teams in the use of long-acting injectable antipsychotics.

4.3 Research Question Three

Was there a systemic and holistic approach to identification and management of risk?

- Was all information used to inform assessment of need and risk management? Were risk assessments/safety plans and care plans in place? How were these used to inform a cumulative picture of risk?
- Was there consideration of capacity in light of mismanagement of diabetes, long term use of substances and trauma and how this may have impacted on ability to safeguard?
- Was there a timely response to referrals/concerns across the key agencies?
- How did the MARAC process inform responses to abuse/harm/exploitation and were these appropriate?
- How was Mental Health Act and Adult Support and Protection Legislation used/ considered in Ms L's case given history of mental illness, trauma, substance misuse, domestic abuse, financial harm and exploitation?
- Was there effective communication, recording and information sharing to manage risk?
- Was there evidence of professional curiosity in relation to risk assessment, health needs, non-engagement and social issues?

Good Practice

NHS Tayside has a Substance Use Liaison Nurse based within the acute hospital who can visit patients who use drugs and / or alcohol on the wards and liaise with clinical staff around key areas such as prescribing and discharge planning.

Acute health records document how difficult it was to support Ms L, particularly as she would often self-discharge against medical advice and there was nothing identified during the review that would indicate health professionals could have done anything further to prevent this. The acute hospital recognised this and attempted to arrange various assessments and tests during inpatient episodes.

4.3.1
Risk assessment and risk management are all considerations for practitioners to inform decisions about the care and support an adult may require. Good practice in risk assessment is about working together with the adult to understand events and behaviours in order to support a person centered approach to risk management.

4.3.2
There were significant risks identified in Ms L's life and these included:

- Mental Health (paranoid schizophrenia)
- Substance use
- Self neglect
- Eviction
- Domestic Abuse
- Physical assault
- Exploitation (including financial and cuckooing[10])
- Isolation
- Death (as a result of ability to manage diabetes)

Any risk assessment for Ms L should have included not engaging with services, safeguarding concerns and repeated hospital admissions in addition to the above risks. Services should also have an awareness of the impact of child removal on a parent's mental health and resilience to self care and survive.

4.3.3
When Ms L moved to Scotland, Community Justice Services were presented with a detailed risk assessment from colleagues in England but there is no evidence as to this being shared across partner agencies.

4.3.4
Recommendations from previous inspections and audits within the locality have identified the need for a shared model of risk assessment and better understanding of thresholds.

4.3.5
For the majority of occasions that Ms L reported criminality to Police Scotland, Ms L was provided with contact information for Victim Support Services in order to self refer in line with standard practice. However, there is no evidence Ms L followed this up. Ms L did request referrals be made on two occasions in 2019 and Victim Support Services attempted telephone calls and sent letters but no response was received.

Finding

There was limited evidence across the records reviewed that workers understood the risks Ms L faced or that information was shared within and between agencies to highlight concerns. There were numerous missed opportunities to share information.

[10]A practice where people take over a person's home and use the property to facilitate exploitation, e.g. drug use.

Recommendation 8

The Public Protection Committees should revise their programme of work to deliver a shared model of risk assessment across the multiagency partnership to identify an expedited but achievable delivery plan with agreed resources to support this.

What has already happened?

- Dundee Health and Social Care Partnership has developed additional guidance for practitioners for chronologies and risk assessment. These have been supported by changes to case recording systems to better enable practitioners to record relevant information.

- Case files audits have been undertaken on both a single and multi-agency basis, including assessing the quality of chronologies and risk assessments and identifying further detail about improvements required.

What else is planned?

- Learning from recent case file audits has been included in the Health and Social Care Partnership Improvement Plan and are currently being implemented across services.

- Further, regular auditing activity will be carried out and reported to the Adult Support and Protection Committee.

- A multi-agency approach to chronologies and risk assessments will be developed as part of the Adult at Risk Multi-Agency Pathway (see recommendations 11 and 12).

4.3.6 Mental Health Service

4.3.6.1
There was no community mental health treatment risk assessment evident within Ms L's notes. Risk assessments and care plans were available within Ms L's electronic notes however these were noted to have been completed following acute psychiatric admissions or contact with crisis mental health services. A paper summary of risk and management from England was noted to be placed within Ms L's paper notes however there is little reference to risk identified other than within continuation notes to identify that home visits should not be undertaken due to the risk of aggression.

4.3.6.2
Ms L's risk was assessed by other services involved in her care; there were other care plans and risk assessment documents within the electronic notes completed by another health service. There was no evidence that the information available on electronic systems was utilised to the benefit of Ms L. There appears to be limited professional curiosity in exploring additional risks identified by another service, or attempts made to communicate with other health services to gather more information on reported significant events.

Findings

Risk assessments and management plans are developed by nursing staff and therefore if a patient does not have contact with a mental health nurse then no risk assessment will be undertaken. On discussion with practitioners within the review process, there was a lack of clarity on any defined process for updating risk assessment or management plans and the information that was offered was that this would be as part of a continuous assessment however there was no assurance provided that changes would be formally documented within assessment and management plans.

There was agreement between the professionals contributing to the review that a shared risk assessment and care plan would not be appropriate as information would "get lost". There was little feedback received on any positive contribution having a shared documentation system brought to patients care and staff advised that there was a difference in documents and documentation styles used in each service therefore information from other services is not often considered during assessment and contact.

Whilst staff identified that information sharing and joint working enhanced patient journeys and outcomes, there was a lack of understanding that information pertinent to the care and treatment provided to an adult was readily available and continues to not be utilised and would indicate a lack of understanding of individual responsibility to consider the wider context of services involved.

The lack of communication between community services and secondary health care services resulted in a lack of recognition of the importance of Ms L's physical health care as a core element of her holistic care needs.

4.3.7 Diabetes

4.3.7.1
Ms L was diagnosed with Type 1 Diabetes in 2014. During her time in England, previous records (shared with the Community Mental Health Team by email but not uploaded to electronic systems) indicate poor compliance with treatment and requirement for support to manage this.

4.3.7.2
During her time in Dundee, Ms L had eight admissions to hospital, managed under the Diabetes Team, and two further Emergency Department admissions. The admissions were for Diabetic Keto-Acidosis or impending Diabetic Keto-Acidosis, usually due to insulin omission. Diabetic Keto-Acidosis is a medical emergency, requiring immediate hospital treatment. A lack of insulin in the body can result in the break-down of fats and a build-up of ketones in the blood leading to severe dehydration, vomiting, breathlessness, abdominal pain and life threatening Diabetic Keto-Acidosis.

Good Practice

Ms L was seen by the Diabetes Team including nurse specialist and consultant during each acute admission. This was Ms L's primary contact with the specialist diabetes service; she did have phone contact with specialist nurses, on an outpatient basis, but never attended a follow-up consultant clinic. The diabetes specialists also offered support to the team treating Ms L during mental health admissions, at their request. The diabetes nurse team had an 'open door policy' so never discharged Ms L.

4.3.7.3
Equipment to manage Ms L's diabetes was issued to her by mail and educational information was discussed whilst in hospital. However, given that diabetes management is inextricably linked to lifestyle, it was noted by the diabetes team that "those helping Ms L socially, and with her mental health, were critical to improvement and stability in her diabetes self-management"'. There does not appear to have been direct links made with the teams trying to implement this support. In addition, although there were attempts to make contact with Ms L by telephone, there were no more assertive attempts to review in the community and/or to link up with others who were seeing her.

4.3.7.4
Primary care services were advised of each of the episodes of Diabetic Keto-Acidosis; GPs made several unsuccessful attempts to contact Ms L by telephone in order to arrange review appointments. Other agencies involved (e.g. Community Mental Health Team, Dundee Drug and Alcohol Recovery Services) were not always aware of hospital admissions; they often found out via Ms L. Although a summary of information re hospital admission would have been available on Clinical Portal, which Community Mental Health Teams and Dundee Drug and Alcohol and Recovery Service health staff could access, they would not have the detailed information recorded on the diabetes services' SCI- Diabetes electronic system.

4.3.7.5
Evidence indicates Ms L was taking some insulin as she did not present in Diabetic Keto-Acidosis every day. It does not appear that this pattern was considered in the context of, for example, spells where Ms L either attended/did not attend for her antipsychotic depot medication. Ms L also noted on occasion, that her unstable diabetes was linked to other risk factors e.g. during a hospital admission in May 2019, with high blood sugars, Ms L advised that she had not been eating due to theft of funds.

4.3.7.6
On another occasion, (e.g. March 2019), not taking insulin regularly was linked with a possible suicidal intent, but this was denied by Ms L during assessment by the Psychiatric Liaison Team, although she did say "I can't be bothered" and that she finds the "injections painful".

Findings

Practitioners across health and social care acknowledge that they experience significant challenges effectively engaging with adults such as Ms L who experience ill health (physical and mental) in conjunction with drug and / or alcohol use.

In Ms L's case, each agency and inpatient area appeared to take a narrow approach, reflective of their specialism.

This approach did not factor in the impact that variable compliance with diabetes treatment would likely have had on Ms L's concentration, motivation and mood.

In addition, the expectation that Ms L would attend, for example, clinic appointments, and answer her phone at pre-arranged times, did not reflect the likely impact of her trauma history and erratic compliance with antipsychotic depot medication.

There were missed opportunities to proactively communicate with key services involved with Ms L following hospital admissions.

Recommendation 9

NHS Tayside should undertake a review of the recurrent Diabetic Keto-Acidosis pathway at an appropriate point following implementation to provide assurance that the pathway identifies those most at risk and whether there are improved outcomes for this patient group as a result of the pathway.

What has already happened?

- The Diabetic Keto-Acidosis pathway has now been fully implemented as part of a wider Diabetes Improvement Plan, which is subject to regular monitoring. Monthly meetings review cases where people have had multiple hospital admissions to consider how risk can be mitigated and whether the person might be an adult at risk.

What else is planned?

- NHS Tayside are sharing information about their approach at a forthcoming stakeholder event.
- Further information is to be provided to the Adult Support and Protection Committee about the impact of the pathway on practice and outcomes for people.

4.3.8 Multiagency Risk Assessment Conference (MARAC) and Gender Based Violence (GBV)

4.3.8.1
Ms L was discussed on two occasions at MARAC during her time in Tayside. The initial referral was following a move from England followed by a referral approximately four months later.

4.3.8.2
Ms L had sought refuge in Tayside as she was fleeing high risk domestic abuse, having disclosed physical assault including punching, strangulation and chemical use.

4.3.8.3
MARAC is a process through which the circumstances of people at higher risk of serious harm from domestic abuse than the general population are discussed. For Ms L, this higher level of risk was associated with her diagnosis of a medication dependent physical health illness, a psychiatric diagnosis that required regular and consistent pharmaceutical treatment and substance misuse. Information about these factors was shared within the MARAC process.

4.3.8.4
An action plan was devised at each MARAC meeting with the intent of enabling Ms L to live safely within the community whilst being a victim of intimate partner violence. The initial action plan agreed by MARAC attendees had three action points, one of which was to agree a safety plan with Ms L. This action was marked as complete due to Ms L not engaging with the service tasked to engage her in completing a safety plan. The other two actions related to sharing information with the homeless accommodation Ms L was residing within and gathering more information on criminality of the perpetrator.

4.3.8.5
Ms L was again discussed at MARAC four months following the first discussion as she had been assaulted by the same perpetrator within her property. An action plan was again agreed with actions mainly related to sourcing information on refuge should Ms L return to England and information gathering related to the perpetrator. An action was identified for the MARAC chair to be notified should Ms L fail to attend a planned appointment. The action pertaining to Ms L was documented as completed as a note had been placed on the computer system to advise the professional to alert MARAC if the appointment was not attended.

4.3.8.6
Neighbourhood services attended the MARAC meeting however no information relating to her move from homeless supported accommodation to her own council tenancy was shared. Ms L was known to the diabetes specialist community team and whilst there is reference to Ms L having diabetes and having acute hospital admissions for Diabetic Keto-Acidosis, there is no reference made to her disengagement from diabetes services or compliance with medication.

4.3.8.7
Ms L was prescribed antipsychotic depot medication and it is documented within the initial MARAC referral that Ms L had self reported “significant increase in violence” when she became mentally unwell however there is no apparent acknowledgement that

compliance with medication was poor and contact with the Community Mental Health Team sporadic.

4.3.8.8
Ms L was a repeat MARAC case meaning that she had been discussed at MARAC on more than one occasion.

4.3.8.9
There was little acknowledgement within the MARAC minutes and actions plans for Ms L of the impact that the intimate partner violence would have on her mental health, physical health and daily living functioning. All agency records reviewed as part of the review process evidenced little to no reference of MARAC discussions and specifically how the trauma Ms L had experienced may require further assessment or action from professionals involved in her care and treatment.

Findings

It is known that Ms L had many services involved whilst living in Tayside however when reviewing the MARAC minutes and action plans there is limited evidence that information relevant to her circumstances were shared as robustly as they could have been.

There was no collective understanding of the issues and risks Ms L was facing due to the lack of adequate multiagency working. Co-ordinating multiagency discussions about risk factors with all those involved with Ms L may have resulted in a holistic approach to risk management. At the time Ms L was discussed at MARAC, there were recognised challenges around the volumes of cases and time allocated for meetings and the appropriate representation from key agencies which was escalated to the Dundee Chief Officer Group (COG) via the Dundee Violence Against Women Partnership.

There is currently no formal information sharing agreement for non-statutory discussions relating to domestic abuse cases such as MARAC and locality triage groups. This has been identified as both a barrier for information sharing with representatives cautious of what information can be shared, what actions can be offered and what information can be documented within organisational systems to identify that a victim has been identified as at high risk of domestic abuse and the subsequent impact this may have on their lives.

There are national and local agreements for attendance and discussion at MARAC meetings, including a draft Tayside Information Sharing Agreement that sets out the grounds for sharing of information and for services to take actions to ensure a robust response to domestic abuse. Each service is responsible for the information provided and for offering actions to be taken from the discussion. Whilst there is guidance provided within the Safe Lives framework, each individual agency

representative attending on behalf of their organisation can determine what, if any information and/or action they are prepared to offer and proactive safeguarding can be varied and dependant on the rep and/or organisation. In addition, MARAC relies on agency representatives having time to undertake the necessary research to support comprehensive sharing of information to inform risk management but the review noted that representatives report that there is often not enough protected time for preparation and research.

Professional thresholds were recognised within the review and it was identified that each organisation attending would have a varied threshold of severity of risk and ongoing impact to the victim.

The review has recognised that along with other services, Community Justice Services and housing missed further opportunities to convene a multi-agency meeting to discuss risks and concerns. Consideration should have been given to housing support whilst Ms L was residing in temporary accommodation and whether the existing support from services was sufficient during Ms L's time in temporary accommodation.

It is unclear how the concern regarding cuckooing[11] was progressed. The alleged assault on Ms L's return to England in October 2019 was reported to Police Scotland and the relevant Police force in England was made aware. However, further investigation was not possible as Ms L was admitted to the acute hospital due to her diabetes and it was left for Ms L to make contact following discharge which she did not do or was likely unable to do.

Recommendation 10

The Tayside MARAC Steering Group should review all relevant policies and protocols to ensure these are fit for purpose and seek assurance from participating partner agencies that these have been fully implemented in practice.

What has already happened?

- A temporary post has been appointed to support multi-agency learning and raise awareness of the MARAC process.
- An audit of agency representation at MARAC has been undertaken, and agencies have been taking steps to address the findings from this.
- An audit of MARAC resources is in the final stages with a focus on ensuring that there is enough capacity across agencies to support an effective MARAC process.
- A MARAC performance framework is in place and is overseen by the MARAC Steering Group.
- A new triage meeting is available in Dundee for practitioners to hold supported discussions regarding complex cases and plan ongoing risk management.

[11] A practice where people take over a person's home and use the property to facilitate exploitation, e.g. drug use.

What else is planned?

- The Health and Social Care Partnership is testing a new arrangement for their representation at MARAC meetings, including a direct link to adult protection functions.
- MARAC induction packs for both representatives and their line managers are to be revised.
- The MARAC Information Sharing Protocol is in final draft format and will be signed off by all relevant agencies by the end of 2023. This will support sharing of key information, including MARAC minutes, in a way that is compliant with data protection legislation and supports ongoing risk management.
- Further work is to be undertaken to ensure that information from the MARAC performance framework is shared more widely, including with the Adult Support and Protection Committee.

4.3.9 Adult Support and Protection and Care Programme Approach (CPA)

4.3.9.1
Ms L was identified as a 'vulnerable adult' by persons involved in her care, treatment and support. There was well documented occurrence of harm including physical assault, psychological harm, and various examples of exploitation, throughout her contact with services.

4.3.9.2
Ms L herself had an awareness of the harm she was victim to and asked professionals for help on numerous occasions. Ms L more specifically requested that she be appointed a person to oversee her finances as she felt at risk of further financial harm occurring.

4.3.9.3
Police Scotland progressed a number of VPDs relating to Ms L in-line with their National Risk and Concern Policy. Where VPDs were shared onward the majority of these were shared only with a third sector agency rather than with statutory partners and raises concern in relation to the expectation that third sector partners are able to manage significant risks.

4.3.9.4
Ms L remained at risk of harm throughout her time within Tayside.

4.3.9.5
There is no evidence within any agency records of consideration of adult support and protection legislation and application of the three-point test in regards to Ms L. Furthermore, discussions within the review process highlighted there is still a lack of understanding around roles and responsibilities for progressing an adult concern referral across a number of agencies.

4.3.9.6
Current arrangements for receipt, recording and onward sharing of VPDs by Dundee Health and Social Care Partnership do not consistently ensure that information relevant

to the Community Justice Service is shared pro-actively with them. Whilst VPDs are recorded within the case notes on the MOSAIC IT system (shared case management system used by both The Health and Social Care Partnership and the Community Justice Service), reliance is placed on individual Community Justice Service workers reviewing case notes to obtain this information. This can lead to delays in Community Justice Service workers receiving, understanding and acting upon new information about the risks and needs of individuals. This is particularly important if the individual is not receiving services and supports from other social work services in either the Dundee Health and Social Care Partnership or Dundee City Council Children and Families Service. As a result of this learning review, the Health and Social Care Partnership and Dundee City Council Children and Families Service (of which Community Justice Services is part) are working together to revise how VPDs for both children and adults are received, recorded and shared appropriately with colleagues in Community Justice Service.

4.3.9.7
When Ms L was seeking support and reporting harm occurring or the risk of harm to her, there is no evidence of support beyond a superficial level documented within key statutory agency records. This powerlessness over her own life, where Ms L can be beaten, exploited, cuckooed, assaulted, lose custody of her child and where the perpetrators are not held accountable would have affected Ms L's resilience and ability to self-care.

4.3.9.8
There is reference to the Care Programme Approach being considered for Ms L and this is discussed at two professional meetings of which Ms L attended one. There is no clarity as to who was taking the lead in Ms L's complex care and responsibility appeared to fall within the remit of the Community Mental Health Nurse with notes of the meeting advising that they would explore and arrange the Care Programme Approach. A Care Programme Approach was never utilised prior to Ms L's death.

4.3.9.9
Despite a 'professionals' meeting taking place, there was little effort to identify the risks Ms L was experiencing or presenting with and therefore no risk management plan. Following this meeting, there was little momentum to address risks and care and support needs. This meeting may have benefitted from a more reflective approach supported by clinical input.

4.3.9.10
There is a lack of clarity of the status of various meetings in Dundee that range from 'professional meetings'/multiagency meeting/discharge planning meeting/risk management meeting and adult support and protection meetings' and this often results in key workers/agencies not being invited and variation in what is minuted and shared.

4.3.9.11
There is increasing recognition across the healthcare workforce of adult protection and Community Mental Health Team staff would now recognise an adult at risk; apply the three-point test and the requirement to progress an adult concern referral to the local authority.

Findings

Ms L's family has raised the question as to whether she had the capacity to keep herself safe and was able to safeguard herself.

Adult support and protection provides a statutory framework to co-ordinate responses where there are concerns of risk to an adult who is unable to safeguard themself. This review has found there was insufficient consideration given to adult protection and that a number of agencies/teams failed to progress an adult concern referral which in turn impacted on information sharing and communication which may have led to more urgent responses from key agencies. There were a number of opportunities when agencies could have come together to discuss risk, capacity and safeguarding. As such, there is a need to review and strengthen multiagency working around adult protection across the key statutory partnerships to support information sharing and working together to achieve the best outcome for adults at risk of harm as previously highlighted in relation to recommendations in respect of adult support and protection pathways.

Feedback during the review process highlighted that there remains a reluctance to use the Mental Health (Care and Treatment) (Scotland) Act. In addition, one of the Community Mental Health Teams has no patients managed under Care Programme Approach. Staff shared that processes are unclear when it comes to risk management meetings and professional meetings and that health staff 'contact Social Work quite often', to raise concerns around safeguarding, but would not follow the NHST adult support and protection guidelines in terms of submitting a referral and awareness of the NHS Tayside protocol was variable.

As part of the review process, staff within the Community Mental Health Service shared that few have submitted an adult concern referral during their time working within NHS Tayside and most advised that they would highlight concerns within their team to social work colleagues. Most staff advised that they had found escalation of adult protection concerns difficult and often felt that their concerns were not identified as adult protection concerns and little action was taken.

IRDs have recently been introduced however these are not yet consistently applied and multiagency partners recognise opportunities for improvement to ensure the process/input of the right people/time period when an IRD is held and explore partners being able to initiate an IRD. It is recognised across the multiagency partnership that IRDs are a vital process to share information and make joint decisions which allow professionals to consider an adult support and protection report, share initial research and information, and agree a response on a multi-agency basis and improvement work is progressing, led by Police Scotland.

The reviewers are of the view that Care Programme Approach should have been progressed. Community mental health staff suggested that the use of the care programme approach has been utilised on occasion to "get all the professionals around the table". The Care Programme Approach is used more widely in one team than the other however there has been a focus on providing awareness and confidence building for staff within the team where Care Programme Approach is being reintroduced. Staff also identified that in all Care Programme Approaches they have been involved in they

have taken the lead role as "it's the only way it will get done". They reported difficulty in securing the relevant persons to attend. The concern of the reviewers is that a Care Programme Approach or professionals' meetings are being utilised as a substitute for consideration of adult support and protection, as it is difficult to engage professionals in attending a discussion of the client's needs and therefore additional safeguarding options are responded to using a non-statutory route.

The role of the lead professional is neither consistent nor understood across the multiagency partnership.

Recommendation 11

The multiagency partnership should ensure agencies understand the various options through which multi-agency risk assessment and management can be progressed outwith adult support and protection processes and the role of the lead professional within this.

Recommendation 12

Dundee Health and Social Care Partnership along with key statutory partners should formally explore the development of an integrated multiagency screening hub for adults at risk of harm.

The Adult Support and Protection Committee and Chief Officers Group have agreed that recommendations 11 and 12 should be responded to through a single programme of work.

What has already happened?

- Strategic leaders have agreed an outline vision for an Adults at Risk Multi-agency Pathway, including a co-ordinated multi-agency risk management approach and the development of a multi-agency screening hub for adults at risk.

What else is planned?

- A programme of work will be undertaken to further consult on and refine the outline vision, plan the detail of the operational model and support full implementation of the model into practice.

4.3.10 Dundee Drug and Alcohol Recovery Service (integrated health and social work, formerly known as Integrated Substance Misuse Service)

Good Practice

Ms L was prescribed Naloxone (an opioid receptor antagonist) to reverse the effects of opioids and counter an overdose, and was trained in its usage.

4.3.10.1
Ms L was first referred to the substance use service in Dundee in May 2019 with initial plan to progress opioid replacement therapy however she had managed to reduce and stop opioid use following a house move thus reducing triggers for substance use. Given that opioid replacement therapy was no longer indicated, Ms L's case was closed to the substance use service with ongoing third sector support in place.

4.3.10.2
Ms L attended a drug service drop-in clinic in late January 2020, accompanied by an Addaction worker and assessment note highlights that Ms L continues to [redacted] Ms L described daily heroin use, indicating signs/symptoms of physical dependence and a plan for commencing opioid replacement therapy agreed and was commenced on buprenorphine.

4.3.10.3
In February 2020, it was noted Ms L had "stopped street working" and had various supports in place. It was suggested to Ms L that she "take the lead" in organising a meeting with workers to co-ordinate supports. However, she was noted on this occasion to have no food or gas, and at the limit for food bank applications. There is no record as to whether these issues were followed up.

4.3.10.4
Ms L had Community Mental Health Team and Integrated Substance Misuse Service appointments on the same day on occasion and would most often attend one of the appointments but would fail to attend the other. Within the healthcare notes there is evidence of both Community Mental Health Team and Integrated Substance Misuse Service documenting information for Ms L on the same day or 24/48 hours after interacting with a service however there appears to be little communication between services documented.

4.3.10.5
The Integrated Substance Misuse Service risk assessment and care plans were initiated with no updates or reviews documented.

Findings

There were often significant gaps between appointments e.g. pre-tolerance test appointment was just over a month after attendance at direct access appointment, and there was therefore possibly a missed opportunity to commence on opioid replacement therapy sooner.

Services working in isolation and taking a tunnel vision view of substance use, in the absence of context e.g. there is no mention of consideration of an adult safeguarding referral when Ms L disclosed examples of exploitation.

There was a negative impact as a result of silo working between the Community Mental Health Service and Dundee Drug and Alcohol Recovery Service.

The requirement to be recommenced on an opioid replacement therapy prescription on multiple occasions following spells of non-attendance at pharmacy; no apparent consideration of chronology of events at roots of this treatment breakdown e.g. compliance/non-compliance with depot antipsychotic medication, and whether the two might be linked.

The approach to risk management appears to be clinician dependent with feedback within the review highlighting that some workers use the Dundee Drug and Alcohol Recovery Service risk assessment, and other staff do not.

There was some recognition of the complexity of Ms L's case in June and August 2020 whereby the Integrated Substance Misuse Service and Community Mental Health Team workers discussed the option of utilising the Care Programme Approach during a Risk Management Meeting but this does not appear to have been followed up.

Assessments appeared substance focused with separate assessment documents completed by different health teams. Whilst there is a clear protocol for addressing missed days at pharmacy, there is no protocol with regard to other risk factors.

Recommendation 13

The Dundee Alcohol and Drug Partnership should continue to monitor and support the implementation of Medication Assisted Treatment standards[12] across services which would address various findings in this review.

What has already happened?

- Drug Services across the city, working together through the Alcohol and Drug Partnership, have implemented a wide range of improvements to address Medication Assisted Treatment Standards one to five. This has included, the expansion of drop-in access for drug treatment, provision of advocacy support, expansion of shared care with GP practice, rapid response to non-fatal overdose and assertive outreach services.
- Through Dundee Drug and Alcohol Recovery Service, experiential feedback from people accessing services is being routinely gathered and is being used to inform further service changes and improvements.

What else is planned?

- As well as continuing to work towards full implementation of standards one to five, partners have developed an improvement plan for standards six to ten. This is subject to regular reporting and self-assessment locally and through national self-assessment.
- The Alcohol and Drug Partnership and Violence Against Women Partnership have jointly commissioned a detailed analysis of the changing pattern of drug-related deaths amongst women in Dundee.

4.4 Research Question Four

To what extent was there evidence of Cultural competence in the context of safeguarding?

- How was Ms L's race and ethnicity considered in the context of her presentation and experiences?
- Was there an element of unconscious bias in respect of how services supported Ms L?
- How aware are staff of cultural issues particularly around domestic abuse and sexual exploitation?
- To what extent did services try to engage Ms L?

[12] Medication Assisted Treatment standards are a set of evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.

4.4.1
There was no evidence throughout the review that Ms L experienced any overt or direct discrimination or racism from any service or agency supporting her, however, the review has found there is a need for services to consider how culturally responsive they are to cultural needs.

4.4.2
Ms L's reputation and the stigma/labelling of her as a drug user and having assaulted a health worker previously informed many of the decisions and outcomes- e.g. expedited ward discharge and housing options. Some services may have perceived Ms L as being more able to safeguard and ask for assistance given she was 'loud' and 'aggressive' but actually she was the opposite.

4.4.3
Ms L shared with a Women's Rape and Sexual Abuse Centre worker that she had been subject to racial abuse by neighbours and other members of the community.

Findings

Stigma impacts on all aspects of life, especially for people who use drugs and / or alcohol, have a mental health diagnosis, criminal conviction or are from a minority ethnic background and can impact their ability to seek and get the help, support and treatment they need. Stigma can often marginalise people like Ms L and make them more vulnerable and at risk of harm. Opportunities and support to assist Ms L integrate into new communities did not seem to be available.

There is little evidence to suggest that practitioners considered cultural competence in the context of safeguarding Ms L and recognise key factors which were present:

- Ms L lacked strong social networks in the city.
- Ms L lived in temporary housing for a period of time and was moved on a number of occasions to new areas that were unfamiliar to her which would have further impacted on her ability to create social networks.
- Ms L's ability to cope with the stresses and practicalities of accommodation moves (e.g. changing addresses with services).
- The impact of exploitation and substance use whereby Ms L found it difficult to manage finances to buy food and travel to appointments.

Recommendation 14

All agencies should reflect on and review where required, what culturally sensitive training is in place to enable and support staff to exercise their professional curiosity and work with adults/families from different cultures and religions, with a priority focus on those services with substantial contact with children, young people and adults at risk of harm.

What has already happened?

- Police Scotland has progressed a national review of institutional discrimination within the organisation, including seeking input from external stakeholders.
- Public sector services continue to deliver a range of learning and development sessions focused on human rights, equalities and cultural competency. Corporate Equalities Teams are involved in a number of sub-groups of the Protecting People Committees and have contributed to the tools and resources available on the new Protecting People Learning Framework.

What else is planned?

- Learning and Organisational Development colleagues are considering the development of a new learning session focused on cultural awareness and humility within a protecting people setting.

4.5 Research Question Five

How did leadership and management oversight support practice in this case?

- Which agency held responsibility and ownership for the management of risk?
- How is management oversight of complex cases/decisions provided within Dundee City Council?
- How are senior managers/professionals updated on complex cases and how are staff supported to manage these?

4.5.1
Management oversight of practice and supervision is a core component of workforce development and of ensuring accountability for decision making. Effective supervision reduces the risk to an adult while identifying their needs and aims to help front-line practitioners provide high-quality care and support, analyse risk and develop risk management plans.

4.5.2
The review of records undertaken notes reference is made to supervision between the Community Justice Service worker and their manager, although details of this content is not contained on the Community Justice Service system. The Community Justice Service worker and manager did carry out a joint home visit and records detail a number of risk factors and evidence of exploitation. Actions in response to this however do not seem to have been considered through a safeguarding lens.

4.5.3
Housing became involved at the point of crisis in the month immediately prior to Ms L's death. There is evidence of management oversight and leadership in the provision of temporary homeless accommodation. This oversight is not evident prior to this time.

Findings

This review has highlighted the need for practitioners and managers to challenge and reflect upon cases through the appropriate supervision processes and learning and development.

Relevant information sharing within agencies in complex cases such as Ms L benefit when there is a lead professional for co-ordination. There was no lead professional with overall co-ordination of Ms L's care and support needs. Ms L was not viewed as a complex case and as such there was no escalation process, despite a professional's meeting.

Ms L's family raised the issue of information sharing with carers and family and specifically how they were updated and made aware of key issues such as Ms L's compliance with her anti-psychotic depot medication but this did not extend to other aspects of her care and support needs. The family are of the view that had they been more aware, they may have been able to help more. The absence of a lead professional contributed to this lack of engagement both to support Ms L but also in terms of support to the family following Ms L's death.

The accumulation of risk should have led to adult support and protection being explored but this did not happen as a result of no one individual person having access to or awareness of all the information to see the full picture along with the required confidence and knowledge to escalate this into adult support and protection.

Any supervision that was provided within a specific agency was minimal and process led rather than person centred. Supervision records lacked detail of what the supervision actually entailed and, where there was management oversight, this to, was applied through a service specific and task focused lens and is an issue that has been reflected in previous inspection findings and local quality assurance processes.

Recommendation 15

All agencies that are involved in the support of adults at risk of harm should ensure they have robust supervision guidance in place that is adhered to and that regular audits are undertaken to explore the effectiveness of provision and adherence to such guidance. As a priority, this should include Community Justice Services, Social Work and Community Mental Health and Drug Recovery Services.

What has already happened?

- The Community Justice Service has a model of supervision that is embedded across the whole workforce.
- The Health and Social Care Partnership has recently audited the recording of supervision and action plans have been developed to address learning from this.
- NHS Tayside Adult Protection Advisors have completed supervision training and are implementing this with health staff involved in more complex adult protection cases or who are acting as Second Workers.

What else is planned?

- Further audits are to be carried out of the recording of supervision across agencies to evaluate the effectiveness of the implementation of action plans by both the Community Justice Service and Health and Social Care Partnership.

5. Conclusion

5.1
This Significant Case Review is the Dundee Adult Support and Protection Committee's response to the death of Ms L, to share learning that will improve the way agencies across the multiagency partnership work individually and together. The Safeguarding Board in the local authority area in England has contributed to this review and may choose to progress areas or themes that are outwith the scope in Dundee.

5.2
Undoubtedly, Ms L had complex health and social care needs and this review has found that there were numerous risk factors and concerns that emerged during Ms L's time in Tayside that presented an opportunity for agencies to work effectively with Ms L and between services.

5.3
The interconnectedness of Ms L's non-compliance with her diabetes and depot[13] and the absence of care plans and risk assessments between agencies along with concerns around domestic abuse, self neglect, and exploitation all increased the risk of harm.

5.4
Ms L engaged well with services at times and at other times, engagement proved challenging. During periods when Ms L was not engaged, given the complexity of her needs, risk assessments were not completed and alternative strategies were not considered.

5.5
Whilst it is not possible without hindsight bias to comment on whether there would have been a different outcome for Ms L, she may have experienced an improved quality of life and support from services if the following areas had been strengthened:

- Management of depot medication.
- Use of adult support and protection and / or Care Programme Approach by range of services and by MARAC as a framework to support multiagency co-ordination and information sharing to inform risk management.
- Use of Mental Health Act legislation to support medication compliance.
- Escalation process.
- Lead professional.
- Information sharing – including of VPDs with statutory partners and at MARAC.
- Correlation between physical health, mental health and substance use.

[13] Slow release form of antipsychotic medication given intramuscularly by injection.

5.6
There was limited evidence of a co-ordinated and robust multidisciplinary approach to Ms L's care and support needs within key agencies/services to respond differently as a result of a lack of co-ordination and planning and not all partners were cited on the same information. Practitioners are working with increasing caseloads and levels of complexity but limited time and capacity to support and empower practitioners to support those at risk more effectively.

5.7
Communication of significant information is a key aspect of effective multiagency working which can result in more joined up working and improved outcomes for the adult, especially if the adult is unable to safeguard them self. In Ms L's case, more effective information sharing would have led to a collaborative understanding of her situation and the risks this posed.

6. What Has Changed?

6.1
Since Ms L sadly passed away, a significant amount of improvement activity has taken place in key areas highlighted within this review and staff reflected on these areas during the discussion groups.

6.2
A Gendered Services group was formed in 2019 in response to recommendations from the Violence Against Women pathways review and the substance use and homelessness strategic planning groups.

This work aims to ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning. To date, this has progressed a number of actions including a successful funding bid for the Dundee Women's Hub, which will provide a multi-agency support space for women impacted by substance use and other multiple disadvantages such as gender-based violence, homelessness, poor mental health, isolation, and trauma. The hub will provide gender-specific, trauma-informed support for women to make informed decisions regarding their support options, reducing barriers to accessing support and to improve their overall health and wellbeing.

6.3
The Women's Rape and Sexual Abuse Centre now lead a Women's Triage Meeting which is a multi-agency meeting to discuss women impacted by drug and alcohol use and other multiple disadvantage in order to create support plans and reduce barriers to engaging with support. This approach recognises the importance of the relationship that women build with workers and that it is often not helpful for multiple agencies to be involved, so this approach can support the 'lead professional' to use the meeting as a forum for guidance and support. The meeting is for women who do not meet the adult support and protection threshold but where there are multiple vulnerabilities/risk taking and may slip through the net.

The multi-agency women's triage meeting is part of the wider CORRA project. A Clinical Psychologist is now in post as part of this project and will provide senior operational leadership for this work.

6.4
The Women's Rape and Sexual Abuse Centre has also introduced an 'Initial Referral Team' who can offer 'here and now' support, with the result that the waiting list has decreased from 100 survivors waiting for support to around 60 in a matter of months. The Women's Rape and Sexual Abuse Centre has also noted that sometimes women coming into the service are reaching out in crisis and although they have experienced sexual violence, their initial support needs are more around other issues (housing, for

example), and are able to provide some input around this. The Women's Rape and Sexual Abuse Centre continue to look at women's needs more holistically and support with barriers to engaging. Lastly, the Women's Rape and Sexual Abuse Centre staff have completed Safety and Stabilisation Training.

6.5
A number of changes have been implemented within housing services over the past two years and these include:

- Domestic Abuse Policy implemented which focuses on supporting those affected by domestic abuse by taking a person-centred approach. It sets the assessment of risk and input from the adult and other professional services. It also sets out the role of child and adult protection and provides appropriate escalation and oversight for each case from a management perspective as well as assessment for multiagency involvement and escalation.

- Increased social need points for those people affected by domestic abuse.

- Pilot of Housing Options Social Worker in partnership with Dundee Health and Social Care Partnership which demonstrated the positive impact of integrated services where information sharing flows, to allow for focussed actions and support being put in place for those presenting to the Housing Options Service.

- Honeygreen partnership with Dundee Women's Aid (Women only temporary accommodation with support) launching May 2023.

- Development of Personal Housing Plans in consultation with members of the Homeless Strategic Partnership Group which facilitates a consistent approach across the partnership to assess housing and support needs.

- Adult support and protection refresher training for the Housing Teams.

- The Housing First model has been re-introduced with a focus on complex needs and mental health needs of women to provide intensive support with Transform as the lead agency.

6.6
Since this incident, there has been significant investment into the Pharmacy workforce in the Community Mental Health Teams across Tayside to support the safe and effective use of medicines for patients, including long-acting injectable antipsychotics. Additionally, the NHS Tayside Mental Health and Learning Disabilities Medicines Management Group has commissioned the development of guidance to support clinical teams in the use of long-acting injectable antipsychotics (including guidance on patients who miss doses). It is expected that this will be completed in the summer of 2023.

There is also evidence of a more proactive approach to enable the breakdown of barriers for persons prescribed depot[14] medication within a community setting including; attempts to make contact and communicate with persons when they have not attended, continued attempts to make contact with the potential escalation to fly by visits and/or request a police welfare check.

6.7
The Scottish Drugs Deaths Taskforce, set up by the Scottish Government in 2019, 'prioritised the introduction of standards for medication assisted treatment to help reduce deaths, and other harms, and to promote recovery'; Medication Assisted Treatment Standards[15] (2021). From this, we will also see a shift in focus on the implementation of standard 9 and the collaborative working between substance use and mental health services, as well as other improvements including access to independent advocacy, support to engage with primary care and medication reviews and harm reduction as part of this.

6.8
Dundee now has five weekly direct access clinics delivered from different locations across the city, providing quicker access to treatment. The direct access clinics have an input from independent advocates and other third sector organisations who are able to identify other basic needs and support individuals such as Ms L to access those supports. As part of the implementation of Medication Assisted Treatment, there is harm-reduction support to provide much broader conversations and the focus is on an individuals' risks and general health. Naloxone is also available much more widely available.

6.9
The majority of Dundee Drug and Alcohol Recovery Service staff have received training from the gendered services project. In addition, through the work of the Tayside Drug Deaths Review Group, there is much more of a focus on the recognition of specific risks for women, recognising these differ from the risks affecting men (e.g. women who have had children removed are at a greater risk of drug death).

6.10
Over the past three years, the Non-Fatal Overdose Group has been strengthened and has a specific focus on women experiencing non-fatal overdoses, including assertive outreach support that was not previously available.

6.11
The Community Mental Health Service in Dundee has introduced disengagement plans in 2021 to support those who have difficulty engaging and is reflective of an individual's needs and supported by assertive follow up and escalation of concerns activity where appropriate. Dundee Teams are introducing a generic email address which will mean that information sharing will not be person-dependent and there will be requirement of attaching to EMIS as part of this.

[14] Slow release form of antipsychotic medication given intramuscularly by injection.
[15] Medication Assisted Treatment standards are a set of evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.

6.12
NHS Tayside record keeping standards are in place and include monthly audits of records and as part of this, ensure that a current risk assessment is in place even if the adult is only open to a medic.

6.13
In addition to the circumstances of Ms L, the NHS Tayside diabetes specialist team have noted an increase in admissions; often young people, with drug/alcohol issues and psychological and/or intellectual issues. A recurrent Diabetic Keto-Acidosis Pathway is now in place with monthly meetings (commencing April 2023) which will review cases of people who have had multiple episodes of Diabetic Keto-Acidosis and consider means of mitigating the risk, including consideration of the 'adult at risk' definition and whether this might be met. An NHS Tayside Adult Protection Advisor will support this meeting to ensure the adult safeguarding perspective is comprehensively considered, including more assertive and creative ways of engaging with a patient.

6.14
There is now a triage group within two localities of Tayside (including Dundee) for complex domestic abuse cases to be discussed by professionals involved should it be identified that a more in-depth conversation of circumstances and vulnerabilities is required, however, this is non-statutory and access for referral is dependent on persons at MARAC being aware that this is an option for further discussion.

There are now MARAC updates of when a victim has contact or has been subject to another domestic abuse incident provided to all MARAC representatives within organisations who attend a MARAC meeting relating to a victim within a 12-month period of discussion

6.15
Police Scotland have a clear escalation process for the number of VPDs for an individual within a defined time period and along with NHS Tayside, have introduced dedicated staff to support adult support and protection processes within each Tayside locality.

6.16
The navigator service has developed since introduction in 2020 and the Navigator's now work three out of four weekends in the NHS Tayside Emergency Department aiming to engage with people who attend with a variety of social issues, including drug and/or alcohol use, emotional distress, domestic abuse, suicidal ideation, homelessness and often a combination of these. During the Monday to Friday period, the navigators work to follow up on patients who have been referred by clinical staff using an assertive outreach model to link them into community supports. The Navigator service works closely with other agencies to ensure the best support going forward for patients.

6.17
The Violence Against Women Partnership/Commercial Sexual Exploitation Working Group has developed and published a 'Commercial Sexual Exploitation' Guidance document which provides information and guidance to those supporting women who may be at risk of sexual exploitation.

7. Summary of Recommendations

Recommendation 1	All statutory agencies should review and provide evidence and assurance that trauma informed and person-centred care is accurately understood within their agencies/services, with a priority focus on those services with substantial contact with children, young people and adults at risk of harm.
Recommendation 2	All partner agencies should review their approach to delivering gendered services, with a priority focus on those services with substantial contact with children, young people and adults at risk of harm.
Recommendation 3	Housing, supported by the wider multiagency partnership should build upon the improvement actions achieved to date to mitigate against the various factors that contribute to vulnerable adults with complex needs experiencing periods of homelessness to ensure they are able to access the right housing to meet their needs.
Recommendation 4	Dundee City Council should ensure that arrangements are in place across social work and social care services to support the workforce to understand how to seek clarity regarding legal obligations of the local authority and how to ensure clarity of voluntary agreements entered into in the absence of legal obligations where service users are moving across geographical boundaries.
Recommendation 5	Scottish Government should consider the need for guidance to local authorities regarding individuals on Criminal Justice Orders or licences from outwith Scotland moving to Scotland where there is no Scottish equivalent.
Recommendation 6	All agencies should ensure their staff understand and adhere to adult support and protection pathways and referral routes in line with the Code of Practice, with an initial focus on Housing, Community Justice Services, Community Mental Health Services and Dundee Drug and Alcohol Recovery Service.

Recommendation 7	The Community Mental Health Service across Tayside should ensure that there is clear and consistent guidance on the management of missed doses of antipsychotic depot injection medication (or other relevant medications) which include a clear escalation process.
Recommendation 8	The Public Protection Committees should revise their programme of work to deliver a shared model of risk assessment across the multiagency partnership to identify an expedited but achievable delivery plan with agreed resources to support this.
Recommendation 9	NHS Tayside should undertake a review of the recurrent Diabetic Keto-Acidosis pathway at an appropriate point following implementation to determine whether this might benefit from update in terms of e.g. additional referral routes into the pathway, and means of factoring in historical Diabetic Keto-Acidosis episodes, outwith NHS Tayside.
Recommendation 10	The Tayside MARAC steering group should review all relevant policies and protocols to ensure these are fit for purpose and seek assurance from participating partner agencies that these have been fully implemented in practice.
Recommendation 11	The multiagency partnership should ensure agencies understand the various ways the partnership deals with risk and the role of the lead agency within this.
Recommendation 12	Dundee Health and Social Care Partnership along with key statutory partners should formally explore the development of an integrated multiagency screening hub for adults at risk of harm.

Recommendation 13	The Dundee Alcohol and Drug Partnership should continue to monitor and support the implementation of Medication Assisted Treatment standards[16] across services which would address various findings in this review
Recommendation 14	All agencies should reflect on and review where required, what culturally sensitive training is in place to enable and support staff to exercise their professional curiosity and work with adults/families from different cultures and religions, with a priority focus on those services with substantial contact with children, young people and adults at risk of harm.
Recommendation 15	All agencies that are involved in the support of adults at risk of harm should ensure they have robust supervision guidance in place that is adhered to and that regular audits are undertaken to explore the effectiveness of provision and adherence to such guidance. As a priority, this should include Community Justice Services, Social Work andCommunity Mental Health and Drug Recovery Services.

[16] Medication Assisted Treatment standards are a set of evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.

APPENDIX 1 – Terms of Reference

SIGNIFICANT CASE REVIEW – Ms L

TERMS OF REFERENCE

1. Initial Case Review

As a result of a referral submitted via Dundee Drug and Alcohol Recovery Service, an Initial Case Review was undertaken and completed into the circumstances surrounding the care and support of Ms L.

The conclusion of the Initial Case Review identified a number of issues that a Significant Case Review should focus on and explore further, in respect of the Terms of Reference which are set out below, with a view to identifying lessons learned and opportunities for practice learning and improvement, as well as recognising good practice.

It should be noted that there has been a delay from the end of the Initial Case Review process to the point where the Significant Case Review process has due to a number of challenges related to the Covid-19 pandemic and securing external reviewer input.

2. Timeframe

The Significant Case Review will explore the involvement and interaction with and between the agencies involved with Ms L from the time of arrival in Dundee in 2019 until her death in October 2020.

Specifically, the Significant Case Review should focus on the following questions;

Research Question 1: In respect of Ms L, to what extent did services hear the voice of the adult?

- How did practitioners work to 'find the person', and seek to understand their perspective and to make safeguarding person-centred?

- To what extent did practitioners develop positive and trusting relationships with Ms L?

- To what extent did practitioners recognise and respond to concerns from Ms L that she felt unsafe and at risk of harm?

- To what extent did practitioners understand the challenges and difficulties that Ms L was experiencing and communicating?

- Was Ms L's voice central to assessments and decisions?

Research Question 2: To what extent were pathways of care and transitions of care person centred?

- What Policies/procedures exist or management of depot/Did Not Attends within the Community Health Service ad were these followed?

- Were Ms L's health and social care needs understood and assessed in an integrated way?

- How was information from England used to inform health and social care needs? How was knowledge of Ms L's history used to understand behaviour and developing relationships?

- To what extent did health and social care needs inform decisions around accommodation and housing?

- Was there a negative outcome for Ms L due to the fact that her social work input was via the Community Justice Service rather than adult services?

- Was there evidence of joint working across teams and agencies to achieve a multiagency approach to meet Ms L's complex needs?

- What crisis pathways are available when core pathways are no longer able to meet a person's needs?

Research Question 3: Was there a systemic and holistic approach to identification and management of risk?

- Was all information used to inform assessment of need and risk management? Were risk assessments/safety plans and care plans in place? How were these used to inform a cumulative picture of risk?

- Was there consideration of capacity in light of mismanagement of diabetes, long term use of substances and trauma and how this may have impacted on ability to safeguard?

- Was there a timely response to referrals/concerns across the key agencies?

- How did the MARAC process inform responses to abuse/harm/exploitation and were these appropriate?

- How was Mental Health Act and Adult Support and Protection Legislation used/ considered in Ms L's case given history of mental illness, trauma, substance misuse, domestic abuse, financial harm and exploitation?

- Was there effective communication, recording and information sharing to manage risk?

- Was there evidence of professional curiosity in relation to risk assessment, health needs, non-engagement and social issues?

Research Question 4: To what extent was there evidence of Cultural competence in the context of safeguarding?

- How was Ms Ls race and ethnicity considered in the context of her presentation and experiences?

- Was there an element of unconscious bias in respect of how services supported Ms L?

- How aware are staff of cultural issues particularly around domestic abuse and sexual exploitation?

- To what extent did services try to engage Ms L?

- Research Question 5: How did leadership and management oversight support practice in this case?

- Which agency held responsibility and ownership for the management of risk?

- How is management oversight of complex cases/decisions provided within Dundee City Council?

- How are senior managers/professionals updated on complex cases and how are staff supported to manage these?

3. Involvement of the Family

The Significant Case Review Lead Reviewers/Independent Chair of the Dundee Adult Support and Protection Committee will seek contributions to the review from appropriate family members and keep them informed of key aspects and progress should they intimate they wish to be involved.

4. Outcomes of the Significant Case Review

With reference to the above Research questions, the Significant Case Review will:

- Identify areas of good practice that should be developed and replicated in adult support and protection work;

- Establish any learning from this case as to how local professionals and agencies should work jointly to safeguard adults at risk of significant harm;

- Identify any actions to be implemented by the Dundee Adult Support and Protection Committee to promote learning and develop training in order to support and improve processes and practice; and,

- To determine whether, and if so, what changes in practice are necessary to prevent future missed opportunities in Adult Support and Protection cases.

5. Approach

Reviewers from Dundee Health and Social Care Partnership and NHS Tayside will work with the Case Review Group to prepare a report based upon the findings from the afore-mentioned research questions and any other relevant information gathered during the course of the review. An independent Adult Support and Protection Committee Chair from neighbouring partnership has been appointed to undertake a 'critical friend' role and support the Lead Reviewers.

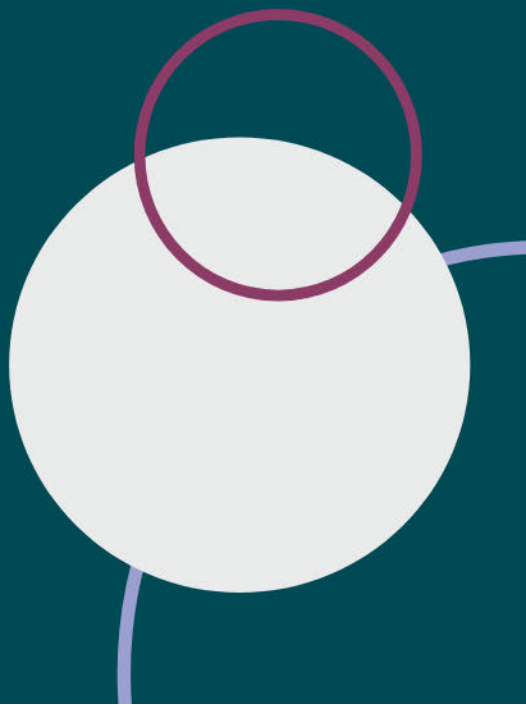
A Case Review Team will be established to take a learning approach to this case and focus on a 'Network of Support' type analysis of the work relating to Ms L to ensure that the views and experiences of the staff involved with Ms L are fully included in the Significant Case Review.

APPENDIX 2 -
DEPOT[17] Medication Timeline

Date Depot scheduled for administration	Date Depot Administered	On Time/Number of days late
3 weekly 500mg Zuclopenthixol Decanoate		
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	7 days late
[redacted]	[redacted]	7 days late
[redacted]	[redacted]	13 days late
[redacted]	[redacted]	12 days late
[redacted]	[redacted]	3 days late
[redacted]	[redacted]	6 days late
[redacted]	[redacted]	
[redacted]	[redacted]	7 days late
[redacted]	[redacted]	28 days late
[redacted]	[redacted]	

[17] Slow release form of antipsychotic medication given intramuscularly by injection.

Date Depot scheduled for administration	Date Depot Administered	On Time/Number of days late
Changed to 2 weekly 400mg Zuclopenthixol Decanoate		
[redacted]	[redacted]	On Time
[redacted]	[redacted]	I day late
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	9 days late
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	On Time
[redacted]	[redacted]	24 days late
[redacted]	[redacted]	25 days late
[redacted]	[redacted]	18 days late
[redacted]	Ms L deceased	



Protecting People in Dundee