SIGNIFICANT CASE REVIEW
ADULT 018

Report by Kirsty Lee and Grace Gilling

ON BEHALF OF ANGUS ADULT SUPPORT AND PROTECTION COMMITTEE

28 FEBRUARY 2020

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Foreword from Angus Adult Protection Committee

As Independent Chair of the Angus Adult Support and Protection Committee, I wish to express my sincere condolences for the loss of Adult O18 and thank their family who have supported the work of this Review in the hope that the Committee and professional staff working with vulnerable adults can learn and improve how we work to support positive outcomes for young people.

The Committee wishes to express its sincere thanks to the Review Team who have conducted a very detailed and comprehensive review of the circumstances of this young person's life and who have diligently addressed the Terms of Reference that were established at the outset of this Significant Case Review. Many other people have also contributed to the work of the Review and their support and assistance is sincerely acknowledged by the Committee.

The Committee accepts in full the recommendations detailed in the Report. Staff involved with Adult O18 delivered a significant amount of excellent professional work and the Review acknowledges that the circumstances presented to staff were on occasions challenging and emotive.

In relation to cases as complex as this one, improvements in process and policy have already been developed to proactively improve our approach to supporting similar complex cases, which require an enhanced level of multi-agency working. An example of this is the work done to improve transitional pathways for young people by introducing a Complex and Co-existing Needs protocol, which supports timely access to advice and guidance through Adult Health and Social Care Services. Similarly, the Committee is already in discussion with the Scottish Ambulance Service to enhance information sharing in respect of vulnerable adults that the Service comes into contact within crisis circumstances.

Despite this and other work that the Committee has embarked upon, the Review recommendations are accepted, and Committee members are committed to delivering lasting system change and will ensure that the learning gained from this Review will drive improvement in practice and training.

The Improvement Plan arising from the Review that will be developed and progressed to ensure where necessary, culture, systems and practice will be changed so that vulnerable adults in Angus receive the highest possible levels of support and assistance to properly address their needs and rights, to improve their quality of life and to ensure their safety. The Plan will be reviewed at regular intervals and where necessary revised to ensure its continued relevance and that it delivers the important changes set out in this Report.

Ewen West

Independent Chair

Angus Adult Support & Protection Committee

PART 1 INTRODUCTION

Adult O18 was a young person who lost their life during autumn 2018. O18 was aged 18 at the time of death. O18 was known to many services and was subject to an Adult Support and Protection Plan. Significant adverse childhood experiences, substance use, poor mental health, homelessness and offending featured heavily in O18's life, particularly between the ages of 16 and 18.

Following O18's death, Angus Adult Protection Committee (AAPC) received a request for consideration of a Significant Case Review (SCR) on the grounds that adult O18 was in receipt of services, was subject to an Adult Support and Protection Plan and that O18's experience of services provided an opportunity to learn and improve how we work. Following completion of an Initial Case Review (ICR), AAPC agreed a SCR was necessary to explore in depth the circumstances of O18's death and the time and events leading up to it.

This SCR has been conducted with regard to Adult Support and Protection (Scotland) Act 2007 and with reference to Tayside Multi-agency Guidance for Adult Support and Protection (updated 2019).

O18 has touched the lives of many of the professionals involved in their support and this was clear from the recollections of those closest to O18. O18's family, professionals involved and members of the AAPC share the same goal; that learning is achieved for all services in reviewing the interactions O18 had with services and that best practice is identified and built upon and that ultimately improvements are made to support positive outcomes for young people experiencing similar challenge and adversity as O18.

Aims of the Significant Case Review

The expected outcomes of the SCR were endorsed by AAPC and agreed by Angus Chief Officers on 16 January 2019. The anticipated outcomes are to:

- Identify areas of good practice and practice that should be developed and replicated in adults support and protection 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 AAPC to promote learning to support and improve systems and practice
- To determine whether, and, if so, what changes in practice are necessary to prevent any such missed opportunities in the future

Terms of Reference

The Terms of Reference posed three specific research questions:

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

Methodology

The SCR is conducted in accordance with the Terms of Reference (appendix 1).

The SCR was conducted in a carefully structured way to include exploration of the key issues by way of case file reading and staff engagement. The approach focused on the outcomes achieved for the young person and reflected on how the systems worked together to achieve these and any barriers to best practice. Individual practice was evaluated but was not the focus of the SCR; where individual practice issues were identified, these were reported to single agency representatives. The focus was on how the culture, systems and processes worked in identifying need, supporting and where necessary, protecting, O18 from harm.

A series of individual interviews with key professionals was held before progressing to an inclusive Network of Support meeting where professionals reflected on key questions together. The questions were raised in a manner that allowed reflection on individual practice within wider systems, process and practice at the time, viewing practice from 'the tunnel'. Participants were encouraged to reflect on how they worked with O18 within the local systems and 'even better if…' focusing on what they think needs to change to improve outcomes for other young people.

Practitioners were asked their view on the typicality of the experience of O18. Whilst they considered O18 as an individual with very unique and complex issues, they recognised a number of other young people with whom they have had, or currently have, contact with, who experience some of the same challenges in Angus.

A Case Review Group offered professional oversight and challenge to the Reviewers throughout the process. Independent support and supervision was commissioned from a consultant with expertise in child and adult social care and protection (group membership is detailed in appendix 2).

The methods used to gather information and perspective on the timeframe, as identified in the terms of reference, are included at appendix 3.

The Reviewers

Angus Chief Officers commissioned individuals from Angus Council and NHS Tayside to lead the Significant Case Review. The individuals were selected based on their experience, skills and knowledge. They have no connection to any operational work involving O18 or operational management of any of the services involved.

Kirsty Lee is a Service Leader in the Children, Families and Justice Directorate in Angus Council with responsibility for Child Protection and Review Services. She has extensive experience as a practitioner and manager in Children's Services and in Quality Improvement and Strategic Planning.

Grace Gilling is the Strategic Lead for Adult Protection within NHS Tayside with a 30-year career within NHS Tayside and broad experience as a practitioner and senior manager in Mental Health Services. Grace has experience of undertaking investigations and reviews, with a particular focus on maximising opportunities for learning and improvement.

Views of the Family

O18's family have been consulted and informed throughout the SCR. O18's family have welcomed the opportunity for learning and improvement to be taken from the tragic loss of O18. In particular, O18's family have highlighted improvements in access to mental health services both pre and post 16 as issues they would like to be addressed locally and nationally.

Part 2 O18'S STORY

Whilst O18's childhood was not subject to the terms of the Review, the Reviewers felt it important to provide a context to aid understanding of some of the matters reported later in this report.

Early Years and Childhood

O18 moved to Angus at approximately two-years-old. O18 had a number of older siblings and a younger sibling and the children lived together with their mother. O18 had no contact with their birth father but had a significant relationship with their mother's partner, who was the father of the youngest sibling.

Social work services were intermittently involved with the family between O18 being two and seven years old in response to referrals for O18 and siblings relating to supervision and care. O18 was the victim of domestic abuse having experienced this in the home at an early age. Support to the family included respite care and advice and guidance. At aged nine, O18 was referred back to social work due to concerns surrounding behaviour in school and poor attendance and had significant periods of contact with social work on several occasions over the next few years. O18 was subject to a short period of Compulsory Supervision at home.

From the age of 14, concerns escalated significantly with several police concern reports, periods of being missing, poor school attendance, aggressive behaviour in the home and at school and concerns over self-harm and low mood. The family situation fluctuated with some significant periods of neglect, poverty, isolation and family chaos. O18 was referred to the Children's Reporter at age 15 and the recommendation was that no order was necessary due to the family complying with support being offered from a Family Support Service. O18's case remained open to children's services, with reactive support being provided to the family up until O18 attained the age of 16 and was not in education, therefore the case was closed.

O18 was involved with Child and Adolescent Mental Health having first been referred at age seven. O18 was diagnosed aged seven with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiance Disorder (ODD) and commenced medication. This was subject to review twice per year. At age 10, O18 was referred for a short programme of social skills and family work. At age 15, O18 was offered a programme of 1-1 support on emotional regulation and mood and further medication was prescribed for a moderate depressive episode in the context of bullying at school at this time. At aged 15, O18 commenced cognitive behavioural therapy and participated in some of the work before requesting a therapist of a different gender. The treatment did not continue and O18 was later discharged from CAMHS.

O18 as a Young Adult

O18 left school at the end of their 4th year with a plan in place to access college education with the support of the 16+ service. Records indicate O18 did not engage with this service and did not pursue further education, training or work. O18's case was closed to children's services as they were not subject to a statutory order and were no longer in full time education. At age 16, O18 became an open case to Criminal Justice Social Work (CJ Social Work) after committing a series of offences in the local community. O18 was assessed for a Fiscal Work Order before being made subject to a Community Payback Order and later a High Tariff Structured Deferred Sentence. The Criminal Justice Social Worker (CJ Social Worker) had consistent contact with O18 from age 16 onwards.

O18 presented as homeless five weeks after their 16th birthday and, following failed attempts at mediation with the family, Housing Services had a legal duty to find accommodation. This was initially provided on a night by night basis at temporary accommodation 1 (hotel accommodation), before moving to accommodation 2 (homeless unit) where, after a short period, O18 was asked to leave due to disruptive behaviour. O18 then moved in with a family member before again presenting as homeless and was placed at accommodation 3 *(*temporary accommodation) where concerns were raised around their ability to manage to live independently. O18 was then remanded in a Young Offenders Institution (YOI). On liberation from YOI, O18 was accommodated in temporary accommodation in a different town (accommodation 4) before another period in a YOI. Following liberation, O18 moved to temporary accommodation 5, where it is acknowledged that O18 was settled in this rural location and there were no concerns raised during their short time here. O18 was reported to have made connections with a family in the community and be engaged in activities they appeared to enjoy. Following completion of an assessment of need, O18 moved to accommodation 6, a supported accommodation tenancy in a different town.

O18 was charged with a serious offence and had a court case pending.

Timeline of Significant Events

The scope of the SCR covers the period from when O18 moved to supported accommodation (accommodation 6) until their death, a period of 16 months.

A detailed chronology was developed as part of the ICR and this helped the Reviewers establish a timeline for key events and identify key episodes requiring more in-depth analysis.

The chronology of events was used to analyse the approach and response taken by agencies in support of O18. The Reviewers have been careful to consider the responses in the context of work and inter-agency work at the time of the occurrences. The Reviewers acknowledge the benefit of hindsight in practice and system evaluation.

PART 3 FINDINGS

Research Questions

The SCR will explore the involvement and interaction within and between the agencies involved with O18 from June 2017 until autumn 2018 when O18 died, in respect of three research questions:

Research Question 1 - To what extent was the information held by agencies in respect of O18 shared appropriately within that agency and with other partner agencies involved with O18?

Information Sharing

The Reviewers had access to a high volume of professional information regarding O18. Through the 16 months in scope for the SCR, O18 was in contact with and/or supported by several professionals from 21 different teams/services. Of these professionals there were a 'core' group who had frequent contact (more than once per week) with O18 and with each other. The chronology of events shows there was a high number of significant events, some with threat to life and many resulting in high risk to O18's physical, emotional and mental wellbeing. The Reviewers found that the core agencies involved with O18, identified as Housing and Housing Support provider, CJ Social Work, Angus Integrated Drug and Alcohol Recovery Service (AIDARS) and WEB Project were in frequent contact with each other to share information, to react to risk and need and adapt support to O18. The case files detail many examples of professionals working together to respond to crisis events, to meet O18, offer support to attend follow-on appointments, emotional support and counselling. Information sharing between these agencies was viewed as strong by the Reviewers with evidence of a commitment between agencies to share the weight of responsibility that some felt. Information sharing between core agencies occurred because of good professional practice but was not supported by joined up recording systems. Each agency has its own recording system which stands alone and does not support or facilitate the sharing of information. For some of the services provided by the local authority and Health and Social Care Partnership, one information sharing system was used and this allowed for some of the services to access shared information. This did not replace face-to-face contact and professional relationships. Good information sharing requires practitioners to be curious, to follow up with other professionals in the network and work in partnership and this was happening routinely between core group members. Professionals have described feeling they were holding a higher degree of risk with O18 than perhaps was their usual experience. There was an expressed 'inevitability' about the poor outcome that occurred for O18 because of

the highly risky behaviour O18 was engaged in, including injecting and chaotic substance use, self-harm and the consequences of vulnerability and risk from others.

Good Practice Example 1
Commitment to openly share information and take action on receipt of information from the core group of professionals in this case is viewed as good practice. There is evidence that the core group of professionals, on the whole, valued each other's input, expertise and relationships with O18 and pulled together in times of crisis to ensure that O18 received help and support. Professionals put in place contingency plans during times of absence and proactively sought information in order to assess and mitigate risk.

Whilst information sharing between core professionals was taking place consistently (despite a lack of a coordinated system to support this), the SCR highlighted that there were significant gaps in information known to the core professionals involved that may have influenced their assessment and decision making and intervention with O18.

In the course of file reading, the Reviewers found there was significant information held by other agencies not central to the support network of O18. The SAS had a significant number of contacts with O18 relating to substance use and self-harm and where O18 was not transferred to hospital. SAS currently do not have a clear system in place to support sharing of information relative to adult support and protection with other services that may already be involved with an individual. SAS are often in attendance at an incident together with Police Scotland and rely on their Vulnerable Person's Database (VPD) system to ensure information is shared. Ambulance crews often do not receive any advance information about the person they are attending and therefore, are unable to identify if the person is already identified as 'at risk'. Whilst there is a reliance on the Police information, the Police are not always able to or required to arrive at the scene before any transfer to hospital.

Whilst there is a policy in place for SAS making adult protection referrals, there is no clear system or process in place to support this and at the time of O18, the practice would be for the attending SAS crew to contact Angus ACCESSLine to share information and/or make a referral. The SAS recording system does not highlight patterns of repeat calls, due to this being based on the location of the incident with often no personal details of the patients being available at the time. The systems in place are there in support of preservation of life and access to treatment and there is work that needs to take place on how systems can support the identification of adults potentially at risk of significant harm. Additionally, as an organisation, the SAS may send a crew from anywhere within the East region to respond to a call who may not be familiar with the reporting procedure within a specific locality. Contacting ACCESSLine is unlikely to offer a sufficient and timely way to share information about people for whom there may be an adult protection concern.

There are a number of local strands of work taking place with SAS to consider how best to share information and make appropriate referrals as, whilst a national procedure would be more beneficial to the SAS, developing an agreed process across Tayside would be a significant improvement.

One of the major difficulties faced by professionals working within complex organisations is the inability to access appropriate and timely information and this was highlighted across all agencies during the review. Information technology and universal access to a person's records remain a considerable problem across health and social care services.

Finding
The absence of any co-ordinated recording system resulted in inadequate information sharing between some agencies with the result that core agencies with a key role in supporting O18 were unsighted on key information which did not support practitioners to recognise a cumulative pattern of significant risk of harm for O18, or consider triggers.

Recommendation 1
AAPC should engage in discussion with all partners to review how information is shared when individuals make complex and repeat presentations to their service. This should include how case management and case recording systems can be integrated to support a solution. AAPC should ensure action is built on learning from the local non-fatal overdose pathway that has been trialled between SAS and Angus HSCP.

The SAS should, on a national basis, review policy and procedures in place to support staff to share information and/or make adult protection referrals where this is necessary to safeguard vulnerable adults being treated by the service.

The SCR found that the core group of professionals were sharing information between them and were operating with a level of confidence that they understood O18's needs and risks when in fact they were not in possession of all of the information that could have been used to make a full assessment of risk and inform a risk management plan. This includes contacts with MIUs and A&E departments in relation to self-harming and overdose. The Reviewers found that the GP was the only professional who received most of the communications in relation to O18 from a range of health-based services.

O18 saw a number of GPs during the 16 months they were registered with the practice rather than always having appointments with a named and consistent GP. This was usually as a result of appointments being urgent rather than planned by O18. As a result, there was no specific GP within the practice who had overall knowledge of O18 which had been accumulated over a number of consultations. O18's GP was not

aware O18 was deemed an adult at risk within ASP legislation prior to death but was sent a copy of ASP case conference minutes. O18's GP was not aware that the last contact with a GP on 31 August 2018 resulted in a Police Community Triage call rather than a face-to-face assessment.

The Reviewers concluded that having a single named GP for complex cases such as O18 would have improved the GP knowledge and understanding of the patient's specific needs and vulnerabilities and recommend this as an improvement action. The ambition should be to extend and identify individuals within a particular practice who would benefit the most from GP continuity of care whereby relationships are developed, and oversight is gained and which supports early identification. Any such process should ensure that all key professionals are made aware of who the identified GP within a practice to liaise with is. Alternative options should be explored within the context of the findings of the Hard Edges Report and evaluation of local improvement work.

Finding

The Reviewers noted a wealth of information within the range of agency records but agencies were not passing on all relevant information in their possession and the GP appeared to be the central location for information to be sent to. This resulted in practitioners operating without the full picture of concerns and actions taken.

Recommendation 2

A single named GP should be identified for complex cases (such as registered adult protection cases) via an agreed process with Primary Care.

Whilst information was shared between core agencies involved, the formation and analysis of the information could have been significantly improved. Chronologies have been discussed in adult support and protection work for several years. AAPC have chronologies guidance in place. The findings of self-evaluation work as reported in the Angus Adult Support and Protection Annual Report 2018/19 and in Angus Adult Protection Case File Audit Report (December 2019) highlights varying presence, quality and use of chronologies in adult protection work. A chronology was available for O18, but it was single agency and started at a point when the case was opened by the AIDARS team and offered little value as an assessment or decision-making tool. Compiling a shared chronology as part of the assessment of risk and resilience could have enhanced the collective understanding of O18's needs. Of particular relevance is the escalation of highly risky behaviour since moving to supported accommodation and establishing a pattern of overdose (either intentional or otherwise) which may have been more prominent if significant events were collated and analysed in a more dynamic way.

Finding

Chronologies were not used to establish and analyse patterns of behaviour or risk and those available were not used as part of the assessment and decision-making framework for O18.

Recommendation 3

Angus APC should establish a clear multi-agency plan for improvement in the area of chronologies linked to assessment of need and risk in adult protection work including a learning and development approach, setting minimum standards of practice and evaluating practice improvement and impact.

Referral and Decision Making for Adult Support and Protection

Early Screening Group

During September 2018 there were a number of incidents (days apart) of attempted suicide, self-harm, suicidal ideation and overdose that Police attended and completed VPD reports for. The police reports were shared with Angus Health and Social Care Partnership as per the Early Screening Group Protocol.

Angus Early Screening Group (ESG) is a multi-agency forum established to ensure that there is an informed and appropriate response to adults about whom the Police have concerns. Policy notes the ESG aims to prevent community care teams from receiving referrals about people who do not need any social work and health support and to target referrals, along with relevant background information, to the community care teams when specific needs are identified, putting adults in need of services in touch with these services at an early stage (ESG Protocol 2014, revised in 2018).

The intended outcomes are to make clear recommendations for action from the following options:

- No further action (NFA)
- To advise GP or adult concerned as to the availability of services
- To refer to a community care team
- To specify whether the referral to a community care team is an adult protection referral
- To consider whether there are concerns in respect to either child concerns or high-risk offending arising out of any case discussed and decide where such concerns should be passed on

Where the adult is an 'open case', the information is routed directly to the Care Manager for their information and appropriate follow up. The Reviewers were unable to confidently ascertain how CJ Social Work fits into this process. CJ Social Work are a separate service dealing with adult offenders in response to specifically identified

needs; as they are not an adult care service, they do not undertake Adult Protection inquiry or investigation. There were a high number of VPD's for O18 (25 during the period in scope; a total of 65 since the age of 14) and there does not appear to be consistency in the way information is shared with this service although it is clear they were receiving many of the completed VPD's.

In response to the particular VPD received in September 2017, the case was scheduled to be discussed at the ESG and the CJ Social Worker was invited to attend a meeting for the particular discussion on O18 (ESG members discuss several referrals in one meeting.) Although unusual for case workers to be invited, the worker together with the third sector worker attended the meeting in the hope that services would follow, particularly mental health support. Participants at the meeting shared what they knew from their single agency record checks and were provided with a summary of information from the attending workers. Following presentation of the information the attending workers left.

There are no minutes of the ESG meeting, and the Reviewers understand the meetings are not minuted but ESG decisions are recorded on the CareFirst system, which is a social work recording system. The outcome of the ESG was that O18 did not require a referral to a Community Care Team, nor that the referral should be considered adult protection (see potential outcomes above). Due to the lack of recorded information, Reviewers were not clear as to how or on what information this decision was reached. The outcome was communicated to the CJ Social Worker via a series of emails.

The decision to discuss this case at the ESG without access to all of the information or available history led to flawed decision making at this time. It is the assessment of the Reviewers that given O18 had a diagnosis of ADHD along with the significant concerns being raised by professionals, O18 should have been referred to Angus CMHS to facilitate a robust mental health assessment and treatment plan.

This was a missed opportunity to convene an Interagency Referral Discussion (IRD) and identify O18 as a potential adult at risk of significant harm (as would happen some months later). The impact of the decision of the ESG led to a developing narrative in this case that O18 did not meet the criteria for adult protection because they did not meet the 3-point test criteria*. This was further reinforced by a series of correspondence in response to Housing submitting an adult protection referral around the same time (see below). The use of the ESG to assess the threshold for adult protection did not support sound decision making on this occasion.

*3-point test - The person is an adult (aged 16 or over) **and**: 1. unable to safeguard their own well-being, property, rights or other interests, **and** 2. is at risk of harm, **and** 3. because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

One potential outcome of the ESG is to advise the person's GP of the incident. The information relating to the incidents discussed at ESG were shared with O18's GP. Angus Adult Protection Committee Annual Report 2018/19 notes that during the year there were 368 ESG referrals for Angus as a whole, 74 of which were passed to the GP

(20%). In this case, VPD reports were being shared with the GP from the ESG. The GP record is noted to contain no less than 47 attachments including Police VPD Reports, letters from professionals, invites to Case Conferences and outcomes of referrals. The GP was unaware of the specific notifications from the Angus ESG for this case. Network of Support discussion highlighted a lack of awareness or understanding by GPs on what is expected on receipt of adult VPD reports. The Reviewers have identified questions for Angus APC in respect of the efficacy of this outcome. Angus APC should assure itself that a shared understanding and agreement exists between professionals and agencies about what should happen when a GP is sent this information and what difference this makes for people in Angus.

AAPC should satisfy itself that this has a satisfactory outcome for adults who have consented to Police sharing information or for whom there are significant adult protection concerns. The GP in this case was not confident in the shared understanding from local GPs in what they might do with this type of information. There is no available information on any quality assurance work which would offer any further assurance that this outcome is achieving added value or positive outcomes for adults who have been subject of a Police VPD referral.

There is also suggestion that correspondence to the GP is sent to a Prescription email address used to get minutes of Adult Protection Case Conferences and this needs to be addressed to ensure this is the appropriate way to share, receive and action information.

Individual interviews and the Network of Support highlighted a lack of shared understanding of the role and purpose of the ESG and how it fits with adult protection referral routes.

There is a lack of understanding about systems in place in Police Scotland Risk and Concern Hub to collate and analyse VPD data with different assumptions made by professionals. For example, one Manager understood that a Conference would be automatically 'triggered' when there are three or more VPD's and another believed that a 'referral' was made if there are five. Police Scotland operate an internal escalation policy which sets out what should happen internally when a number of VPDs are submitted in a set timeframe. There are a number of assumptions that are made in multi-agency practice that further dilutes individual responsibility i.e. that a system will take action automatically.

The ESG is used to screen out the high number of Police VPD referrals and is in place to protect adult care teams who are already under significant resource pressures. The role and function of this group, its interface with all other services including when cases are open to CJ Social Work (and other adult services) merits further exploration to ensure it fits as part of a wider system of identification and decision-making for adults at risk.

Finding

The role of the Angus ESG in appropriately diverting Police VPDs was conflated in this case and hampered effective decision making for O18 at a point in time. The poor quality (and resourcing) of recording of decisions reached through the Angus ESG caused confusion for staff and diluted accountability and opportunity for support and challenge in adult support and protection work.

There is a lack of clarity amongst professionals on the role and function of the Angus ESG.

There are assumptions made by some professionals and managers about how Police Scotland collate and analyse VPD information to trigger adult protection referrals.

The outcome of the ESG to share information directly to a GP lacks rigour and scrutiny with no evidence reported as to the effectiveness of this practice and/or on outcomes.

Recommendation 4

Angus Adult Protection Committee should review the principles of an Early Screening Group approach and consider if this remains fit for the intended purpose; if so, the protocol for the Angus Early Screening Group should be revised in consultation with partners to ensure that there is a clear role and remit of the group, which is supported by a process and system to robustly scrutinise effectiveness including the impact and outcomes.

Police Scotland should ensure that information from VPDs support identification and assessment of risk to adults including how patterns of concern are reported.

Specific work should take place with GPs on the 20% of cases remitted to them for follow up with a programme of evaluation of impact and outcomes.

Systems for GPs should be in place to ensure all patient information is used to make appropriate care and treatment plans including to contribute to the assessment of risk.

First Adult Protection Referral

The cluster of concerns that were referred to the ESG were also considered by a Housing Officer involved with O18. The Housing Officer sought advice from management as they recognised a potential adult protection referral and considered O18 would likely meet the 3-point test criteria. The Housing Officer followed local procedure in completing an ASP1. The Officer discussed this with the Angus Health and Social Care Partnership Adult Protection Review Officer and following their advice, completed a form which was sent to the First Contact Service in line with agency protocol. The referral was sent to a care manager who in turn sent it to the Adult Protection Review Officer for 'advice'. The response noted it was an operational decision and offered some guidance including liaising with a manager and considering an adult protection investigation and case conference '*before too much time elapses'*.

The Team Manager reached a conclusion based on the available information that the 3-point test criteria was not met and, therefore, the adult protection referral was not progressed.

The Reviewers have questions about the process of decision-making for adult support and protection in Angus and whether there is a clear, established and consistent process which is easily understood. Network of Support and staff engagement findings support the view that the process could be more clearly laid out. One staff member believed the process depended on '*who you get on the day*'.

AHSCP adult protection structure has a singleton post holder (Adult Protection Review Officer) who carries out the role of AP Review Officer and is also responsible for pre-screening, diverting and deciding what referrals are required to be considered by the ESG. They are responsible for chairing the ESG and are also called upon (as happened here) for informal advice and guidance in adult protection matters. The same singleton post is responsible for chairing many of the IRDs and all of the Adult Support and Protection Case Conferences. Angus HSCP have a very experienced, skilled and trusted individual in the post and staff report positive and accessible support and advice. The systems in place to inform decision-making, however, are less clear and the interface between the First Contact Service (as was then), Early Screening Group, Adult Protection Review Officer and the role of practitioners and managers should be clearly laid out for the avoidance of delay and doubt in planning and decision making.

The Reviewers are aware there have been recent changes in access to adult care services, including for adult protection, and First Contact has been replaced by a duty system. Although early in the changes, it is clear that there remains a high degree of confusion on how adult protection referrals should be made and how they progress through a system which supports good quality enquiry, decision making and action.

Second Adult Protection Referral

An IRD was initiated for O18 after a disclosure of sexual harm in December 2017. The minute of this meeting highlights a range of professionals invited and in attendance including Police. The minute highlights thorough discussion and planning and a subsequent adult protection interview took place. This was recorded verbatim and included a disclosure that was followed up. The matter was then recorded as an adult protection investigation, recommended for Case Conference and taken through to the formation of an Adult Protection Plan, all within timescales. The workers fulfilled their duties under the legislation, acted timeously, included and prioritised O18's views and took a holistic approach to considering the sexual abuse in the context of the complex issues affecting O18. This is a good example of following the local Adult Protection Guidance and achieving a good outcome; identification of risk and the pulling together of a multi-agency network. The workers involved in this are Council Officers experienced in adult support and protection. They acted with a level of confidence based on knowledge, competence and experience. The workers questioned why adult support and protection procedures had not previously been instigated? One worker commented "*it was as plain as the nose on your face (O18) was an adult at risk*".

As noted above, an earlier ASP1 referral had been completed but not progressed after screening from First Contact. CJ Social Worker had presented to the ESG on their concerns. Had an IRD been instigated at this point it may have provided an opportunity for a more thorough exploration of O18 as an adult at risk of harm.

There are a number of reasons that the earlier opportunity to consider O18 as an adult at risk was not taken, including lack of clarity on decision making, the divergent role and outcome of the ESG and lack of confidence and professional expertise of the staff involved at the time. CJ Social Worker and Housing staff involved noted they experienced their assessment and requests for adult support and protection to be minimised and not fully explored; their acceptance of this was that people more experienced in this area than them had made competent decisions based on all of the available information. The lack of written evidence on decision making through this process meant they could not challenge or escalate the issue and they accepted that the decision was the right one. This led to a narrative that O18 did not and would not meet the criteria for adult support and protection and that this avenue was not open to them to pursue. Consequently, the CJ Social Worker asked their Area Manager to chair a meeting to pull professionals together to explore what could be done to manage risk. The meeting was referred to as a 'Case Conference' in the files of 2 agencies (in the case notes), leading to some confusion that the meeting was a more traditional 'Adult Support and Protection Case Conference'. The minute was recorded on MAPPA headed paper and followed MAPPA meeting headings (reasons for this are not known and suggest an administrative error) adding further to the confusion that perhaps O18 was now considered under MAPPA (given the pending charge for a serious offence, this seemed possible). The meeting focussed heavily on

the risk O18 may present to themselves and others. Actions were identified to support the CJ Social Worker, but no follow up meeting was arranged.

Finding

The systems for making an adult protection referral in this instance did not support adequate consideration of O18 as an adult at risk.

There were a number of missed opportunities to refer for an IRD and consider O18 as an adult at risk and devise a risk management plan involving all agencies until three months later when the practice of the AIDARS team showed highly competent practice.

Recommendation 5

Angus Health and Social Care Partnership should consider how the current arrangements for decision-making at point of referral, inquiry, during an adult protection investigation and through the Case Conference process occurs and ensure there are adequate arrangements in place which are clear and well understood. The system and process should be subject to a programme of quality assurance, scrutiny and planning for improvement in order that there is confidence the system is well understood and is achieving the desired outcomes.

Relationship Based Practice

The CJ Social Worker involved with O18 held the most enduring relationship with them throughout the period of this review. It was clear that the worker developed a positive relationship with O18, often taking upon themselves to check in with them via phone and text over the weekend and during absence. This is not usual practice but indicative of the level of nurture and concern held for O18 and relates back to the reference of an 'inevitability' that significant harm would occur. Towards the later part of 2018, O18 accepted an AIDARS referral and a specialist substance use social worker and support worker were allocated. Positive relationships were developed quickly with evidence of open and honest communication. O18 was treated with respect and their views heard, acknowledged and acted upon. Both AIDARS workers spent time with O18 exploring their views and wishes, trying to support them to understand the consequences of their behaviour and why they were considered an adult at risk of harm. The AIDARS worker and manager instigated an adult support and protection referral when O18 disclosed sexual harm very early on in their involvement. The workers had a clear pathway to follow as they are experienced Council Officers. The response was well managed and resourced. An IRD was held, an Interview undertaken, and report completed leading to an Adult Protection Case Conference. This led to O18 being considered an adult at risk of harm.

Good Practice Example 2

The importance of establishing strong therapeutic relationships, not giving up, seeing beyond behaviour to the person were evident in the practice of the lead professionals in CJ Social Work, AIDARS and the Housing Support Provider and this is recognised as good practice. O18 benefited from strong, caring and consistent relationships with staff who often operated at a level beyond what could usually be expected.

Research Question 2 – Determine the extent to which decisions and actions were person centred.

Transition from Children's Services

Children's Services closed O18's case when O18 was 16 and no longer in education, in line with their usual practice. O18 was described as being settled at home and had secured a place at College (via 16+ service). Advice and guidance was provided to O18 after relationships broke down at home five weeks after O18 turned 16 and presented as homeless. O18 was not eligible for Through Care Service as they were not looked after but were offered to attend a drop-in service to access advice. O18 did not attend.

As a 16-year-old in temporary accommodation, O18 was isolated and vulnerable. Family relationships had completely broken down with the exception of some contact with older siblings who were dealing with their own issues. Support was offered by Housing Officers dealing with housing options and by CJ Social Worker after O18 was convicted of offences and made subject to a Community Payback Order.

As a young adult, O18 did not follow a clear transition pathway to adult services as there is no established pathway for young people with the diagnosis O18 had. Children's Services records detail plans to 'transition' O18 into adult care services and contact was made with relevant access services. However, it was advised and accepted that O18 did not meet the eligibility criteria for an adult service. The use of the term 'transition' suggests that there will be purposeful, planned movement from child centred to adult oriented social care systems. This pathway was not available, and the response of children's social work service was to signpost O18 to housing advice service when they presented as homeless. The team felt a degree of responsibility for O18 and supported them to use social work facilities to clean up, access food, make calls etc. but they could not offer any further package of support.

O18 did not experience a planned transition between CAMHS and adult mental health services. O18 was discharged from CAMHS but their record remained open on the e-health system resulting in early adult mental health referrals being rejected (on account of O18 being in receipt of an existing mental health service). O18's prescription for ADHD medication continued through the GP without specialist review. O18 was last seen by CAMHS in September 2016 but remained open on the system for six months. O18 did not receive coordinated adult care support until they was deemed an adult at risk, aged 17.

O18 had clearly identified needs that were known to both Children's Social Work Services and to CAMHS. These needs were not diminished by O18 turning 16 and in fact were enhanced significantly by them becoming homeless. The matter of increased vulnerability and risk at the point of transitioning from childhood to adulthood is fairly well researched (CELSIS 2015, Vincent and Petch, 2012, Care Inspectorate, 2018).

A co-ordinated approach to young people's needs is often lacking and is governed by the application of thresholds and eligibility criteria. The Reviewers noted the complexity and range of risk factors which increase risk for young people were all present for O18, including alienation from family, education difficulties and accommodation instability, abuse by adults and misuse of drugs/alcohol, and emotional or mental health difficulties. O18's needs were largely predictable based on previous history and concerns running up to their 16th birthday. O18 could not access any services until they met the threshold for CJ Social Work aged 16 and was offending and made subject to a statutory order. The initial assessment made by CJ Social Work when O18 was 16 and one month was that they were vulnerable with complex needs, not suited for an individual work placement due to vulnerability and that work would focus on poor social skills and consequential thinking.

During staff engagement, a question was asked about how flexible is the multi-agency partnership when considering agency thresholds? How effectively did and do children's services work with adult services, and adolescent mental health services work with adult mental health services? Those involved felt that partnership working could have been improved and that what is lacking is sufficient flexibility in our systems for a young person with a complex presentation. Young people in Angus can be more vulnerable within the system we have created for them. The Care inspectorate evaluation of SCRs (2018) note "*that risks for some children and young people may be increased or become more difficult to manage at times of key transition and change*". This was the case for O18.

Finding

The multi-agency partnerships in Angus is not sufficiently arranged to identify, plan for and meet the needs of all young people who have identified complex needs increasing the risk that some 'fall through the gap' between children and adult services.

Recommendation 6

Work is taking place in Angus to develop a transition pathway for young people who have identified needs but who do not meet the current threshold for services via Angus Health and Social Care Partnership.

It is recommended that the lived experience of O18 and the learning from this SCR is used to influence this work and inform the improvement actions arising from the work with specific reference to:

- Development of pathways to support for young people who are highly vulnerable
- Pathways to deliver seamless transition between CAMHS and Adult Mental Health Services

AAPC together with Angus Child Protection Committee (ACPC) should monitor the progress and actions arising from this work to ensure that it is sufficient to deliver services to support positive outcomes for young people in need and/or at risk.

Involvement in Decision Making, Planning and Support

Person Centred planning and decision-making are central values in working with adults. Where high risk is involved and in the context of adult support and protection, the right of a person to self-determine actions and decisions becomes more challenging.

There is good evidence throughout case notes that O18 was consulted on matters involving them. The way that workers recall their interaction with O18 also supports this. Those who supported O18 regularly demonstrated a good understanding of them. The Reviewers felt they got an insight into O18 and their character, hopes and aspirations. The CJ Social Worker maintained contact with O18's family to try to build and repair fractured relationships. This was with O18's consent and based on their wishes. O18 was supported to attend Case Conferences, core group meetings and other forums. Their voice was clear, and their views were easy to find in case recordings. Where the voice of O18 was less prominent was around the description of symptoms and what they were experiencing as described during mental health assessments. There are examples where it was clear that O18 was not believed and self-reported symptoms and experiences were given less weight than professional observations.

A number of examples of good practice were observed with O18 which reflected the compassion and commitment of a number of individuals going that "extra mile" to support O18. Nurturing and caring relationships were present for O18. Chances to learn, be nurtured and recover were provided by staff working with them (see Good Practice Example 2).

O18 was in receipt of a high level of service provision. Some of this was conditional (of a Court Order etc.) but they sought out a significant level of support themselves. O18 regularly attended a local lunch and drop-in provision offered by a local Church. O18 sought out the advice and support of the Housing Support Provider and was noted to drop into the office often and sometimes just to chat. There were frequent planned and unplanned appointments with services either at the behest of O18 or in response to an incident. The planned programmes of work to address offending and substance use were rarely able to be completed due to other crisis or lack of ability of O18 to focus on the work. Professionals involved saw O18 far in excess of the time they had allocated for them. The SCR found that O18 received a very high level of face-to-face support from professionals. Despite best efforts, this was not always well coordinated or communicated and resulted in duplication of some support. The

resource involved across all agencies was considerable but was not able to address the specific or presenting issue.

In this case, professionals were engaged to separately address substance use and recovery, offending, mental health, housing support needs and physical health needs alongside adult protection work. Services to people who have complex needs as experienced by O18 would benefit from integrated services offering flexibility to accommodate the needs of those who do not fit into eligibility criteria but remain vulnerable and require support. This is a systemic issue and not down to individual or team practice. For example, on examining the experience of O18 the 'timetable' of service contact both mandated and sought by O18 themselves, was considerable and cut across each other. A more robust and embedded planning process (as discussed below under question 3) may have supported this but there should be a more strategic consideration of how resources can be used to meet the needs of people in the best way.

Finding
The provision of service to O18 to meet need was significant; there were several agencies involved on a weekly basis with several appointments for O18 to attend.

Each service had a particular focus i.e. recovery work, consequential thinking, reducing offending, and emotional support. Services were focused on component parts of the person making the person's experience of support and recovery fragmented and highly resource intensive. Whilst individuals communicated well and shared appointment information, the systems in which they operated were not flexible to support integrated working.

Recommendation 7
Service Leaders in agencies such as the Local Authority, Health and Social Care Partnership, Housing and Third Sector should review and consider current structures, systems and processes to support integrated planning and support to individuals to enable more integrated and targeted support and ensure that resources can be used most effectively.

Mental Health Services

NICE Guideline 43 (Transition from children's to adult's services for young people using Health or Social Care; 2016) recognises the need for CAMHs and Adult services to work together to transition a young person's treatment. In addition, there is already a significant evidence base from safeguarding reviews that demonstrate the ways in which poor transitional planning can contribute to young adults slipping through the net, sometimes with tragic consequences. The Interim Report for the Independent Inquiry into Mental Health Services in Tayside (Strang, 2020) also highlights difficulties

in relation to transition from CAMHs to adult CMHS, suggesting that O18 was not a unique case and that problems exist within the current system.

A request was made by O18's children's services social worker in October 2016 to transfer O18's care to adult services to provide the ongoing support and treatment that O18 had been receiving from CAMHs since 2009. O18 was reviewed by locum medical staff within CAMHS in September 2016 which noted the requirement for a subsequent three-month review. This review appointment was not arranged and there was no transition of care to adult mental health services or any evidence to suggest this was discussed with O18 or their family.

O18 had an appointment for a nurse review within the CAMHS out-patient clinic in March 2017 which O18 did not attend and as a result of this one episode of non-attendance, was discharged from CAMHS. This was compounded by a delay in reflecting this discharge within the e-health system and communicating this to the GP, both of which took place in July 2017, some four months after discharge.

During the period February to June 2017, two referrals were made to adult mental health services but were rejected on the basis that O18 appeared as an open case to CAMHs as reflected on the e-health system. As noted above, O18 was already discharged from the service.

The absence of a proactive and co-ordinated transition plan coincided with O18 leaving the family home, experiencing a number of temporary housing placements and incarceration with a YOI along with ongoing mental health and wellbeing needs which would require additional support as a result. The Reviewers were of the view that the discharge from CAMHS after one episode of not attending an appointment along with failure to progress a co-ordinated transition process was not person-centred and demonstrates an inflexible response based on process (non-attendance) rather than the assessed needs of O18.

Professionals shared a view that the mental health input into O18's case was singular and did not take a longer-term perspective. They reported considerable frustration in their attempts to support O18 to access adult mental health services and believe that information sharing should have been much improved.

Finding

The lack of any planned and coordinated transition between children's and adult mental health services prevented O18 from accessing a service that they were assessed as requiring. A failure to update the electronic system (where O18 was not closed to CAMHS) further prohibited O18 from receiving a service as the system deemed them already in receipt of appropriate services.

Recommendation 8

NHS Tayside should ensure implementation of the NHS Scotland Transition Pathway across Angus and Tayside as a priority to ensure the services for young people with mental health problems are coordinated during transition, address their individual needs and provide a holistic approach, including meeting safeguarding needs.

NHS Tayside should review and reinforce processes for ensuring a patient is discharged on the NHS electronic recording system to ensure it is happening routinely and to avoid repeat incidents.

A number of routine referrals from the GP for a mental health assessment were made in relation to O18 before and after ASP processes.

One of the routine referrals from the GP in November 2017 resulted in an appointment for January 2018 but O18 did not attend this appointment and no follow up appointment, or opportunity to rearrange, was offered to O18. As the appointment was with a Consultant Psychiatrist, the current process for a further appointment is at the individual Consultant's discretion. There was no evidence of attempts to engage with O18 and/or explore reason for non-attendance with regard to O18's personal circumstances.

O18 had been assessed by Liaison Psychiatry in early January 2018 following an admission to an acute hospital as a result of a drug overdose where O18 reported deterioration in mood and was noted to be "*unable to identify any protective factors".* There is no evidence that this episode was considered along with O18s vulnerability and complexity of needs when making the decision to offer no further appointment.

The Health and Social Care Alliance Scotland Report (2018) informing the Independent Inquiry into Mental Health Services in Tayside acknowledges the experiences of individuals being referred and rejected from CMHS with GPs often unclear of criteria or reason for rejection of referral.

Finding

O18 experienced two episodes of discharge from a service, or no follow up being offered, after failing to attend one appointment; services failed to recognise the range of complex and interacting factors O18 was experiencing that impacted on this. This approach limited O18's ability to access the support required in a timely manner and ensure services provided safe and effective care. There is a need for greater professional curiosity and an enquiring approach to understand an individual's actions in the context of their needs and vulnerabilities.

Recommendation 9

AHSCP should support Angus Mental Health Services to develop an operational procedure to manage DNAs and criteria to inform decisions for individuals who are difficult to engage and those who do not attend appointments, which recognises the complexity around non-engagement and attendance and the balance between autonomy and duty of care. This finding is consistent with several other reports including Hard Edges (2019), which highlights how hard to reach/engage behaviour should be understood and managed.

Angus HSCP should review the current system of managing referrals and discharges within the CMHS to ensure that all cases are considered by the wider CMHT team and that all essential information is available to inform full discussion and risk assessment.

O18 was assessed by a Consultant Psychologist whilst on remand in YOI in November 2017 and by a Consultant Forensic Psychiatrist in March 2018 during another period of remand. Both provided detailed assessments confirming ADHD diagnosis and recommended follow up by community mental health services in relation to overseeing ADHD medication, reviewing mood and to consider further interventions to provide support with their conduct disorder.

The November 2017 assessment undertaken by a Consultant Psychologist recommended the Court request a full mental health assessment from the Community Mental Health Team due to concerns of a psychotic illness. The report highlights that a referral to the CMHS had already been made by the GP in November 2017.

The March 2018 assessment by the Consultant Forensic Psychiatrist highlighted that O18 was exhibiting a number of concerning personality traits, including difficulty controlling anger, lack of remorse for actions, tendency to blame others and a disregard for social norms and rules. It was noted that O18 had difficulty controlling emotions and used self-harming behaviours as a way of regulating negative emotions and distress and may represent an emerging personality disorder in adult years.

O18 was remanded to YOI in February 2018 and due to concerns held by the core group in relation to mental health, AIDARs staff intervened with the Sheriff, requesting the remand period be extended to facilitate a mental health assessment in YOI due to the difficulties obtaining this within the community (this is further discussed in question 3 below).

The Consultant Forensic Psychiatrist discussed this assessment with the Consultant Psychiatrist within the CMHT who agreed to provide an appointment if O18 was not subject to remand. On this occasion O18 was subject to remand.

At this point, O18 was already an open case to AIDARs, which forms part of the Angus mental health service and has access to a Consultant Psychiatrist, mental health nurses and Psychologist within the team and this was a missed opportunity for AIDARs and the CMHT to work together to support O18 or, at the least, CMHT to be in a position to offer mental health advice and support to workers who were, at this point, managing O18 on a daily basis, including administering first aid and medical interventions.

Finding

O18 had a history of trauma, homelessness and contact with the Criminal Justice Service along with co-morbidity in relation to substance misuse and mental disorder and required an integrated approach to care and support, rather than the parallel services that were provided.

Recommendation 10

Angus HSCP progress improvement work that has commenced in relation to integration of mental health and substance services to ensure that pathways provide services that are person-centred, trauma informed and better integrated to respond to a person's needs. Learning from this Review should be considered in line with the work already initiated in Angus.

It required a further routine referral from the GP in April 2018 for O18 to be offered an appointment in May 2018 with a Consultant Psychiatrist. During this appointment it was identified that O18 was likely to be moving to another locality in Angus within a few weeks and there was agreement that there would be merit in transferring care to the CMHT in this locality rather than starting with one team and transferring. O18 did not move accommodation until over four months later and during this time, no follow up from the CMHT was provided.

The reviewers conclude that care provision was not flexible across geographical boundaries, which resulted in a further four-month delay in securing Mental Health support and treatment. Whilst there is evidence to suggest this may be informally considered within Angus at present, there would be merit in reviewing residency and cross-boundary issues across the wider multi-agency partnership to ensure consistency across the area.

The Reviewers also noted that O18 was subject to the 'Talk to Me' suicide prevention strategy during periods of remand within the YOI which O18 was reported to have found supportive and engaged with. In keeping with a pattern observed through this review, when people made efforts to engage O18, they were receptive to contact and to the service.

Finding

There were a number of documents and mental health assessments available to the Reviewers, but these did not appear to inform and identify any clear approaches to how community mental health services could effectively support O18 with their ADHD and ODD diagnosis and additional mental health issues.

Assessments (both by CRHTT and CMHT) were singular and did not take account of the available information or take a longer term perspective when O18 needed the consistent input of community mental health services. There is evidence that services started to routinely 'flag up' or make 'referrals' in the hope mental health services would follow.

Recommendation 11

Angus HSCP review how agencies work together in sharing relevant information and concerns and are supported to work together to ensure individuals are enabled to access the right services with flexibility across professional, service and geographical boundaries.

Following a routine referral by GP in August 2017, an appointment was provided for O18 to be assessed in September 2017 and following a significant incident, this appointment was brought forward in recognition of the possible risks to O18.

O18 was seen within the assessment clinic by a CMHN and the CJ Social Worker was present. The outcome of this mental health assessment was no further contact with the CMHT with the rationale that "medicalising O18's problems" would be counter-therapeutic. This would suggest a lack of clarity and/or non-adherence to the CMHT Referral criteria which includes the '*Shared care agreement and specialist management of ADHD*' being consistent with the remit of the CMHT. This was also seen as a one off assessment and there is a need to recognise the importance of information from one source being triangulated with information from others in order that a full assessment is delivered.

Finding
Angus HSCP CMHS has clearly defined CMHT criteria which, if applied, would have included O18 on the basis of ADHD diagnosis alone. The Reviewers found there was a failure to apply or adhere to the agreed criteria in this case; it is outwith the scope of the review to comment on how widespread this practice is, but it is recommended the service explore it's response to similar referrals. The Reviewers note that access to mental health services and rejected referrals based on narrow criteria have been highlighted as a key theme within the Interim Report of the Independent Inquiry into Mental Health Services in Tayside.

Recommendation 12
Angus HSCP review CMHS referral criteria and processes around access to services to ensure these are person-led rather than service-led.

The Reviewers also heard from a range of professionals outwith mental health services who expressed frustrations in attempts to engage with the CMHT and that their ability to access advice and support when working with people with mental health was limited. This was reflected as more to do with a limited system than helpful individuals who would offer advice when they were asked. This issue is acknowledged by the CMHT who highlight the challenges in giving informal advice and guidance on someone who may not be known to the service and accountability issues associated with this. The CMHT staff shared that General Data Protection Regulations (GDPR) has impacted on the ability to provide advice/information.

Reviewing the training needs across the wider HSCP staff group to support people with complex needs with specific reference to the inter-relationship between adverse childhood experiences, trauma, substance use and mental health would be beneficial to understand roles and responsibilities and identify training needs in relation to current challenges such as ADHD and Suicide.

Finding
Professionals operating outwith mental health services did not feel they were sufficiently trained, equipped or provided with access to specialist advice to have increased confidence in managing the level of complex behaviour displayed by O18. They identified a need to access specialist knowledge and guidance when supporting people with similar behaviours and managing the level of risk associated with O18. The Reviewers identified potential opportunities for consultation and advice with mental health professionals with specialist knowledge.

Recommendation 13
Angus HSCP develop a process that facilitates staff to identify cases and access support and advice from fellow professionals. The process should be inclusive of

opportunities for reflective practice to develop and support professional trust and accountability and be supported with clinical input.

Meeting Housing Needs

O18 experienced six different accommodations from the point of becoming homeless at 16. At the time of death, O18 had been allocated a permanent tenancy in the town where they originated. The temporary nature of O18's housing situation, the lack of stability experienced and disruption during periods of incarceration all contributed to and escalated O18's vulnerability. The majority of temporary homeless accommodation in Angus is provided by the local authority in mainstream, furnished properties based within the community.

Most of the temporary accommodation is within the largest town with the remainder spread across the area. There is no hostel-type accommodation in Angus. To encourage stability and social inclusion, the Council's policy has been to maximise the use of dispersed homeless accommodation.

O18's placement in supported accommodation was the longest of the temporary accommodations provided. Time spent in this accommodation provided O18 with access to 24-hour support. O18 benefited from staff on-site and contacted them regularly for support and help. Staff were called on a number of occasions which resulted in either O18's life being saved or significant minimisation of harm (by delivering CPR, administering Naloxone, physically intervening for safety by removing knife, calling ambulance etc.) The support described by staff and noted in written records was delivered with O18's wellbeing at the centre. Staff offered support beyond the remit of the service, for example, strategies for managing safe medication. Staff were proactive in disrupting exploitation, making reports to Police, coaching O18 to make better decisions and sharing information with the support network surrounding O18. The staff described feeling a weight of responsibility for such a young and vulnerable individual.

The Reviewers were struck by the level of responsibility held by the staff working in the supported accommodation and, as is described in this report, the stressful and emotionally challenging work they undertook with O18, including removing weapons, calling for Police/Ambulance, responding to threats to life, drug use, exploitation, disclosure of abuse and self-harm. The workers involved in the Review shared their experiences and some described being significantly affected by the work they did with O18.

Whilst the nature of the service offered through this placement provided support and protection for O18, it also undoubtedly, significantly increased risk to O18. Staff who knew them well described O18's longing to belong to a peer group as being strong and central to behaviours O18 mimicked. O18 assumed accents, behaviours and 'labels' they associated with individuals and small groups within the accommodation.

Accommodation staff were dealing with the needs of 15 individuals with different and often competing needs. The youthful appearance of O18 further contributed to the risk they faced from others including financial and sexual exploitation.

Rapid Rehousing Transition Plan

The Rapid Rehousing Transition Plan (RRTP) is a planning framework for Angus Council and its partners to transition to a rapid rehousing approach. When homelessness occurs, rapid rehousing should be the default position. Recognising that some people need more than just a house and have multiple complex needs that must be addressed alongside their homelessness, the Housing First model of intensive support is the preferred model. For people who require the emergency safety net of temporary accommodation, the time they spend there should be as short as possible. It should be spent in accommodation that is of a high standard and in a location that minimises disruption to their daily lives.

The focus of Housing First is to provide a stable, permanent home within the community as a first response to people with complex support needs who are homeless. From that point, any other support needs can be addressed through co-ordinated and intensive support. Work has commenced to implement Housing First in Angus from April 2020.

Review of Supported Homeless Accommodation

Work has commenced to evaluate the effectiveness of the current models of supported homeless accommodation in Angus, considering the current and projected support needs of homeless households, how these needs are being met and outcomes for those who have been placed there.

Led by an independent consultant, this research will consider whether the current model of short term supported accommodation continues to be part of the local homelessness response. It will also consider opportunities to meet the vision for rapid re-housing by ensuring people with multiple needs beyond housing (where housing first is not possible or preferable) have the option of highly specialist provision within small, shared, supported and psychologically informed environments.

Finding

O18's needs and risks were both exacerbated and protected by their placement in supported accommodation. The nature of a close group of tenancies housing vulnerable people significantly raised the risk of harm to O18 given their young age, impulsivity and susceptibility to impression. The provision of flexible, responsive and nurturing staff support offered some protection and minimised the risk but exposed O18 to a range of other risks, which they found difficult to avoid or manage.

Recommendation 14

Angus Council Housing Service should progress the RRTP and assess the impact on both provision and support of good quality housing and housing support to young people.

The placement of O18 in supported accommodation and the learning from this SCR should be shared with the independent consultant leading the review of supported accommodation provision in Angus to inform and influence future service development.

Research Question 3 – To what extent did one professional/agency have a lead role and hold the responsibility for O18 protection planning; to monitor what was being achieved, gaps in assessment, planning, decision making and associated risks?

Assessment, Planning and Risk Management in Adult Support and Protection

O18 was deemed an adult at risk and the case file reading shows that the established processes were followed appropriately. Professionals were meeting together to plan and manage risk for O18. There is evidence of core group meetings taking place alongside professional network meetings to share information, however, as the Core Group was routinely sharing information via email, calls, through electronic recording system (CareFirst) much of the available information was known amongst the group.

The interim plan established at the Initial Adult Protection Case Conference included a task for the Core Group to "*carry out, amend and develop this initial adult protection plan*". It also noted "*the plan agreed at the IRD should be considered by the Core Group*". The Core Group met within the 10-working day timescale set out in the Adult Protection operational instruction. The minute suggests they worked through a process of action and update noting many actions were already 'met' and some ongoing. The meeting moved on to 'updates' and sharing new information. As O18 was remanded in a YOI, the meeting focused on how the group would obtain an updated mental health assessment as was required by the Court. The discussion focused on how this might be achieved in custody and that O18's case was due before the Sheriff for a review. A mental health officer (MHO) was in attendance in order to give advice. It is minuted the MHO was in agreement that seeking a psychiatric report whilst in prison seemed appropriate. The minute further notes 'all core group members' agreed that a discussion should take place with the Sheriff on the risks present to O18 on being released (risks to personal safety and personal risk taking) and the benefits of a psychiatric report being carried out in the prison environment as opposed to the community (taking into account O18 failed to attend the community psychiatric appointment some weeks before). The action plan established identified only one action to manage risk; to request that O18 remain in custody. No risk management plan was established.

Following the Core Group meeting, the CJ Social Worker sought advice from the Team Manager relating to the decision of the core group, which she believed was contradictory to social work values and would serve to increase personal risk of self-harm and possible overdose on liberation (due to reduced tolerance levels). The Team Manager shared the concerns and instructed the Social Worker not to request a further period of remand, as O18 was considered to be manageable in the community and, given their age and mental health concerns, was likely to be just as vulnerable within a prison setting, if not more so. During staff interviews, those involved recall there being difficult discussions on differing views on using custody to secure O18's safety and some professional tension developing around this time. It is difficult for the Reviewers to form a view of how the core group was used to explore agency

dissent and professional challenge as this is not reflected in the minute. As a newly formed core group, it may be that relationships were not sufficiently well developed to support this.

The CJ Social Worker submitted a nil report to the Court (as was expected given the psychiatric assessment was not yet complete) but advised the Sheriff that an appointment was set up for the Psychiatric Assessment to be carried out in the Community and arranged for one week later. Arrangements were to be put in place for O18 to be taken to the appointment by staff. After this discussion with the Sheriff, the AIDARS worker and manager submitted a letter outlining the current risks for O18, their concerns for O18's safety and asked the Sheriff to consider a further period of remand in order that the psychiatric assessment could be completed. At O18's appearance then next day, they were remanded for a further period in custody due to appear approximately two weeks later, but this was delayed further as the report was not complete.

There are a number of issues that emerge from this episode of practice; there was a breakdown in open communication at this point in the management of O18 and staff reflected feeling this was very much at odds with how they had worked and later continued to work together. The focus on obtaining the psychiatric assessment became almost the sole focus of the first Core Group meeting which focused heavily on the matter of remand and access to a mental health assessment and identified only one action to manage risk; to request that O18 remain in custody. The Core Group did not establish an Adult Support and Protection Plan that involved planning for both custody and liberation and, therefore, there was no plan in place clearly articulating what each agency and O18 themselves would do to reduce and manage the identified risks. A plan was not identified until the second Core Group meeting which took place eight weeks after the initial Conference and two weeks before the Review Case Conference.

The plan that was developed at the second core group meeting reflected much of the crisis that was occurring at the time and, thus, most activity remained crisis-driven and unable to focus on sustained interventions beyond the immediate presenting issue. The quality of the risk management plan was poor and did not reflect either the work that was already taking place or deliver a coordinated and cohesive intervention plan.

Although the Reviewers noted some good examples of information sharing, this did not always translate into documented action plans or risk management plans to minimise the risks and be actively monitored, rather, individual services seemed to identify actions which were reviewed singularly. The chronology developed to support the review highlighted numerous incidents that were only known to one or two services with the result that incidents were dealt with sequentially, but in isolation and without aggregating them into a picture of wider concern. There were numerous occasions when incidents occurred, which in turn generated opportunities for assessments to be undertaken and for decisions to be made about the need for

professional interventions. The cumulative effect of professional concerns was not sufficiently recognised by any of the involved agencies in a timeous way.

The Reviewers concluded that it was unclear as to how O18s mental health, substance use, care and support needs and adult protection risks were considered to construct a whole-system way forward with clearly identified tasks, outcomes, timescales and progress measures. There was no one place where all of the relevant information, including background information, patterns of risk and resilience and identified actions were presented; rather information and parts of chronologies were present in different documents. A reasonable summary of information was collated to report to the Review Case Conference, but there was a lack of a coordinated plan of support and an absence of escalation between services/agencies.

Finding

The initial Core Group meeting did not focus sufficiently on establishing a clear plan to manage the identified and presenting risks to O18. The subsequent Core Group plan identified a series of referrals in support of moving tenancy and accessing services. Workers involved with O18 were closely involved with them, the core group and well-briefed on what was happening, however, were not sufficiently focused on coordinating and delivering a shared and agreed plan. A Risk Assessment (ASP3) was completed in July 2018 and, again, it is unclear how this document interfaces with assessment and risk management planning.

Recommendation 15

AAPC should review the learning and development and quality assurance opportunities in place to support staff, managers and Review Officers to develop consistent practice in producing adult protection plans that are linked to a clear assessment of need and risk, are dynamic in nature, clear for the adult at risk and offer direction to agencies involved.

Finding

There is a misconception amongst some professionals that on some occasions a person may be safer in prison and that prison may provide appropriate opportunities to access services that people either fail to engage with, or that cannot be secured in the community. Whilst it is accepted that this course of action was very unusual and was taken by a service in response to significant concerns and frustrations surrounding community services for O18, professionals have indicated a view that, on occasion, prison might enable some people to be safer.

Short-term prison sentences are proven to be ineffective and can increase the risk of future offending. Where possible, and when there is not a high risk to the public, community-based alternatives should be considered, with person-centred meaningful interventions and / or restrictions explored, in order to address social and criminogenic needs, promote desistance and rehabilitation, whilst considering victim and community safety.

Services have made Reviewers aware that a joint event between Justice and AIDARS that took place around the same time as the incidents described here were well-evaluated in sharing information, service values and practice, policy and procedure across the Services.

Recommendation 16

AAPC should provide staff with guidance on escalation in adult support and protection cases where there are significant service deficits and/or risks that is likely to result in death or serious harm; and/or where they intend to take a course of action that contradicts policy, including where remand is being recommended by any professional relating to the persons safety/access to support.

The escalation policy should include how to record dissent in decision making and any follow up action including roles of the workers themselves and their managers.

AAPC should consider whether there is a need to develop a rolling programme or further opportunities for shared service events to enable a shared understanding and appreciation of each other's work and promote positive joint working.

Support and Supervision

There is no doubt that the management of O18's case was experienced as emotionally challenging, stressful and risky by those professionals closely involved. Those staff delivering direct support were faced with regular incidents requiring them to make difficult decisions, call for emergency services, administer CPR and seek support to access mental health support out-of-hours. Despite the number of services involved, a number of staff reported feeling' isolated'. Professionals reported a feeling of 'inevitability' and whilst some managers were available for support and de-brief,

this does not appear to have been consistent across agencies or related to a specific escalation policy where cases can be formally escalated to Senior Management.

As highlighted throughout this Review, the core agencies acted in pursuit of a mental health assessment and mental health service support to O18 as they believed they could not adequately assess, manage or plan for O18 without specialist input.

Finding
Protected time for support, supervision and planning is critical for high risk and emotionally challenging situations often including adult support and protection. Access to this was highly variable for those interviewed for this Review.

Recommendation 17
AAPC should consider the extent to which there is a culture of support in managing complex adult support and protection cases, including the promotion of space and time for cases to be explored, risks to be escalated and decisions to be given some further oversight.

Medical Workforce

The Use of Locum Consultants was noted by the Reviewers as a possible issue for O18 within CAMHs and the CMHT and this has also been reflected in the Review of Adult Mental Health Services in Tayside (2019). A number of risks around continuity/processes were identified by the Reviewers including:

- CMHT remit included specialist management of ADHD however the Locum Consultant Psychiatrist did not accept O18 onto caseload despite this diagnosis and recommendations from Psychology and Psychiatry assessments
- The Reviewers were made aware of the scale of caseload management and the need for manageable caseloads
- Correspondence sent directly to named Locum Consultant staff versus via Trak care when manager/team can access this and have oversight
- The GP wrote directly to the Locum Consultant Psychiatrist in June 2017 regarding O18s ADHD medication but received no response

Finding
In line with the emerging themes within the Interim Report of the Independent Inquiry into Mental Health Services in Tayside, the use of and reliance on locum Consultant Psychiatrists impacts on the continuity and consistency of care.

Recommendation 18
There should be an urgent review of the medical model across Tayside Mental Health Services with a view to a long-term sustainable model of delivery which reduces use of Locums and ensures Consultants are able to support those patients who need Consultant input.

Links to Other Review Processes

As part of the review process, the Reviewers noted that O18's death was reviewed by the Tayside Drug Death Review Group. This group is established to identify risk and trend information relative to drug deaths. A matter to note is that information available/documented within this review was incomplete and inaccurate in some background detail and it is, therefore, suggested that Angus APC highlight information gathering as a practice issue for the Tayside Drug Death Review Group to consider.

PART 4 HOW COMMON WAS O18'S EXPERIENCE?

Exploring professional care systems through the journey of one person provides an opportunity to explore the experience of the person and gain a rich understanding of how systems worked, reacted and interacted to support professional practice. There are of course limitations to how this window on the system is representative of the whole system for the wider group of service users. Through this review those professionals closest to the client group have been asked to comment on the typology of O18 and their presenting health and social care needs. As is reported above, whilst O18 themselves were recognised as being particularly vulnerable and 'at risk' in an adult system, the cause and symptoms of their trauma, adversity and poor health are clearly recognised in many other young people.

The Care Inspectorate have published reviews of the learning themes from Initial and Significant Case Reviews across Scotland (2014 & 2019). The 2014 review highlighted the following increased risks to young people coming through the care system into adulthood:

- Lack of resources to meet young people's needs
- Risks presented by transition to adult services
- Professional powerlessness
- Mental health needs not met
- Housing needs not met (regarded as homeless adult rather than as vulnerable young person and exposed to homeless hostel associates)
- Numerous staff involved, meaning it is difficult to run tight care plan with strong working relationship(s)

Care experienced young people are highly over-represented in prison and homeless populations. CELSIS (2015) report on the added disadvantage for young people who have been on the fringes of care and how this can mean their needs are even more likely to be overlooked. "*As a result systems, support and services are developed and delivered in ways which marginalise children and (who are not looked after) or young people looked after at home such that whilst they are officially overseen many of their needs may be overlooked*". CELSIS 2015

Recent research in Scotland, Hard Edges (2019) established a statistical profile of the extent and nature of multiple disadvantage and further reinforces earlier research on the links with early adverse experience, poverty and poor outcomes for people in adulthood. This research identified five co-existing disadvantages for people in Scotland (homelessness, mental health, substance dependency, offending and domestic abuse) all of which were present for O18. Criminal Justice Services are identified as a 'last resort' and gateway to support services….. Homeless services are 'carrying the can'….. And mental health services are missing. The research also identifies the added complexities and unique solutions needed in small urban and rural settings.

"The report identifies that people are often not able to access services until they have reached crisis point. It also highlights the necessity for services to become more consistent and tailored to each person, taking trauma and underlying causes such as poverty and childhood experience into consideration, to address the current gaps which are locking people in extreme disadvantage" (Hard Edges; 2019).

The research context summarised here, together with local and national data on death by substance use and the views and experiences of the professionals involved with this SCR, supports the fact that as unique an individual as O18 was, it is clear that many other young people continue to face the same challenges, including access to mental health assessment and services, appropriate housing and housing support and access to seamless health and social care services.

PART 5 SUMMARY AND CONCLUSION

O18 was recognised as an adult at risk of harm and identified risks were death through substance use or self-harm. Professionals involved, including the core group and wider agencies such as SAS, Police Scotland and NHS Tayside, prevented O18 coming to significant harm several times and prevented death on a number of occasions. They are not responsible for the harm that occurred to O18 in September 2018 resulting in death. O18 was a victim of abuse, trauma and endured significant emotional and mental health issues through childhood and early adulthood. Whilst there are practice improvements that can be made in some single agency process and procedures, in how systems work across boundaries and enable flexible support and where specialist input would have much improved support and treatment to O18, there is no one identifiable action that would have changed matters. Rather the interconnection of mental health assessment and support, identifying risk and delivering risk management plans together with O18 and information sharing all played a part on the overall experience and outcomes for O18.

This has been both a challenging case and a challenging process for some. The emotional impact of the work and of the case outcome is understandably still being felt. The involvement by those staff who worked closely with O18 was essential to the learning available from this Review and, without exception, their engagement has been open, positive, constructive and reflective.

There are lessons to be learned from the exploration of O18's journey. Through discussion with AAPC, there are many strategic and operational developments already underway that, if seen to completion and with robust evaluation and review, will make a difference to how young people experience support and achieve positive outcomes in recovery, employment, relationships and health. Developments on transition pathways and emerging developments on Housing First show a clear intention of senior managers to make changes to how support is accessed and delivered in Angus.

As was stated in the introduction, this SCR was commissioned from AAPC to be delivered by internal Reviewers in order that the best local learning could be achieved. The review has highlighted findings and broad recommendations that will enable the AAPC to reflect on their partnership and collaborative leadership and develop an action plan and associated performance outcomes to ensure long term sustainable system change is achieved.

AAPC are committed to supporting partners to ensure the organisational culture both within and between agencies involved in adult protection creates the conditions for real learning and change to occur. The Reviewers would encourage AAPC to involve and consult staff in ideas for change, as there were ideas and innovations borne from individual experience within our systems that should be capitalised upon.

Summary of Findings and Recommendations

Finding The absence of any co-ordinated recording system resulted in inadequate information sharing between some agencies with the result that core agencies with a key role in supporting O18 were unsighted on key information, which did not support practitioners to recognise a cumulative pattern of significant risk of harm for O18 or consider triggers.
Recommendation 1 AAPC should engage in discussion with all partners to review how information is shared when individuals make complex and repeat presentations to their service. This should include how case management and case recording systems can be integrated to support a solution. AAPC should ensure action is built on learning from the local non-fatal overdose pathway that has been trialled between SAS and Angus HSCP. The SAS should, on a national basis, review policy and procedures in place to support staff to share information and/or make adult protection referrals where this is necessary to safeguard vulnerable adults being treated by the service.
Finding The Reviewers noted a wealth of information within the range of agency records, but agencies were not passing on all relevant information in their possession and the GP appeared to be the central location for information to be sent to. This resulted in practitioners operating without the full picture of concerns and actions taken.
Recommendation 2 A single named GP should be identified for complex cases (such as registered adult protection cases) via an agreed process with Primary Care.
Finding Chronologies were not used to establish and analyse patterns of behaviour or risk and those available were not used as part of the assessment and decision-making framework for O18.
Recommendation 3 Angus APC should establish a clear multi-agency plan for improvement in the area of chronologies linked to assessment of need and risk in adult protection work, including a learning and development approach, setting minimum standards of practice and evaluating practice improvement and impact.

Finding

The role of the Angus ESG in appropriately diverting Police VPDs was conflated in this case and hampered effective decision making for O18 at a point in time. The poor quality (and resourcing) of recording of decisions reached through the Angus ESG, caused confusion for staff and diluted accountability and opportunity for support and challenge in adult support and protection work.

There is a lack of clarity amongst professionals on the role and function of the Angus ESG.

There are assumptions made by some professionals and managers about how Police Scotland collate and analyse VPD information to trigger adult protection referrals.

The outcome of the ESG to share information directly to a GP lacks rigour and scrutiny with no evidence reported as to the effectiveness of this practice and/or on outcomes.

Recommendation 4

Angus Adult Protection Committee should review the principles of an Early Screening Group approach and consider if this remains fit for the intended purpose; if so, the protocol for the Angus Early Screening Group should be revised in consultation with partners to ensure that there is a clear role and remit of the group, which is supported by a process and system to robustly scrutinise effectiveness including the impact and outcomes.

Police Scotland should ensure that information from the VPD supports identification and assessment of risk to adults including how patterns of concern are reported.

Specific work should take place with GPs on the 20% of cases remitted to them for follow up with a programme of evaluation of impact and outcomes.

Systems for GPs should be in place to ensure all patient information is used to make appropriate care and treatment plans, including to contribute to the assessment of risk.

Finding

The systems for making an adult protection referral in this instance did not support adequate consideration of O18 as an adult at risk.

There were a number of missed opportunities to refer for an IRD and consider O18 as an adult at risk and devise a risk management plan involving all agencies until three months later, when the practice of the AIDARS team showed highly competent practice.

Recommendation 5

Angus Health and Social Care Partnership should consider how the current arrangements for decision-making at point of referral, enquiry, during an adult protection investigation and through the Case Conference process, occurs and ensure there are adequate arrangements in place, which are clear and well understood. The system and process should be subject to a programme of quality assurance, scrutiny and planning for improvement in order that there is confidence that the system is well understood and is achieving the desired outcomes.

Finding

The multi-agency partnerships in Angus are not sufficiently arranged to identify, plan for and meet the needs of all young people who have identified complex needs increasing the risk that some 'fall through the gap' between children and adult services.

Recommendation 6

Work is taking place in Angus to develop a transition pathway for young people who have identified needs but who do not meet the current threshold for services via Angus Health and Social Care Partnership.

It is recommended that the lived experience of O18 and the learning from this SCR is used to influence this work and inform the improvement actions arising from the work with specific reference to:

- Development of pathways to provide support for young people who are highly vulnerable
- Pathways to deliver seamless transition between CAMHS and Adult Mental Health Services

AAPC together with Angus Child Protection Committee (ACPC) should monitor the progress and actions arising from this work to ensure that it is sufficient to deliver services to support positive outcomes for young people in need and/or at risk.

Finding

The provision of service to O18 to meet need was significant; there were several agencies involved on a weekly basis with several appointments for O18 to attend.

Each service had a particular focus i.e. recovery work, consequential thinking, reducing offending, and emotional support. Services were focused on component parts of the person making the person's experience of support and recovery fragmented and highly resource intensive. Whilst individuals communicated well and shared appointment information, the systems in which they operated were not flexible to support integrated working.

Recommendation 7

Service Leaders in agencies such as the Local Authority, Health and Social Care Partnership, Housing and Third Sector should review and consider current structures, systems and processes to support integrated planning and support to individuals to enable more integrated and targeted support and ensure that resources can be used most effectively.

Finding

The lack of any planned and coordinated transition between children's and adult mental health services prevented O18 from accessing a service that they were assessed as requiring. A failure to update the electronic system (where O18 was not closed to CAMHS) further prohibited O18 from receiving a service as the system deemed them already in receipt of appropriate services.

Recommendation 8

NHS Tayside should ensure implementation of the NHS Scotland Transition Pathway across Angus and Tayside as a priority to ensure the services for young people with mental health problems are coordinated during transition, address their individual needs and provide a holistic approach, including meeting safeguarding needs.

NHS Tayside should review and reinforce processes for ensuring a patient is discharged on the NHS electronic recording system to ensure it is happening routinely and to avoid repeat incidents.

Finding

O18 experienced two episodes of discharge from a service or no follow up being offered after failing to attend one appointment; services failed to recognise the range of complex and interacting factors O18 was experiencing that impacted on this. This approach limited O18's ability to access the support required in a timely manner and ensure services provided safe and effective care. There is a need for greater professional curiosity and an enquiring approach to understand an individual's actions in the context of their needs and vulnerabilities.

Recommendation 9

AHSCP should support Angus Mental Health Services to develop an operational procedure to manage DNA's and criteria to inform decisions for individuals who are difficult to engage with and those who do not attend appointments, which recognises the complexity around non-engagement and attendance and the balance between autonomy and duty of care. This finding is consistent with several other reports including Hard Edges (2019), which highlights how hard to reach/engage behaviour should be understood and managed.

Angus HSCP should review the current system of managing referrals and discharges within the CMHS to ensure that all cases are considered by the wider CMHT team

and that all essential information is available to inform full discussion and risk assessment.

Finding

O18 had a history of trauma, homelessness and contact with the Criminal Justice Service along with co-morbidity in relation to substance misuse and mental disorder and required an integrated approach to care and support, rather than the parallel services that were provided.

Recommendation 10

Angus HSCP progress improvement work that has commenced in relation to integration of mental health and substance services to ensure that pathways provide services that are person-centred, trauma informed and better integrated to be able to respond to a person's needs. Learning from this Review should be considered in line with the work already initiated in Angus.

Finding

There were a number of documents and mental health assessments available to the Reviewers, but these did not appear to inform and identify any clear approaches to how community mental health services could effectively support O18 with their ADHD and ODD diagnosis and additional mental health issues.

Assessments (both by CRHTT and CMHT) were singular and did not take account of the available information or take a longer term perspective when O18 needed the consistent input of community mental health services. There is evidence that services started to routinely 'flag up' or make 'referrals' in the hope mental health services would follow.

Recommendation 11

Angus HSCP review how agencies work together in sharing relevant information and concerns and are supported to work together to ensure individuals are enabled to access the right services with flexibility across professional, service and geographical boundaries.

Finding

Angus HSCP CMHS has clearly defined CMHT criteria which, if applied, would have included O18 on the basis of ADHD diagnosis alone. The Reviewers found there was a failure to apply, or adhere to, the agreed criteria in this case; it is outwith the scope of the review to comment on how widespread this practice is, but it is recommended the service explore it's response to similar referrals. The Reviewers note that access to mental health services and rejected referrals, based on narrow criteria, have been highlighted as a key theme within the Interim report of the Independent Inquiry into Mental Health Services in Tayside.

Recommendation 12

Angus HSCP review CMHS referral criteria and processes around access to services to ensure these are person-led rather than service-led.

Finding

Professionals operating outwith mental health services did not feel they were sufficiently trained, equipped or provided with access to specialist advice to have increased confidence in managing the level of complex behaviour displayed by O18. They identified a need to access specialist knowledge and guidance when supporting people with similar behaviours and managing the level of risk associated with O18. The Reviewers identified potential opportunities for consultation and advice with mental health professionals with specialist knowledge.

Recommendation 13

Angus HSCP develop a process that facilitates staff to identify cases and access support and advice from fellow professionals. The process should be inclusive of opportunities for reflective practice to develop and support professional trust and accountability and be supported with clinical input.

Finding

O18's needs and risks were both exacerbated and protected by their placement in supported accommodation. The nature of a close group of tenancies housing vulnerable people significantly raised the risk of harm to O18 given their young age, impulsivity and susceptibility to impression. The provision of flexible, responsive and nurturing staff support offered some protection and minimised the risk, but exposed O18 to a range of other risks which they found difficult to avoid or manage.

Recommendation 14

Angus Council Housing Service should progress the RRTP and assess the impact on both provision and support of good quality housing and housing support to young people.

The placement of O18 in supported accommodation and the learning from this SCR should be shared with the independent consultant leading the review of supported accommodation provision in Angus to inform and influence future service development.

Finding

The initial Core Group meeting did not focus sufficiently on establishing a clear plan to manage the identified and presenting risks to O18. The subsequent Core Group plan identified a series of referrals in support of moving tenancy and accessing services. Workers involved with O18 were closely involved with them and the core group and well-briefed on what was happening. However, they were not sufficiently focused on coordinating and delivering a shared and agreed plan. A Risk

Assessment (ASP3) was completed in July 2018 and again it is unclear how this document interfaces with assessment and risk management planning.

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The escalation policy should include how to record dissent in decision making and any follow-up action, including roles of the workers themselves and their managers.

AAPC should consider whether there is a need to develop a rolling programme, or further opportunities for shared service events, to enable a shared understanding and appreciation of each other's work and promote positive joint working.

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Recommendation 17 AAPC should consider the extent to which there is a culture of support in managing complex adult support and protection cases, including the promotion of space and time for cases to be explored, risks to be escalated and decisions to be given some further oversight.
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Recommendation 18 There should be an urgent review of the medical model across Tayside Mental Health Services with a view to a long-term sustainable model of delivery, which reduces use of Locums and ensures Consultants are able to support those patients who need Consultant input.

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Appendix 1 Terms of Reference

O18 Significant Case Review - Terms of Reference

Context

An Initial Case Review was completed into the circumstances of adult O18. The outcome of the ICR was:

- Some of the issues pertinent to mental health services identified in the ICR should be shared with the 'Independent Review for Mental Health Services in Tayside (Strang Review) so that the issues can be considered as part of the investigation and improvement planning for mental health in Tayside

- Ensure that the information identified in the ICR, in relation to gaps in service provision for young people with complex needs, is fully considered and informs the work being taken forward by the 'Transition Work Stream'

- Some issues identified in the ICR do not need further exploration and the ICR has provided an opportunity to identify the changes that should be progressed – an Action Plan will support delivery of the improvements

- There is a need for a SCR to explore some of the remaining matters identified in the ICR and set out in these Terms of Reference

Timeframe

The SCR will explore the involvement and interaction within and between the agencies involved with O18 from June 2017 (start of a significant period of escalation in behaviour/risk) until 14 September 2018, when O18 died, in respect of the following questions:

Research Question 1 - To what extent was the information held by agencies in respect of O18 shared appropriately within that agency and with other partner agencies involved with O18?

- Explore good practice in information sharing which impacted positively on assessment and decision making for O18
- Explore what, if any, barriers existed to sharing information to impact positively on assessment and decision making for O18

There will be specific follow up on some of the issues identified in the ICR in respect of:

- Information sharing within health services to other services involved with O18
- Information known to single agencies such as Scottish Ambulance Service
- The effectiveness of systems in place to use information from the Police Vulnerable Persons Database to inform risk assessments and plans
- Information held by Housing and the extent to which O18's needs were understood

Research Question 2 – Determine the extent to which decisions and actions were person centred.

Specific consideration will be given whether appropriate weight was given to the diagnosis of O18 of ADHD, ODD and un-socialised conduct disorder in assessment, intervention and decision making and how this affected professional support.

Research Question 3 – To what extent did one professional/agency have a lead role and hold the responsibility for O18 and his protection plan; to monitor what was being achieved, gaps in assessment, planning, decision making and associated risks?

There will be specific reference to the implementation and understanding of adult support and protection processes and opportunities to intervene with O18.

There will be specific reference to the use of chronologies and risk management plans and opportunities to have a fuller understanding of O18's risk and experiences.

Involvement of the Family

The SCR Lead Reviewer 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. The Terms of Reference will be shared with the family.

Outcomes of the SCR

With reference to the above research questions, the SCR will:

- Identify areas of good practice and practice that should be developed and replicated in adults support and protection 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 Angus Adult Protection Committee to promote learning to support and improve systems and practice
- To determine whether, and if so, what changes in practice are necessary to prevent any such missed opportunities in the future

Approach

A Lead Reviewer will be appointed to lead the work.

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 in the young person's life to ensure the views and experiences of the staff involved with O18 are fully included in the SCR.

Approved by Angus Chief Officer Group – 16 January 2019

Appendix 2	**Case Review Group Membership**
Kirsty Lee	Lead Reviewer
Grace Gilling	Lead Reviewer
Peter McAuley	Service Leader, Integrated Mental Health Services
Bill Troup	Head of Mental Health Services, Angus
Linzi DeVries	Team Manager, Justice
Lynsey Dey	Team Leader, Housing
DI Leanne Blacklaw	DI Police Scotland
Bill Atkinson*	Independent Consultant

*Bill Atkinson, Independent Consultant was commissioned to offer support and supervision and was an independent member of the case review group there to overview the practice of the lead reviewers.

Appendix 3 Work in Support of SCR

Lead Reviewers Appointed – 19 March 2019

Access to Initial Case Review Reports

- Single agency reports
- Completed ICR Report and Chronology
- Minutes of APC ICR discussion/decision making

Meeting with Family

- Meeting with Ms X (O18's mother and next of kin)

Case File Reading & Agency Interviews

- SW Children's Services Case File
- Angus Adult Protection Service Case File & Interview
- Angus Council Housing Case File & Interview
- Angus Criminal Justice Case File & Interview
- Angus Integrated Drugs and Alcohol Case File & Interview
- CAMHS Volume I and Volume II & Interview
- Havilah Interview
- Housing Support Provider Interview
- NHS Tayside Mental Health Records (paper and electronic) & Interview
- NHS Tayside A&E Contacts (scope of SCR)
- Scottish Ambulance Service Contacts (scope of SCR)
- Scottish Prison Service records (scope of SCR)

Network of Support Meetings (multi-agency)

Network of Support – Session 1

Questions

During individual and group consultation, the following four questions were used to structure discussion:

1. What key outcomes did you/your services achieve with O18 and how do you know?
2. What challenges did you/your service face in achieving positive outcomes for O18?
3. What learning, if any, is there to be taken from this work? Even better if….
4. How typical is the experience of O18 with your service? Particularly unique or typical? How do you know?

Agencies involved

The following agencies and services have been identified from the development of a detailed chronology to having input with O18 during the scope of the SCR focus:

- Angus Council Housing
- Angus Council Criminal Justice Service
- Angus HSCP AIDARs
- Angus HSCP CMHT
- GP
- Police Scotland
- Havilah
- WEB Project
- NHS Tayside CRHTT
- NHS Tayside A&E
- NHS Tayside Acute Services (A&E and Orthopaedics)
- NHS Tayside Arbroath MIU
- NHS Tayside Psychology (Court Report)
- NHS Tayside Forensic Psychiatry (Court Report)
- NHS 24
- Scottish Ambulance Service
- Scottish Prison Service- YOI
- Scottish Judiciary Service
- Gowrie Care
- Turning Point

Report	Presented to	Decision
Final Draft	Mandated AAPC Tuesday 28th January 2020	Approved
Final Report	Final presentation to Angus AAPC TBC	
Final Report	Presentation to Angus Chief Officers Group (COG) Monday 9th March 2020	Approved