PERTH AND KINROSS COUNCIL ADULT PROTECTION COMMITTEE

24 January 2023

L22 Learning Review

For the purpose of maintaining anonymity, the adult will be referred to as L22 throughout this learning review.

This informal learning review is based on the findings from the 2022 ASP joint inspection. A formal escalation was raised on the basis of a number of concerns found following their joint review of L22's case file.

The joint inspection team note that although they did not find L22 to be an adult left at risk as a consequence of the multi-agency intervention, they did find a number of areas of practice that they considered required escalating.

This learning review follows the principles of an learning review, although it is noted that L22 does not meet the criteria for a learning review as defined by the revised ASP learning review guidance: (https://www.gov.scot/publications/adult-support-protection-learning-review-guidance/documents/)

A L22 APC learning review panel was formed to identify and take forward learning. The review panel met initially on 14 November 2022 to review a combined chronology. An interim learning review report was shared with the APC on 2 December 2022. The L22 learning review panel met again on 20 January 2023 to review initial findings.

As part of the post ASP inspection improvement work, it has been agreed that the APC will oversee this work.

Parameters for the L22 Learning Review

The following has been taken directly from the joint inspection escalation:

"This is a young woman with EUPD, living in supported accommodation with intense support. For several years she has had a history of self-harm that has brought her in to frequent contact with the Police, social work, and health services. The adult's life is chaotic and risky. Over the years services have made great attempts to support and protect the adult but because of her illness the outcomes for this young adult remain uncertain. The adult's self-

harming is frequent and extreme. The pressure on all the agency services and resources is intense and unrelenting. The risks of serious threat to life are great.

- Police. We note that there are three occasions where escalations were missed. These were in January 2021, July 2021, and August 2021. We would have expected to see evidence of Local Area Command oversight and senior management involvement. We would have expected a strategic response by a senior officer that considered both single and joint agency responses.

- Health. The young adult made it very difficult for health services to support them. The relationship between health services and the adult were undermined by the adults dis-engagement and non-attendance. Implementing a trauma informed approach was difficult but there is little evidence that service leads/senior medical staff reviewed their approach to the challenges set.

- Social work completed the ASP investigation in April 2021 to a good standard. But instead of going forward with ASP initial case conference they convened a multi-disciplinary meeting. This may have constituted a missed opportunity in terms of a more formal and joined ASP protection planning opportunity. These meetings were frequently held apparently but there are no records of them in agency records. Therefore it is unclear who attended, how often, at what level, and for what purpose. SW case notes suggest they were positive and helped to coordinate a joint approach to support the adult, but the evidence should be in the file. The April 2021 investigation determined that the Guardianship order the adult was subject to may have been granted on a misdiagnosis. It took until the 23rd of March the following year to revoke. Finally, on the 27th of April 2022 the adult makes an allegation of rape. The perpetrator is charged in the days that followed. Despite the level of vulnerability there is no evidence in the records that an ASP intervention was required.

- Joint agency responsibilities. While each individual agency was working hard to engage the adult partnership agencies did not have a high level joined up strategic approach in place. Such an approach would have provided a platform to better consider the risks for both the adult and partnership's perspectives and would have strengthened accountable decision frameworks.

In view of this, this review has been framed around 5 key questions:

1. Did a senior Police officer escalate concerns about L22 within this time that considered both single and joint agency responses, and if not, what prevented this?
2. Is there any evidence to support that health delivered a trauma informed approach to L22
3. The escalation refers to missed recording within social work records. Do the minutes from the multi-agency meetings exist and have these been uploaded on to L22's AIS case file? The escalation also refers to no reference within social work notes about the need (or not) to apply ASP following L22's allegation of rape. Was this considered a missed opportunity

to safeguard? Does learning exist about the need to retain uptodate recording of any intervention?

4. Why did the welfare guardianship take 11-months to revoke?
5. The escalation is critical about what the joint inspection team considered this case to lack a joined up strategic approach to safeguarding L22. Does a joined up strategic approach exist in Perth & Kinross to support front line practice? If so, could/should it have been implemented with L22?

A combined chronology was prepared from single agency chronologies provided by:

- Adult Social Work
- Mental Health Officer Team
- NHST AP Team
- The Richmond Fellowship Service

Chronologies were requested for the ASP period inspected (April 2021 through to 30 June 2022), but where it was considered relevant, some chronological events were shared that predates this timeframe.

Thirteen professionals from Health, Social Work, HSCP and the 3rd sector made up the L22 learning review group.

What the Learning Review panel found:

Response to question 1:

The VPD Escalation Process was followed. Despite the opinions of the officers conducting the Inspection, there is clear evidence that the escalation process was followed, in line with national guidance. However it is acknowledged that processors simply did not entitle their VPD chronology entries with the nationally agreed phrase: 'Escalation Protocol Review.' As such, reviews were likely missed by the Inspection team.

National guidance did not mandate local area oversight or senior management involvement at the relevant escalation trigger points - It is unclear what the HMICS Inspection Officers meant by: "*We would have expected to see evidence of Local Area Command oversight and senior management involvement",* given that the escalation trigger points did not meet the threshold for review by Hub Supervisors (Detective Sergeants), let alone the Hub manager (Detective Inspector)[1].

Introduction of automated escalation triggers – A planned VPD upgrade will provide automated escalation trigger point updates in the future and ensure details of tactical options available, which can include the involvement of Local Area Command.

As there was no requirement for the matter to be escalated to a senior officer (rank of Inspector or above) as at no point were the escalation trigger points (9 concern reports in 30 days) ever

1. [1] Please note that within police terms, a senior officer is considered to be the rank of Inspector or above only.

actually met. As such, no engagement with Local area command would routinely take place. That option will become available with the new VPD upgrade, but again must stress, that it is contingent on actually hitting the escalation trigger points.

Response to question 2:

The learning review panel universally agreed that the reading of the combined chronology suggested that services were tasked focused rather than person centred and trauma informed, although it was clear from those within the meeting who delivered or continued to deliver direct support to L22 that compassion for L22 did and continues to exist.

The learning review group heard that L22 likes to publicly blog[1] her journey and agreed to share some of this to support that compassion and practitioners being trauma aware did exist within her support network, although this was not always consistent. The group considered this important to share within this review because it gives the review a more personal and person-centred context on the supporting relationship L22 shared with some of those supporting her. The review group acknowledged that this was not reflected in the written records for L22.

November 2020

> *"For me to build relationships with people is so hard. In the past I could hardly speak to anyone and everything anyone would say to me my answer would be "I don't know" I just couldn't have a conversation... Now, what can I say, I've came on leaps and bounds. I can now have a normal chat with people without using the words "I don't know" or trying to cover my face and fiddle with things! Since starting one of my medications I feel like a new person. I went from only letting few people into my life to letting loads. My last placement before hospital, I got on so well with the staff, but I was scared to speak, scared to open up. I was scared to come out my room. Now I'm rushing out my flat to go socialise with staff in my new placement, the placement I've been in nearly a year now!!! This is not a blog to put anything or anyone down but to see how far I've came on. My last placement I was in I adored the staff but was still wary in speaking to some, I was so upset leaving and when I moved into the place, I am in now I always said I wanted to go back, I wouldn't do well but look where I am now... I have built relationships with staff I couldn't imagine I would have ever been able too; I can speak to them like I would never off been able too before. There's a select few I feel like I can open up to about my thoughts and feelings (I've never been able to do that before) I feel so at home in my flat, I also know I've got wonderful staff around me I adore and couldn't imagine life any better. I've changed for the best. The staff make me feel so welcome and loved in my flat and it takes a lot to feel like that, but I could honestly say it's the best move I've made, and I've been at my happiest I've been in years and that's all down to the staff I couldn't thank more off."*

[1] A web based, publicly shared diary owned and regularly updated by L22

May 2022

> *"This morning I had a positive meeting on whether my guardianship should be renewed and hearing what the professionals are saying it won't be the case!! It was only one year ago I'd be having conversations with people saying I'd never get off that, and look I think I'm wrong!! 3 years ago I was at my most vulnerable place in hospital, lacking capacity, I am now 2 and a half years in my own tenancy- having decorated it all myself!! I will and still have down days but I'm doing a million times better! For the past month or so, my life has been dependent on support staff, I am forever grateful for everything they do for me! But an extra special thanks to my social worker. When I build relationships with people, some are stronger than others and build a strong attachment. A certain few staff members I've build a strong attachment too, I feel they're like family. There obviously not but it's the bond you build with people and my bonds with my support staff are strong and my social worker that is sadly leaving me with her job soon to go onto further opportunities. Sometimes social workers are in your life for a negative reason but for me, mines has made my life 1000 times better! My social worker hasn't just been my guardian, but she's been there as a shoulder to cry on. This past year, I've shared my good days and bad times with her and without a doubt she helps me through them. She has literally made me the best version of myself, and never ever hesitated to help me. she 100% deserves a gold medal for putting up with my cheeky sense of humour 🤣 you might be leaving me next month but it's not a goodbye it's a I'll see you later 😝🩶"*

The review group found that recording of the support lacked a depth of analysis of the decision making, particularly around the recurring use of detention and the decision to impose and revoke the Mental Health Act in quick succession. The panel also acknowledged that the recordings also lacked evidence around information sharing and joined up hospital discharge planning. This resonates with the findings from question 3.

Area for improvement and further learning:

The review group heard that the journey to improve trauma informed services within the NHS has started but there is acknowledgement that this will take time to embed this into practice. Learning sessions are already being delivered around a gendered service approach within NHS Tayside. These focus on young women with trauma backgrounds, and how health services need to take a gendered service approach to how services are delivered. Within health, there is also improvement work following P19 around developing guidance for staff on supporting those patients who are hard to reach, hard to engage and how services can make sure it is trauma informed. This improvement work links in with risk assessments and risk management planning before individuals are discharged from services for non-engagement.

The APC and CPC continue to jointly fund trauma informed training. Furthermore, a dedicated trauma informed learning and development officer has recently been appointed by Perth & Kinross Council. There is an expectation that this post will challenge as well as support services about their ability to deliver in a way that is both trauma informed or trauma aware.

Response to question 3:

Question 3 relates to consistent recording, in particular, the recording and decision making surrounding a sexual assault alleged by L22. Much discussion surrounded this, and the social worker for L22 at the time was able to evidence where multi-agency decisions had been taken not to progress to formal ASP activity following the allegation, and how multi-agency and specialist supports had been implemented to support L22 at the time. The social worker was able to draw upon the principles of the Act to defend and justify why, at that time and following the allegation that the ASP Act was considered to be unnecessary, and that informal safeguards were able to be used without the need for implementing the Act. This was seen as being consistent with the principles of the ASP Act. Evidence also existed that these decisions were taken with management oversight.

***Area for Improvement and further learning*:**

As found and subsequently discussed in question 2, it was also recognised that the level of analysis of the case recording within social work, health and the Richmond Fellowship was not always reflective and analytical that that left the reader clear why decisions had been made. This was already acknowledged as an area for improvement, and therefore features in the APC Improvement Plan 2022/23.

Response to question 4:

Question 4 relates to the length of time it took to revoke L22's guardianship order. The learning review panel heard from those involved in supervising the welfare guardianship and from those responsible for the application to renew or revoke the order where necessary.

The apparent delay was influenced by a number of factors:

1. The formal review of L22's welfare guardianship order occurred during the Scottish Government's period of COVID easements where all welfare and financial guardianship orders were automatically extended to allow for additional Court time for all review or amended guardianship orders to be heard.
2. In this time, L22s guardianship order was reviewed in line with the codes of practice, and questions were rightly raised about her fluctuating levels of capacity and incapacity. L22's capacity was reassessed, but this was contested, and time was lost deciding whether a 2nd opinion capacity assessment was required. A number of multi-agency meetings were heard to unpick this further until such times as agreement was reached to apply to revoke the order.
3. A decision was taken not to revoke the welfare guardianship, but to allow this to naturally lapse. The initial welfare guardianship was framed around a dual diagnosis of Autistic Spectrum Disorder (ASD) and a diagnosis of Emotionally Unstable Personality Disorder (EPUD), and although the diagnosis of ASD had been reviewed and considered no longer relevant nor applicable to L22, the diagnosis of EUPD remained consistent. Therefore, the time left on the guardianship allowed the opportunity (with safeguards) to test out how safeguarded L22 could be with diminishing legal authority until the welfare guardianship order officially lapsed. The panel shared the view that supporting L22 to transition from being subject to robust

legal safeguards from within the welfare guardianship to one where welfare guardianship as not required was appropriate, proportionate and in keeping with the principles of the AWI Act.

Area for improvement and further learning:

The assessment of incapacity is central to the application of the AWI Act. Medical assessments of incapacity underpin any guardianship application. The AWI Act defines incapacity where an adult is considered incapable of:

- acting; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or
- retaining the memory of decisions.

Any welfare guardianship application also needs to evidence how the power(s) sought in any welfare guardianship is directly associated with assessed incapacity.

Where the outcome of capacity/incapacity assessments are challenged, there is no clear escalation pathway in Perth & Kinross. The intricacies and complexities that underpins capacity assessments are framed within other learning reviews, particularly the recent A22 learning review, but also features more prominently in the P19 significant case review. This is seen as an improvement area.

The ASP coordinator is currently in discussion with the HSCP Associate Medical Director about how recent learning reviews and contemporary research is challenging how capacity is considered and therefore assessed. This work will dovetail with the work being done to review escalation practices, particularly where one practitioner is able to consent or not to the use of an adult legal safeguarding framework and how and where to escalate this if that view is challenged. This forms part of the APC Improvement Plan 2022/23

Response to question 5:

The perception that L22's case lacked a strategic joined up approach was discussed within the learning review. A number of existing integrated strategic and governance structures exist in Perth & Kinross, both at locality level and at an integrated management level. The panel agreed that the opportunity existed for L22s case to be escalated to anyone of these, but it was considered that the multi-disciplinary risk management plan that supported L22 was sufficient to mitigate the risks. Evidence within the combined and social work chronologies support that the social work service manager also had oversight of the protection plan and how effective this was to safeguard L22. In summary, it was considered that at the time, that no evidence existed to escalate concerns beyond those who were currently supporting L22.

Area for improvement and further learning

It was clear from the health records that there were updates shared between partners at times, but this was not consistent or clearly documented. This suggests there is a need to revisit and

review standard operating procedures around information sharing and joint working to ensure this is consistent.

Social work provision has recently been aligned back into CMHTs within Perth & Kinross. Therefore, there is an expectation that this brings a more integrated approach to supporting those whose mental ill-health may be considered severe and/or enduring.

The use of the Care Programme Approach was mentioned within L22s clinical records as a means to coordinate support, but this was not progressed. Whilst the use of CPA is under review, it is still in use and considered as a useful framework to assess, identify and coordinate supports across different disciplines.

This review highlights the need to explore where CPA could be better used to coordinate supports, particularly where a number of different agencies contribute to the support plan. Consistent use of CPA may have addressed some of the concerns highlighted within this escalation.

The concept of escalation is also a recurring theme that is emerging from a number of learning reviews within Perth & Kinross. Supporting practitioners and managers to understand and have confidence in the escalation guidance is an area highlighted in the APC Improvement Plan 2022/23. A number of learning development sessions have been arranged for 2023 to drive this work forward.

Summary

The L22 learning review panel acknowledged the concerns raised as part of their escalation. The panel universally agreed that at the time L22s case file was inspected, she was experiencing regular period of extreme distress, resulting in risky behaviours. The multi-agencies supporting L22 used the learning review to share the challenges and complexities in trying to support L22 throughout periods of crisis, in a way that was person centred, trauma informed but also kept her safe. The review panel heard that being able to keep her safe whilst promoting choice and autonomy, rights and responsibilities, all in a climate of fluctuating capacity and consent was not easy.

This review has found a number of improvement areas, some of which formed part of an improvement plan prior to inspection, and others that were identified as part of this learning review following escalation.

1. Need to review existing information sharing protocols
2. Revisit escalation guidance and deliver learning opportunities for practitioners to ensure that they are aware of who to escalate concerns to and when
3. Continue to develop opportunities for services to become trauma aware and trauma informed.
4. Explore how the Care Programme Approach can be used alongside ASP structures to coordinate support, particularly where support is complex.
5. Offer learning to practitioners to develop analytical, reflective, defendable and defensible recording

Recommendation:

On behalf of the L22 learning review group, I ask that the contents of this learning review report are noted by the APC and that this report gives the APC the necessary assurance that any learning drawn from this now forms part of the APC Improvement Plan 2022/23

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Reports to be presented to a Member / Officer Group, Committee, Sub-Committee, or the Council ***must be signed off*** *by the Chief Executive or the relevant Executive Director.*

Appendix 1:

Combined Chronology

ASW 06/01/21 L22 disclosed information about 'friends' bullying her. Also spoke about having a new boyfriend. Support staff started noting in weekly reports to Social Work that L22 appears 'low in mood'.

ASW 07/01/21 Vulnerable Person Report (VPR) received from Police Scotland. L22 left her accommodation under the influence of alcohol and in her pyjamas. She had consumed substantial amount of alcohol on this evening and has also taken ibuprofen liquid. No harm occurred and she has had some insight to contact support staff. L22 was traced safe within a neighbour's home that evening and Police returned her home. In later discussion with Social Worker, L22 reflected that this was not the best idea and that she had been 'messing about'.

ASW 19/01/21 – 21/01/21 L22's mental health poor, appearing to be in crisis with frequent statements about plans to complete suicide. Self-harm incidents. Consuming large quantities of alcohol on a daily basis and becoming heavily intoxicated. Non-compliant with medication. Aggressive behaviours towards support staff.

ASW 21/01/21 VPR received from Police Scotland. Police attended L22's accommodation to support due to welfare concerns. L22 conveyed to Carseview by Police for assessment. L22 had stated that she planned to complete suicide by slashing her wrists. Discharged home.

ASW 27/01/21 VPR received from Police Scotland. Police attended due to welfare concerns as L22 expressing suicidal thoughts. Triaged by Carseview and left in the care of her supported accommodation.

ASW 01/02/21 AWI Case Conference for multi-disciplinary discussion regarding current support and risk management plans in place. Highlighted recent multi-agency interventions due to L22 experiencing a deterioration in her mental health and expressing suicidal intentions. Discussion about risks and protective factors. Reviewed the safeguards in place through existing Guardianship Order and reflected on decision making by SW not to proceed with interventions under ASP.

ASW 08/02/21 L22 reports that she is receiving abusive texts from an acquaintance. The other party is also known to Social Work and Mental Health services. Information now received that L22's boyfriend is an ex-partner of the 'friend' which appears to be the root of the problem.

ASW 16/02/21 L22 disclosed to Support Workers that she had been sexually assaulted last year. Stated to workers that she had been feeling anxious and ruminating over this.

ASW 26/02/21 – 01/03/21 L22 drinking alcohol daily and expressing suicidal thoughts. Police attended due to welfare concerns when L22 left her flat and lay out on the road.

ASW 01/03/21 L22 disclosed that a male has been sending her text messages asking her to perform sexual behaviour. The male sent abusive messages when L22 said no. L22 feeling upset and confused, trigger to previous sexual assault which is why she had discussed this with support workers the previous week.

ASW 02/03/21 L22 consuming alcohol and edibles[2] and stating that she is using alcohol/drugs as a coping mechanism. Expressing dissatisfaction about her weight, statements indicating low self-esteem and unhappy with body image.

ASW 03/03/21 L22 purchased cannabis edibles from an unknown male she found through Snapchat. She invited this individual to her supported accommodation to supply her with the drugs. This prompted concerns from Richmond Fellowship over safety of L22 and other residents.

ASW 04/03/21 L22 consuming cannabis edible and alcohol. Aggressive behaviours and disruptive within service. Police contacted and attended, confiscated 'edibles.' TRFS stating that L22s placement at TRFS is at risk.

ASW 05/03/21 L22 disclosed to Social Worker that she has a plan in place to complete suicide but stated that she did not carry this out because she got scared. She stated that she would not take an overdose because she knows that this would result in a hospital admission, and she does not want to go through this process. She stated that physically harming herself by cutting is her only choice right now to cope with her feelings until she can take the next step in her suicide plans. Stated that she wants to 'disappear' and referred to an overdose last year which resulted in a hospital admission. L22 stated 'I want the help sooner before it's too late'. Again stated that she is constantly fearful that someone is hiding in her cupboards, that people are watching her and hearing noises like rats scratching.

ASW 12/03/21 VPR. L22 left her accommodation and was expressing suicidal intentions. Police traced L22 and returned her home.

ASW 21/03/21 L22 displaying paranoid behaviours and stating that she felt under attack. Stating that she could see people in her room at night, that someone was trying to blow her phone up and she was fearful that someone would break into her flat to harm her.

ASW 17/03/21 VPR. L22 purchasing and consuming cannabis edible. Police confiscated.

ASW 24/03/21 L22 making allegations against support staff that they are attempting to over-medicate her. Posting on social media. Continued to state thoughts and feelings that she is under attack from unknown others in her flat at night. Stating that someone would come to her home and shoot her with a gun.

ASW 02/04/21 – 06/04/21 L22 has attended A&E a total of 4 times over a 4-day period to have self-inflicted wounds treated. Mental health assessment offered but L22 declined.

[2] Edibles are food products that may contain cannabis

ASW 23/04/21 VPR in relation to self-harming episode. Recent ASP investigation carried out and agreed that these episodes are in relation to L22's mental health and that health should be contacted to support. Ongoing MDT meetings in place to manage risks and ongoing concerns, KW to report to Health professionals as per protocol and support staff to manage and report and further contact

Health 08/05/21 Admitted to ward 4 PRI. Deliberate paracetamol overdose. Medical Treatment given, seen by psychiatry, safe for discharge with plan in place for community follow up by CMHT. Discharged 09/05/21

ASW 13/05/21 Incident in relation to medication error. Harm has not occurred. Care provider has acted appropriately and has contacted health who advised accordingly. No further action under ASP. Provider to ensure further training for staff in relation to managing L22 whilst administering medication and distraction

Health 02/06/21 Admitted to hospital. Deliberate Paracetamol overdose. No medical treatment required, referred to psychiatry liaison for review. Deemed safe for discharge with plan in place for community follow up by CMHT. Discharged 03/06/21

ASW 04/06/21 VPR in relation to L22 having taken overdose on 02/06/21 and also sending text and pictures intimating she was going to commit suicide. L22 sent this to staff, who contacted Police. L22 was traced and triaged by Carseview as fit to return home with staff support in place. This is in relation to mental health and there is ongoing support in place from MDT. Passed to KW to contact all parties and ensure continued supports and monitoring is in place and to arrange Regular risk manage MDT to review continued supports as being sufficient. KW also to Contact parties to ensure risks management is being followed and ensure mental health follow up.

ASW 23/06/21 MDT approach currently being implemented to best support L22 with social work, health and the service providers involvement. L22 is appropriately placed at present. L22's presenting behaviours are as a result of her diagnosed personality disorder. Also in accordance with Guardianship powers that the Local Authority hold we have a duty to seek relevant medical support for L22 when she is expressing suicidal thoughts and feelings. These powers have been delegate to the provider and legally we have a duty of care to request NHS 24 input to ensure L22's welfare. No further action under Adult Support and Protection.

Health 06/07/21 Call from The Richmond Fellowship staff that L22 refusing to attend appointment with nurse in CMHT. As L22 had missed 4 appointments if she does not attend next week she is to be discharged from caseload
Health 06/07/21 Alleged to have taken 18 Paracetamol 500mg tablets. No intervention required at A&E. No suicidal ideation, plan or intent. Discharge to TRFS.

ASW 09/07/21 VPR received, details L22 leaving the house with a bag of clothing. Alleged that she spoke of buying paracetamol. L22 did not return to the accommodation therefore staff followed protocol and called Police, L22 was traced well with no suicidal ideation, but under influence of alcohol as was with friends. No incident of harm. No further action under ASP.

Health 12/07/21 Deliberate Self Harm. Doctor did not feel required assessed due to regular presentation.

ASW 14/07/21 VPR Received. Screening note: Report saved onto ESCR. No harm came to L22, and the service provider took appropriate action in accordance with the MDT support plan that has been developed and implemented to ensure client's wellbeing. Social Work has ongoing with involvement with L22 alongside health and Richmond Fellowship in supporting L22. Police are fully aware of L22's needs and potential risks and regular MDT updates are held. No further action required under ASP.

ASW 11/08/21 VPR received. No harm came to L22, and the Police and service provider took appropriate action in accordance with the MDT support plan that has been developed and implemented to ensure client's wellbeing. Social Work has ongoing with involvement with L22 alongside health and Richmond Fellowship in supporting L22. Police are fully aware of L22's needs and potential risks and regular MDT updates are held. No further action required under ASP.

ASW 02/09/21 VPR. Involving L22's behaviours and stating she was going to harm herself. Police attended and she was traced safe, however had been consuming alcohol with friends. She was taken back to support and medication was undertaken. There is regular MDT[3] with mental health, support staff and SW to monitor this and agree actions/behaviours protocols. KW also discusses within supervision to monitor risks., there is also an open-door policy with Team Leaders. Passed to KW to continue with ongoing work and highlight any concerns.

ASW 16/09/21 Case discussion with Key Worker and Local Authority Guardian. The incident form from Richmond Fellowship records concerns regarding £50 going missing of L22's monies. TRFS also hold DWP Appointee for L22's monies. Police Scotland have been contacted and currently undertaking investigation. Sufficient safeguarding measures are in place, and it was agreed that there would be no further action under ASP. Also, as Police are investigating discussions have taken place with TRFS to ensure appropriate action is taken not to compromise a potential criminal matter. Nonetheless, concerns have been raised directly with TRFS regarding the delay in reporting the incident that took place on 28th August 2021. TRFS are to undertake a review of their processes for reporting and undertake relevant staff training as the manager who was providing cover for the service due to other managers being on annual leave was 'unaware of reporting protocols.' TRFS are to provide SW with a copy of the incident review and confirm appropriate action has been taken to ensure competency of staff and to improve the service provision. TRFS have also agreed to refund the money if the Police are unable to establish criminality. This approach is in keeping with the principals of the ASP and AWI act implementing least restrictive approach, which is of benefit for L22 taking account of her needs

ASW 24/09/21 VPR in relation to missing money which L22 has access to and has allegedly taken. Passed to SW to make further contact with staff, L22 and Police to ascertain how safeguards can be implemented to prevent future occurrences, L22 ask staff for her

[3] MDT – Multi-disciplinary Team meetings

money and was money in locked box and where is this kept. NFA under ASP as at present there is no harm. SW to update TL should there be further concerns in related to ASP.

Health 17/11/21 The Richmond Fellowship Service staff contacted duty worker CMHT described L22 as withdrawn, hostile, banging head and punching walls. Safety plan in place. Duty worker spoke with L22 who admitted to using large amounts of alcohol up to 1 litre daily until 11 days previously and when stopped “getting myself into a state”. Positive encouragement for recognising alcohol resulted in her feeling worse.

Health 20/11/21 L22 swallowed three batteries. No suicidal ideation. L22 not keen to speak to CRHTT. A&E referral triage declined as L22 not keen to speak with CRHTT staff.

Health 09/12/21 The Richmond Fellowship Service staff called re appointment for L22 Nurse had advised L22 that she needed to contact herself to request appointment. Agreed to engage. Nurse CMHT. Agreed to appt and confirmed for 14/12/21.

Health 14/12/21 L22 attended. Unsure of why she was referred. Explanation of safety and stabilisation work again

Health 17/12/21 Outpatient clinic with Locum Consultant Psychiatrist L22 declined psychotherapy; declined group work; to practice sleep hygiene; Increase antidepressant and change in future if required. Review in 6 months

Health 21/12/21 L22 did not attend appointment with CMHT. No contact

Health 30/12/21 L22 did not attend appointment with CMHT. Not feeling well
.
Health 11/01/22 L22 Did not make appointment with CMHT. Discharged for DNA;s and expressing wish not to engage with psychotherapy

Health 13/01/22 L22 admitted to ward 4. Ingestion of batteries.

ASW 15/01/22 OOHs MHO. Call from Dr (NHS 24) to request attendance to L22 home in Scone for a possible EDC (S.36). L22 had swallowed battery's and needed to go to PRI for an x-ray. She was refusing to go. I attended and tried to persuade L22 to go voluntarily however she was continuing to refuse. We got to the point of filling in the paperwork (unsigned) and L22 agreed to go. Dr called for an ambulance. EDC did not proceed

MHO 17/01/22 T/C 17:01 hrs from psychiatric consultant, requesting an MHO attend as he is looking to detain L22 as she has batteries and paracetamols in her possession and is threatening to harm herself. Consultant requested MHO attend Perth CMHT to complete joint assessment. Consent given to STDC. Suitable bed/nursing team transfer being identified. Eventually admitted hospital in Kirkcaldy.

Health 17/01/22 Duty worker CMHT received call from social worker to advise L22 in hospital over weekend and discharged today. L22 disclosed suicide plan (batteries and Paracetamol) to Social Worker. Assessed by Psychiatrist. Outcome was detention and admission to hospital as L22 refused to safety plan. Admission to Fife services as no beds in

Tayside. Duty workers contact from SW guardian. Reported L22 admitted to psychiatric inpatient bed in Fife over weekend. Discharged 17/01/22 and disclosed to social worker she had purchased large quantity of paracetamol and batteries with intention to take them. Detained under MHA as refused to safety plan or relinquish batteries and wanted to go home. Admission 17/01 – 20/01/22 out of sector bed then IHTT for a week

MHO 19/01/22 Phone call to Hospital, Fife. Informed that L22's crisis is over, she is unwilling to work with nursing staff, and therefore she will be discharged home tomorrow. Scone Project Supported Accommodation agreed with L22's discharge. The Short-Term Detention Certificate to be revoked and L22 to be discharged 20/01/22.

Health 20/01/21 Discharged. Intensive Home Treatment Team to support for 1 week

MHO 21/01/22 Revocation of STDC.

MHO 27/01/22 EDC granted. L22 had swallowed batteries and expressed suicidal ideation. MHO gave consent

MHO 27/01/22 Duty MHO requested to attend PRI to review EDC granted on 27.01.22. STDC granted to enable further assessment and treatment of mental state and physical health issues arising from self-harming (swallowing batteries).

Health 31/01/22 Increase of hostility on ward. Required restraint

MHO 03/02/22 STDC revoked. MHO involvement ended. Discharged. Referred to IHTT and to CMHT

MHO 17/03/22 Duty MHO, assessment for detention following admission to PRI for treatment of paracetamol overdose. Did not meet criteria for STDC. Remained in hospital as informal patient.

Health 19/03/22 Crisis call received by Crisis Home Response Treatment Team via NHS24. Expressing suicide intent. No clinical need identified

Health 23/03/22 Discussion by CMHT. Offred opt-in appointments. Third party call to CRHTT. L22 feeling suicidal. Advised to phone 999.

Health 24/03/22 Visit following call last night. No input required

Health 07/04/22 OOH involvement after 111 call by support worker at supported accommodation reporting L22 had swallowed approximately 12 batteries. L22 "unwilling to engage in proper assessment". Discussed with A&E medical staff. To be seen at hospital due to quantity of batteries. L22 refused though said she would consider attending tomorrow. Appointment Ninewells at 11am 08/04/22 arranged. L22 and support worker supported accommodation aware.

TRFS 07/04/22 L22's social worker contacted Staff at 14.30 to advise that she was on a video call to L22 & witnessed her swallowing 4 AAA batteries. 999 called. L22 told

paramedics she had swallowed more than 5 batteries & ambulance crew requested doing checks on L22 to which she refused. Police made aware of the situation & L22's refusal to go for treatment stated they were unable to forcibly take L22 to Hospital for this. Staff called social worker (Guardians) to report this & ask what steps to take. It was agreed that ambulance crew would contact consultant psychiatrist & discuss actions required. It was decided that due to L22 refusing to go for treatment staff to monitor L22 & if she experienced any changes or symptoms including abdominal pains to contact them via 999 again. Paramedics then left. SSW visited L22 & whilst speaking with her, L22 proceeded to produce more batteries Staff were unable to retrieve any batteries from L22 who was seen consuming more of these. Her Social Worker informed of this; SSW contacted NHS24 due to L22 stating she wished to harm herself & die.
Paramedics arrived and due to seriousness of L22 swallowing 10 or more batteries between 14.30 & 17.30. They advised she went to Ninewells for them to make checks. L22 refusing, they relayed to L22 the consequences of digesting the batteries & impact this could have on her physical health (ruptured bowel, potential death). L22 continued to refuse. An appointment has been made for L22 to attend Ninewells tomorrow (08/04/2022) at 11am where checks can be made. Assessor did not feel that L22 fitted the criteria to be detained & they advised as L22 staying at her flat that welfare checks carried out. In the event L22 changes her mind & will go to Ninewells or if her health deteriorates (experiences abdominal pain, becomes unconscious) 999 to be called. Parent & Carer Information Form completed by Paramedics & advised this was to be given to any other Paramedics should they visit the Service later
Later that Evening (around 8.45pm), Staff received a call from a friend of L22's informing Staff that L22 now wished to go to A&E & arrangements made for a Taxi to collect L22 who went to Ninewells with her friend where she was admitted & received treatment

Health 08/04/22 CMHT notified about incident yesterday. No requirement to contact L22 at this time.

Health 16/04/22 Liaison Psychiatry assessment of L22 in ward 8 Ninewells Hospital 16/04/22. L22 ingested 15 triple A batteries with suicidal intent and later changed her statement to self-harm intent. No alcohol involved. After event L22 contacted support staff in 24 hour supported accommodation – attended PRI and transferred to Ninewells. Escalation due to alleged sexual assault in past week. On discharge follow-up by IHTT.

TRFS 25/04/22 L22's alleging sexual assault by her boyfriend. TRFS contacted Tayside police to report the incident with permission from L22 and informed TRFS on-call Senior Support Worker. At 22.15pm two CID officers arrived to see L22. They went over the incident trying to gather as much information as possible. Police officers explained to L22 her options moving forward. Police officers left L22's flat. SP x 2 ensured L22 was okay before leaving her flat. SP gave her statement to police officers. Further proceedings were scheduled for the next morning.

ASW 26/04/22 2 x VPR received from Police regarding alleged sexual assault. L22 is to be interviewed by the Police with an appropriate adult present and Police will be carrying out further investigations. MDT approach currently in place through social work, health, Police and care provider. Strategic discussion with social worker that there would be no benefit in holding IRD as the existing multi-disciplinary team members are aware of the background information relating to L22 and her support needs. Agreed that there are sufficient powers

through Adult with Incapacity and the Welfare Guardianship to safeguard L22. She resides in 24-hour accommodation supported by TRFS who will ensure that the alleged perpetrator does not have any access to the building or L22.

Health 29/04/22 Duty worker CMHT call from support worker at TRFS requesting advice. L22 swallowing batteries. Advised contact 999

Health 01/05/22 Liaison psychiatry ward 7 Ninewells. Advised L22 she needs to engage with services. When medically fit, follow up with IHTT (not clear if she is an inpatient at this time)

Health 09/05/22 Community police triage call – suicidal thoughts of thinking about jumping out of window. Also self-harmed cutting arm with razor. At party earlier and this did not go well. Outcome – aware of CMHT appointment next day. L22 stated no intention of attending. If L22 needs support, then contact NHS 24.

TRFS 09/05/22 L22 had 3 friends' round at her flat on Monday evening who were drinking alcohol. The friends left at 20:30 & staff went up to L22's flat to do a welfare check & see how L22 was. L22 still had a one of her friends with her and was asking staff if she could stay overnight. Staff informed L22 that it was not a good idea and that she would have to prearrange any sleepovers & L22 asked staff to contact on call and ask. Staff phoned on call manager and explained the situation and decision made to not allow this. L22 unhappy and became aggressive towards staff (shouting obscenities and throwing drink can at staff). L22s friend left the service at 20:45. L22 then phoned staff and sent several text messages saying that she was going to jump out of her window. Staff went down to L22s flat where she was seen sitting on her living room window ledge with the windows wide open. Staff tried engaging L22 in conversation but was asked to leave her flat which staff then did & returned to the Office. Staff followed procedure and called the IHTT who asked staff to call the police on 999 to report this. Staff spoke with police who arrived at the service at 21:20. They spoke with L22 & informed TRFS that L22 had spoken with Mental Health Team Staff, and they felt like she was ok to remain in the service. Police left the service after speaking to staff at 22:40

Health 10/05/22 CMHT appointment. L22 arrived 30 minutes late for appointment; staff had called earlier to say they were running 10 minute late. L22 not keen to engage and reverted back to "I don't know" and "I am not sure" when asked about situations and emotional reactions to it. However agreed to print off her blog and agreed to use it as a way of looking at emotions and situations which have prompted the emotion. L22 agreed to participate in sessions.

TRFS 12/05/22 L22 had sent a support worker at TRFS a photograph of lithium cell batteries that she had just bought. SP went to L22 flat to see if he could retrieve the batteries from L22 & going to her flat L22 would not allow staff in. Both staff members went together to L22 flat for a welfare check, they observed L22 was lying on her bed with one fist clamped holding an unknown quantity of lithium cell batteries, both staff members tried in vain to talk L22 into giving the batteries up, but she refused. L22 then placed one of the batteries in her mouth before swallowing it. SP phoned 999/ambulance. The ambulance arrived by 18.40. L22 was on her bed clutching whatever batteries had not been swallowed & when the paramedics arrived L22 was initially refusing to go to the hospital, the paramedics then explained the

seriousness of what L22 had swallowed and what could happen as a consequence L22 after some persuasion left with the paramedics just after 19:00.

Health 13/05/22 On call psychiatry Doctor called to review L22 by surgical team Ninewells hospital. L22 had reportedly ingested 2 lithium batteries and brought for assessment insisting on returning home. Mental capacity assessment requested. Deemed to have mental capacity. Agreed to stay. Doctor noted that given the ongoing self-harm behaviours there is also a recognition that there may be misadventure leading to serious self-harm but her actions of seeking help/making others aware do not keep in line with a determined nature of wanting to end her life once, but rather reflect care seeking .

MHO 16/05/22 Consultation with MHO. Social worker seeking MHO and RMO view on L22's capacity to 'enter intimate relationship.' This followed L22 making an allegation of sexual assault. MHO advised that she is not in position to give a view on this, but view of SW and previous MHO is that L22 has capacity in most areas.

MHO 17/05/22 MHO attended meeting convened to discuss the merits of seeking a second opinion on capacity and if the WGO is not to be renewed, should it be recalled. It was agreed that an AWI CC should be convened as other interested parties such as care provider and AMP may want to contribute to decision-making. SW to convene

Health 17/05/22 L22 did not attend CMHT appointment

TRFS 17/05/22 L22 left service at 00:00 wearing shorts, hoodie and trainers. Staff attempted to call L22 at 00:10 but there was no answer. Staff messaged L22 to ask if she was ok and where she was going. L22 replied she was going for a drive. Staff tried to call L22 again but no answer. Staff then messaged L22 to ask who she was with and when she would be back. L22 replied she was with a friend. Staff called OOHs SW at 00:30 for advice as per protocol in place. Staff spoke to the OOHS SW Coordinator, and after a discussion decide to message L22 and let her know that if she was not back at service within half an hour the Police would need to be called. OOHs SW said they would call back in half an hour. Staff messaged L22 and informed her of what had been decided and L22 replied at 00:45 that she would be back soon. Out of Hours SW called at 01:10 just as L22 returned to service. L22 went straight to her flat. L22 messaged staff to say she could not sleep and later that she felt scared. Staff attempted to reassure L22.

TRFS 18/05/22 L22 had sent pictures to her Social Worker showing her with shoelaces that L22 had around her neck as if choking herself. Staff visited and L22 refused to give the laces to staff when asked. Not engaging a number of welfare checks carried out throughout the afternoon. L22 left to go into town. L22 refusing to divulge what she was going into town for but agreed a member of the staff could join her. Before getting the bus L22 was observed purchasing 2 boxes of paracetamol. She refused to give these to staff and made a call to her SW who also tried to deter L22 from going into town where she intended to purchase more. It was agreed with Social Worker that once L22 in town she would be left independently by TRFS staff as it was felt that TRFS staff being present would prolong things or make the situation worse. The staff at the service were made aware of the situation & asked to monitor L22 on her return. L22 had roughly 5-6 packets of empty paracetamol tablets on her table and was

holding another box which she informed TRFS staff held 80 tablets in. She spoke of her plans to try and kill herself by ingesting these.
TRFS staff followed protocol and contacted NHS24 who assessed L22. The assessor stated he was going to get the Dundee crisis team to contact L22 and assess her further. Roughly an hour later the Crisis Team spoke to L22 & during this conversation L22 was observed starting to ingest a paracetamol tablet. TRFS staff informing Crisis team of this. Crisis team was firm with L22 telling her that if she did not hand over the remaining tablets to TRFS that TRFS was to hang up the phone and contact 999. L22 refused to do this so 999 was contacted. TRFS returned to the office to let paramedics into the building at this point on call SSW was informed of the situation. The paramedics arrived at roughly 20:30hrs. Assessed L22 and L22 declined to engage with them. They left as there was nothing further, they could do at this point.

Health 18/05/22 NHS 24 call initiated by support worker at supported accommodation who found L22 in room having purposely bought five packets of paracetamol today with intention of taking an overdose to end her life. Support staff to call 999 and assessment requested via pathways if required.

ASW 19/05/22 No incident of harm. L22 suffers from EUPD and can often self-harm. This not new behaviour. She has also recently swallowed batteries and has been seen by PRI and Mental Health. There has been previous ASP/IRD and an agreement to regular MDT approach to supporting L22 with her self-harming L22 resides in 24hr supported accommodation with Richmond Fellowship. They have protocols in place for supporting L22 at times of distress and suicidal ideation. L22 is open to Cairnwell to complete a Safety and Stabilisation Course before she can move on to more long-term recovery focussed work. L22 has been given crisis helpline numbers L22 has been encouraged to use the Calm Harm app and to think about safe self-harm if she cannot use other coping strategies. Please see case notes for work undertaken. There is appropriate ongoing support in place and protocols to contact relevant professionals to direct to appropriate agency and manage risk around this Team Leader Discussed with Service Manager.

Health 24/05/22 L22 did not attend CMHT

TRFS 26/05/22 At 17:15 female and male arrived at the building informing staff that they were L22's friends they went upstairs to her flat. Staff SP MP shortly after went upstairs to L22's flat for a Welfare check & when staff arrived only L22 was in her flat. Speaking with L22 she informed staff that she had given them £60 to go and buy alcohol for them all and they were returning. It soon became apparent that they were not coming back & L22 called her Social Worker JL who advised that the Police be contacted, Staff called the police with L22 & SP KW contacted on call. Police arrived after 19:00 speaking with L22 they asked her a number of questions in relation to the incident before advising the best they can do is to ask the adult to pay L22 back. They went on to explain that this is because even though L22 is a vulnerable person, she gave away the money without being threatened (not theft).

ASW 27/05/22 Incident of potential financial exploitation; L22 gave £60 to two individuals to purchase alcohol for a party however the individuals left her flat with the money and did not return. Police are aware of the incident and have spoken to L22. NFA will be taken by them. Agreed not for ASP, although L22 meets three-point test, ASP is not the least

restrictive option. MDT approach continue. TRFS aware of protocol and to ensure all staff aware of this and not to allow individuals, particularly those known to be a risk to L22 into the building. Currently utilising

Health 06/06/22 CMHT letter sent for opt-in

Health 10/06/22 Aim2change invite sent (Moveahead project)

MHO 15/06/22 AWI Case conference. Agreed that welfare guardianship should be recalled. Consultant psychiatrist, of the opinion that L22 has capacity to make decisions in the areas that the current guardianship order covers. Therefore, welfare guardianship should be recalled. MHO to progress.

TRFS 16/06/22 L22 aggressive and hostile in the provision after being in town. The decision was made to contact Police Scotland on 101 as per reactive plan. 2 officers arrived within the next 20 minutes and approached L22. L22 was firmly prompted to return to her flat, which she did.

Health 21/06/22 Call to CMHT. Call from police who responded to image shared by L22 on her social media last night of box of medication. Attended today, Image was old one and staff at accommodation CMHT expressed surprise as L22 “upbeat and laughing/having a good day”. L22 refused to cooperate with police questioning regarding risk and sought advice from CMHT – submit VPR.

Health 21/06/22 L22 did not attend appointment with CMHT. Discharged from caseload.

ASW 24/06/22 Social Work carried out home visit to L22. It had been a difficult week for L22 and apparent her relationship with staff was breaking down. Reports of L22 barricading staff flat, not allowing other residents to receive their medication on time. Challenging behaviours towards staff (invading personal space, being threatening and verbally abusive). L22’s case was also reallocated to her previous social worker the same week. Social Worker planned visit and advised L22 that she will need to leave around 12pm due to other work commitments. Throughout visit, L22 was challenging boundaries when discussing current “falling out” with staff and did not engage in conversation regarding this. When near the end of the home visit, L22 attempted to stop Social Worker from leaving by blocking the door and getting into personal space. L22 then stole Social Worker’s car keys out of coat pocket. Social Worker attempted to discuss this with L22 and asked L22 to walk her downstairs. Behaviours continued and apparent that L22 was not willing to engage. L22 began shooting water out of a water gun at social worker and became verbally abusive towards her support staff when they tried to intervene. Social Work then retreated to staff flat and informed L22 to hand car keys over through the staff letter box as she is not willing to have a conversation about this, or the police will be contacted. L22 refused to do this continuing to be verbally abusive towards staff and social worker. Police were then contacted and arrived 70 mins later and got the keys from L22.

ASW 29/06/22 L22 successful in obtaining a job as a carer with Kippen Care.

ASW 07/07/22 Professionals Meeting with Social work and Richmond Fellowship. Agreed that Scone Project was no longer suitable accommodation for L22 and Social Work to explore housing options via Independent Living Panel for L22. L22 has also had conversations with her social worker at this stage about having her own flat.

Health 08/07/22 TRFS call CMHT advising L22 keen to start groupwork. First session due 04/08/22.

ASW 19/07/22 Incident where L22 has posted a picture of pills on social media, Police have attended, and L22 has not taken theses. Police has been deemed safe and left in the care of staff unharmed, L22 does not meet three-point test at this time. Passed to KW as ongoing work and MDT approach to supporting L22.

Health 20/07/21 L22 attended appointment with The Richmond Fellowship Staff. Offered 1:1 , group to learn skills but L22 did not wish either. L22 said “not for me” when asked about engaging in skills of emotional regulation. Discussed aim2change again ambivalent. Commitment outlined. Given opportunity to discuss with The Richmond Fellowship staff and to notify of decision.

Health 26/07/21 Out of hour GP requesting contact from CRHTT as self-harmed. Open wound but L22 declining to attend A&E. Doctor not willing to consider emergency detention as not life threatening and regular self-harm.

Health 02/08/21 L22 left supported accommodation reporting suicidal ideation. Located by police safe and well ; returned to accommodation

Health 03/08/21 L22 did not attend appointment (not sure with whom) or contact team.

Health 04/08/21 CMHT discussion. No support from CMHT at this time as L22 not engaging in interventions. Suggestion of Moveahead (encouraged to self-refer) and social worker to speak with L22 again. Remain open to medical review Discharged from nurse, CMHT due to non-engagement. Discussed at Contingency meeting. Team decision re discharge from 1:1 in CMHT. Remains open to Psychiatrist out-patient clinic and duty worker in CMHT.

ASW 16/08/22 L22 presenting as low moods however did not wish to discuss what has been going on. L22 did not engage in conversation about this. She later informed Social Worker that she wanted to harm herself however has chosen not to do this.

ASW 19/08/22 Telephone call with TRFS. L22 had ordered a package that was addressed to staff flat. It contained live insects. Concerns raised regarding L22 ingesting this following discussions around tape worms for weight loss. Agreed that this would cause L22 harm if ingested. Opened package and it was stick insects. Upon discussion with L22 she advised it was a practical joke for staff as she knows they hate insects.

ASW 31/8/22 Care Review held for L22 with Richmond staff. L22 has presented as quite low all week due to feeling socially isolated. L22 has been doing well with her employment and even when feeling low, she has chosen not to self-harm. She has informed

staff of low moods, however ongoing difficulty with L22 engaging with her support staff for activities.

ASW 06/09/22 L22 received letter from Police regarding VIPER identification – L22 has been asked to attend Perth Police Station regarding video evidence whereby L22 is involved (either as witness or potential perpetrator). L22 anxious about this however has been forthcoming with discussions and has agreed to go. L22 worried about how this will impact her job.

ASW 12/9/22 L22 had meeting with MHO to discuss recall of Welfare Guardianship Order. L22 is happy with this being recalled.

Initial Police Response to questions raised within formal escalation:

January 2021

3rd concern report acknowledged and clearly reviewed by assessor (although chronology does not state that 'escalation review' take place, it was reviewed in line with VPD guidance, following a 4th concern in 30days, an APCC was held.

July 2021

3rd concern report acknowledged and clearly reviewed by assessor (although chronology does not state that 'escalation review' take place, it was reviewed in line with VPD guidance.

August 2021

Appears to be the same as before: 3rd concern report acknowledged and clearly reviewed by assessor (although chronology does not state that 'escalation review' take place, it was reviewed in line with VPD guidance

Would suggest that the issue is that processors are simply not writing words to the effect of: Acknowledging 3rd concern report in 30 days. Reviewed by assessor in line with VPD escalation policy but assessed as not requiring escalation to Hub Supervisor. If a 6th concern report is received within 30 days, this will be escalated for review by the Hub Supervisor

Abbreviations

ASP	Adult Support & Protection
APC	Adult Protection Committee
EUPD	Emotionally Unstable personality Disorder
IHTT	Intensive Home Treatment team (Health)
CMHT	Community Mental Health team (Health)
MDT	Multi-disciplinary team
SP	Support Practitioner (The Richmond fellowship)
SW	Social Worker
VPR	Vulnerable Police Report
AWI	Adults with Incapacity (act)