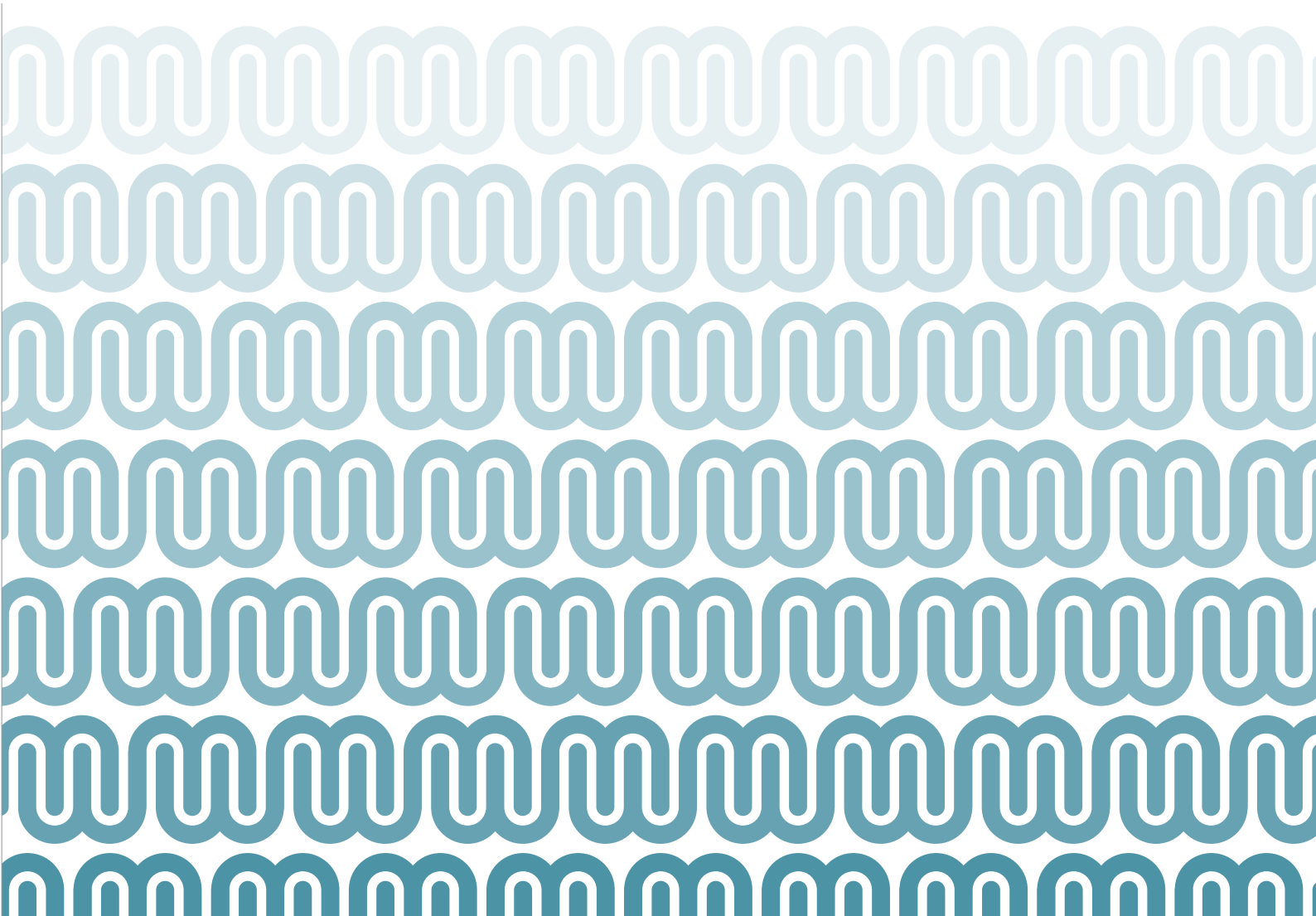
mental welfare commission for scotland

Learning through review: a summary of our investigative role, and looking to the future

June 2022



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Notes

We acknowledge and appreciate the cooperation of all the individuals, organisations and staff who assisted us in the completion of this report.

The case summaries within this report have been anonymised as is our practice.

While this report is primarily directed at those working in mental health and learning disability services, we hope it may also be helpful to those who use those services.

Contents

Foreword – Julie Paterson, chief executive

When people need care and treatment, they are often at their most vulnerable. This is particularly the case when a person is dealing with mental ill health, or with difficulties related to learning disability, dementia or related conditions.

In most situations that care and treatment is provided by caring professionals in an appropriate manner. But sometimes this is not the case, and individuals themselves, or families or carers, will contact the Mental Welfare Commission seeking help in resolving a problem in mental health or social care services.

Sometimes health or care professionals contact us directly when they are concerned about an individual. And our own teams will raise issues when they are visiting wards or visiting people at home.

This report considers how we handle these concerns, in work that comes under the broad category of 'investigations'. Investigations can range from an immediate approach from one of our Commission mental health or social work professionals to a service, seeking reassurance on a patient's or family's behalf, to a national, published investigation into a single case.

While the lessons learned in our national investigations are widely shared, this report seeks to identify how we can extend that work, sharing lessons learned from every level of investigation – from relatively straight forward situations to the most complex.

As part of our drive for continuous improvement, this report also looks at how we are reviewing our own internal systems, and aiming to improve our engagement with individuals and families during the fraught experience of trying to deal with sometimes poor care and treatment.

We hope this report explains this area of our work more fully; we aim to build on this work in the years ahead.

Introduction

The Mental Welfare Commission for Scotland (the Commission) has a duty to undertake enquiries and investigations. Sections 11 and 12 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) provide the Commission with a range of duties which mean we can investigate serious incidents. This duty has led to the completion of a number of published investigations, highlighting particular deficiencies in care and treatment.

These published investigations placed emphasis on key findings which we believed may have wider implications for practice across Scotland. In some instances, our investigation reports make recommendations that address significant gaps in service provision, systems and mental health policy and law.

This investigative duty is one of the Commission's five main functions, and underpins all of the work that we do. Our additional functions are - monitoring mental health and incapacity law, visiting individuals and services, providing information and advice and influencing and challenging. We undertake all of these activities with the purpose of improving mental health care and treatment, policy and legislation.

Alongside our published investigations, we carry out a range of other enquiries on a daily basis; for example following up calls to our advice line and following up on issues raised during our visits to individuals in wards or in community settings.

Sometimes enquiries can be instigated by our own staff, who see or hear situations that cause concern, and we duly follow them up seeking change or reassurance from services.

It is our role to be curious, to ask important questions and ultimately to provide analysis and rationale for individuals, families and services as we do so.

At times, answers can be unclear and the process of investigating in itself can be challenging for all involved. There is also a recognition that the investigative process alone will not always lead to improvement. To ensure positive outcomes from any investigation, targeted follow up, action planning and dissemination of key knowledge and developments in practice are all required.

Internal review

Within the Commission we have been looking at the way we carry out our own investigations and how we can improve our approach.

This report is the culmination of that work, including a review of what we investigate, how we decide this, how we report our findings and ultimately how we share our learning.

Over the last 18 months we have also been host to a project review team, funded by Scottish Government, tasked with recommending a consistent, national programme for reviewing deaths that occur under compulsory detention and also homicides that are committed by an individual with mental ill health or learning disability, who was or had recently been receiving care and treatment. Both of these projects will be discussed in more detail later in this report.

We also include sample case summaries of work undertaken by the Commission. We do this to highlight something of the range of enquiries we receive, and to illustrate learning points we are keen to share across a wider audience.

Chapter 1

Current investigation role and powers

As detailed above, the Commission has a defined role under the 2003 Act in relation to investigations. Section 11 of the 2003 Act states:

The Commission may carry out an investigation into the patient's case; and make recommendations as it considers appropriate as respects the case. Those circumstances are:

(a) that the patient may be unlawfully detained in hospital;

(d) that the patient may be or may have been subject, or exposed to –

(i) ill -treatment;

(ii) neglect; or

(iii) some other deficiency in care or treatment

(e) that, because of the mental disorder, the patient's property –

(i) may be suffering, or may have suffered, loss or damage; or

(ii) may be, or may have been, at risk of suffering loss or damage;

(f) that the patient may be –

(i) living alone or without care; and

(ii) unable to look after himself or his property or financial affairs.

Sections 12, 13, 14 ,15 and 16 of the 2003 Act go on to detail duties in relation to holding formal enquiries, requiring evidence on oath, undertaking visits, interviews, medical assessments and inspection of records .

Our published investigations

We have undertaken a number of detailed investigations over the years and 35 of these are published on our website. All of these reports are anonymised. They focus on learning and where required, recommendations are made both on a local and national level.

These investigations have all been managed through our formal internal arrangements which involve appointing an investigation team, scrutinising records, and interviewing relevant parties. This information is analysed and reviewed and our findings form the basis of our reports.

These investigations have their own levels of governance via our senior management team, who approve the decision to investigate at the outset and continue to monitor the investigation's progress throughout its duration. The Commission's Board considers and approves all reports on an individual basis prior to publication.

Investigations we prioritise for publication include those that may lead to sharing of wider learning across Scotland and in particular areas of practice which may not have been investigated by the Commission previously. We need to have some limits around this function; we are not able to formally investigate all matters raised with us in the form of a full process with a published report.

Each published investigation requires significant resource and can be subject to unavoidable external delays at times - for example, gathering archived records, locating staff who may have moved on or retired and ensuring sensitivity around interviews in terms of timing and venues. We usually publish one of these investigations each year.

Wider investigations and enquiries

While these published investigations are a valuable part of our work, there is a range of additional investigation work being done across the Commission that is not widely shared or published, but still provides important learning opportunities.

This is something we want to improve upon by publishing more case summaries and findings of the work we undertake.

We receive a high volume of information relating to deaths, serious incidents and alleged harm, from a range of sources which includes individuals who use mental health and learning disability services, family members and friends and mental health and learning disability professionals and services. Information is shared with us via correspondence, telephone calls, through our formal notification processes and through mental health and incapacity act paperwork.

On receipt of this information we need to determine if and when to intervene. These decisions are taken by our staff team of nurses, social workers/mental health officers and psychiatrists. Staff will determine if an issue can be resolved by advice, by a level of enquiry or if more formal investigation is required. They will consider this in line with our legal duty and if there are any systemic failures or concerns and they will consider potential learning and what can be improved upon.

While we undertake this work, it is important to note that the Commission is not a complaints authority, we therefore advise on the importance of local complaints processes and the role of the Scottish Public Services Ombudsman (SPSO).

Internal investigations group

If an issue is still giving us cause for concern following our enquiries, it will be escalated to the Commission's internal investigations group. Staff members will have already reviewed any adverse event review documents and made enquiries both of services and (where relevant) to family members and carers, prior to this level of discussion taking place.

This does not mean that, at this stage, the matter will become a full published investigation, but it does indicate that an investigative level of scrutiny is being applied by a wider multi-disciplinary group of staff, including senior staff members, of the Commission.

The investigations group make recommendations for action and determine if further work or escalation is required prior to any recommendation for a more detailed investigation by the Commission. Final decisions are made by the senior management team.

In terms of additional work or raising an issue, the Commission can consider the following actions:

- Raise our concerns with services concerned at the highest level if alternative discussion has not been successful. This could involve chief officers of a range of differing organisations not solely health and social work.
- Ask for local adverse event reviews or case reviews from health and social work services to take place if these have not already occurred.
- Make further enquiries of services and request case records to gain additional information.
- Request action plans from services or updates where we find that interventions may not have taken place.

In many cases we take forward all of these actions to ensure that we have accurate and current information to inform our decisions on any next steps.

If a full detailed investigation is agreed, a report is written by our team and we share a draft with services and individuals concerned for accuracy prior to publication. Our reports focus on learning and are anonymous.

Chapter 2

Summary of investigation themes and recommendations

Historically, the Commission has completed at least one published anonymised investigation a year, with each going through the above process. As highlighted, we wish to share more of our work and disseminate more learning.

As part of this report we reviewed the last 10 years of investigation work, from 2012 to 2021. Throughout this period we published 16 investigations (see appendix 1) and these are available on our website. These reports show:

- The type of situations we investigate.
- The common gaps in practice, systems and knowledge that were identified throughout this time.
- Areas where common recommendations continued to re–emerge or were repeated.

These 16 investigations looked at the care of eight men and nine women (one being a male and female couple).

All of the issues we looked at involved death or serious incidents of harm. Eight deaths were investigated during this period, with five being due to suicide, and the remaining three related to physical health care problems.

We are informed of such events by a range of means, however, the most frequent are by family members contacting us, professionals seeking guidance from our advice line and professionals formally notifying us of serious incidents.

We have also investigated at the request of Scottish Government on three occasions in the last 10 years.

The type of mental health conditions included in the cases we investigated were varied. They included individuals who had no clear diagnosis, or had been diagnosed with differing conditions over the years. There were five people diagnosed with a learning disability, and one person diagnosed with autism. Two individuals had a diagnosis of personality disorder. Other conditions were psychosis, depression, dementia, alcohol related brain damage (ARBD) and acquired brain injury.

The incidents we investigated were also varied, and although unique to the individuals involved, there were some common features. These included situations where vulnerable people with mental health issues or a learning disability wrongly end up in the criminal justice system or prison. They include a lack of parity between mental health and physical health care leading to poor treatment and prognosis and poor engagement and communication with families and carers, who have often been able to provide reliable and important information in relation to their relative's care, but have been overlooked.

Summary of themes

An overview of additional themes that have featured is detailed below. We would want to acknowledge that for every issue identified here, our investigation work also uncovers good practice and a recognition that staff are often working in difficult circumstances. Some of the issues mentioned date back 10 years, but we felt it was important to share these as some continue to feature across many aspects of our work today.

Initial assessment and care planning, including risk assessment

We have found instances where this has either not been completed or is lacking, is not person centred nor inclusive and is not shared with individuals or members of a wider multi-disciplinary team.

Communication

A lack of communication with individuals, families, carers and between professionals. This is in relation to communication prior to and following incidents where information and reviews are not well shared. The need for improved communication between different professionals working in the same organisation has also featured.

Knowledge and training

A recognition that a range of professionals in health, social care and social work have gaps in knowledge and training in relation to mental health and capacity law. At times we have found a lack of clear local procedures that can assist and direct staff in complex situations, a lack of refresher training programmes and a hesitancy on how and when to intervene legally. Staff access to legal advice also appears inconsistent.

Leadership and staff supervision

Staff across a range of professions during some investigations have told us that they have lacked direction or leadership particularly in a multidisciplinary team setting. This has led to a lack of independent monitoring and oversight on work. Staff are also working in complex situations sometimes without professional or managerial supervision leading to an inability to raise and discuss concerns and air and reflect on practice. We have noted situations where staff have subsequently not felt confident to professionally challenge colleagues or recognise unconscious bias in situations. Both of these have led to serious negative outcomes for individuals and services.

Integration and dispute resolution

We have witnessed examples of health and social care services not working together or recognising each other's role, strengths and responsibilities. Where disagreements occur there can be long periods of inaction or delay leading to poor outcomes for individuals. In such instances we saw little evidence of mediation or dispute resolution. We would hope to see formal mechanisms in place to address such issues and agree ways forward which focus on the individual and what is important to them.

Transitions in care and treatment

Periods of change in mental health care happen frequently but require clear preparation, planned support and good communication. We have continued to investigate incidents surrounding transitions, be they discharge planning from hospital to community supports, transfers of care to different teams, or different areas and services. Each transition brings with it elements of risk, changes in support and treatment and requires clear co-ordination between all parties to ensure these happen smoothly. Individuals and their families are

sometimes not involved in discharge planning and at times, not given clear direction on how to access new services when changes occur.

Summary of recommendations

We have made recommendations for learning and improvement through our investigative work over the last 10 years. These recommendations range from local and national recommendations to recommendations to the Scottish Government, including those relating to policy and law.

Taking account of recommendations made over the past 10 years we find different circumstances yet some similar recommendations:

Review of local policies and procedures

We have recommended review across a wide range of local service policies where gaps in information are evident, or the process itself is flawed, leading to poor outcomes for people.

On occasions where we uncover that no policy is in place, examples of recommendations we have made include to create policies, for example relating to nursing observation practice and 1:1 engagement on hospital wards, AWI procedures and dispute resolution between services.

Another key factor is the dissemination of this information across the workforce, as we find this can be a challenge, and not all staff are aware of their organisation's policies and procedures. Failure by some staff to recognise an organisation's process when faced with a complex or crisis situation remains a recurring feature.

Audit and evidence gathering

We have noted a lack of internal audit to support policies and processes, where information has been found to be outdated, not fit for purpose and not achieving its original aims. This can lead to assumptions of a process working when there is no evidence to support it and this can lead to delays, or gaps in provision. We have recommended updated audits to a number of local services including audit of medication pathways, pharmacy audits or completion of timely hospital discharge letters and risk assessment documentation.

We acknowledge that we are able to identify these with the benefit of independent scrutiny and hindsight, but we would want to see self-evaluation adopted and embedded in mental health service governance locally.

Training issues

Training in mental health and incapacity law has been identified as a theme across our work in the last 10 years, however, legislation remains a significant area of our work and one where we continue to recommend updated training delivery plans or a training needs analysis of wider groups of staff. All staff working in the complex area of mental health and learning disability need access to a continuum of training that ranges from increased awareness to enhanced specialist training depending on where they work and their skills set.

We have made recommendations in relation to access and availability of training for staff and clear understanding of differing professional responsibilities and legal authority in a range of situations. A number of our investigations have highlighted poor knowledge or inaccurate misinterpretations of the 2003 Act, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007. This has led to delays or inaction where legislation may have supported a particular area of practice. Issues around capacity to consent to mental health treatment or physical health care when someone is unwell, are

continuing themes. These situations are not always straightforward and we continue to produce and update good practice guidance to support professionals in these and other areas.

Care plan and risk documentation

Recommendations made in this area can be linked to both preparation and audit of care plans. We find care plan templates that can be too long or too short, and do not capture relevant person-centred information about what matters to the individual. Recording can be scant with gaps in chronological history and risk assessments with no contingency alerts or clear risk management.

Care and risk plans may seem a small part of an individual's overall support and treatment but our rationale for recommending improvement in these areas is that we find these key documents are not person centred, they do not include multi-agency views and there is often little evidence of involving carers, who may know the person best. Without a coordinated approach, risk can be underestimated and essential background history can be lost, leading to assumptions or bias on occasion.

The inclusive process of care planning itself should lead to a quality document which informs care, and defines key staff roles and the roles of carers and relevant others to produce positive outcomes to aid recovery. A one size fits all approach does not work effectively and we have published guidance in this area to support best practice.[1]

Formal apology and duty of candour

In a small number of our investigations we have recommended that organisations provide formal apologies to those affected by significant deficiencies in care and treatment. This reflects the level of our concern regarding the issues presented and the impact on individuals and families.

Since 2018 the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 has placed a statutory duty of candour to all health and social work providers including the independent sector. The overall purpose of the duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in harm or death.

Organisations are required to follow a duty of candour procedure which includes notifying the person affected, apologising and offering a meeting to give an account of what happened.

Organisations must publish an annual report on when the duty has been applied. This will include the number of incidents, how the organisation has implemented the duty and what learning and improvements have been put in place as a result.

We are often advised by families that they can experience problems communicating with services following an incident. We therefore welcome the recognition and implementation of this duty by services over the last few years.

[1] https://www.mwcscot.org.uk/node/1203

Chapter 3

Future investigative role and developments

In addition to this current review of our investigations, we have hosted a small multi-disciplinary project team, funded by the Scottish Government, who are looking at specific proposals at how certain deaths should be investigated.

The proposals for this work, which were submitted to Scottish Government in April 2022 are detailed below. If agreed by government, the introduction of these new pieces of work will mean changes in the way that we work and an expansion of our investigation role in the future.

Deaths in mental health detention and homicide reviews

The Commission has submitted proposals to the Scottish Government for new processes to review deaths that occur under mental health detention in Scotland and also to investigate cases where someone who had been in contact with mental health services commits a homicide. We have suggested that:

- The Commission should carry out investigations in all cases where the case meets the criteria for a mental health homicide.
- The Commission should initiate, direct and quality assure the process of reviews of deaths during mental health detention in Scotland.

The proposals put forward by the Commission are, we believe, human rights compliant, will improve patient safety, improve the experience of families and carers, improve clinical outcomes, minimise delays and remove variation in the quality of reviews and investigations carried out across Scotland.

Further information on these proposals can be found on our website.[2]

As part of this development process, the Commission has undertaken four investigations (two mental health homicide investigations and two death in detention reviews) and will report on these later in 2022/23. It is important to note however that any further work in this area remains subject to Scottish Government approval.

Other investigative work

In the last 12 months, the process of how we highlight, escalate and report on significant incidents has been reviewed and while this is still in early stages we have developed new processes and identified new thinking which will assist us in our future investigation work.

Our overall aim is to target our resources better, and highlight incidents resulting in greater impact both in terms of wider learning and improvement for services and for individuals and families.

We would also want to adopt a more streamlined approach to the work itself, have better engagement with families in relation to our work and publish our findings more regularly.

The review of the last 10 years of investigation work detailed in this report has identified that some of the themes and issues we have raised continue to happen. The landscape of health and social care/social work has changed significantly during this period and learning from

[2] https://www.mwcscot.org.uk/policy-and-research/deaths-detention-reviews

review and past incidents of harm remains inconsistent throughout the country; we want to contribute to the improvement of these systems and add to learning.

The following are the identified areas that we have changed or are in the process of changing from our review and are what we will continue to work towards:

- Improve our investigation process internally. This includes developing new guidance and paperwork for our staff, a more effective decision making forum, an escalation system for pieces of work and identifying differing levels of investigation resulting in a wider range of cases being looked at.
- Improve our governance structure of the above process alongside a performance management framework so we can monitor how well we are doing.
- Review and refine our notifications process on deaths and serious harm.
- Introduction of achievable timescales for investigation work and report on identified outcomes for services and individuals.
- Work alongside the project team in relation to deaths in detention and homicide work and integrate where appropriate.
- Plan how we can disseminate learning both across our own organisation as well as nationally.
- Review and develop a process on how we can better engage with families and carers during an investigation.
- Improve our data systems so that we can analyse efficiently and look at gaps and identify themes in investigation work. This will include improvements in relation to gathering statistics on protected characteristics.
- Enhance and improve our liaison and engagement with a range of other improvement, quality and investigative bodies in the course of our investigation work. For example Health Improvement Scotland, Care Inspectorate, Health and Safety Executive and Crown Office.
- Develop our in-house learning and expertise with focused training, but also consider external experts for particular aspects of our work.
- Be clear that in all aspects of our work we tackle discriminatory practice and identify racial disparities in line with our published report –*Racial inequality and mental health services in Scotland*.[3]
- Consider how we can continue to improve, for example learning from NHS England regarding their work with people with learning disabilities (see *LeDeR Learning from Lives and Deaths*[4]).

[3] https://www.mwcscot.org.uk/node/1634
[4] https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/

Chapter 4

An overview of our current work

As detailed earlier, the Commission continues to investigate and consider work through its internal investigation process. At any one time the Commission will be making enquiries and investigating between 10–20 cases across Scotland, seeking assurance and positive outcomes.

The breadth of our work is extensive. For example we have received referrals from sheriffs in relation to cases where the disposal is more appropriate to mental health law than criminal justice; we have made further enquiries and ensured appropriate advice and information is provided to support the most appropriate outcome for the person. We have scrutinised case records and identified discrepancies in relation to medicines and forwarded these concerns to appropriate agencies for action and learning. We have received a number of referrals from solicitors concerned about matters of excessive security, visited individuals for whom this applied, attended judicial reviews as a result and in 2021 developed a good practice guide to support learning.[5]

The following two example case summaries provide a more detailed insight into some of the issues raised with us, the range of agencies we link with and lessons for learning. It is these types of summaries that we also hope to publish in future.

We give our thanks to all of the individuals, families and others who have assisted us in this work and indeed in all of our work.

Case summary 1

Introduction

The Commission was contacted by a criminal justice social worker about a prisoner with a diagnosis of dementia who was receiving treatment for a physical health condition in a local hospital. We were told that he was in a small single room and was handcuffed to a security officer with up to four staff observing at all times.

The social worker expressed concern about his circumstances and a number of additional complex issues, focusing on; his time in prison and his social care needs, and contact with the parole board and joint health and social care planning for a potential release from prison (made more complex by the fact that the prison was not in the person's home local authority area). The social worker said that, given both his mental health and physical health care needs, the prison did not feel he should return there.

Investigation

What we did

Further enquiries were made to a range of individuals representing a series of organisations.

A member of our Commission health and care staff visited the prisoner in the local hospital; at this point he was subject to a local authority welfare guardianship order. The Commission staff member also attended the social work department within the prison and examined a

[5] https://www.mwcscot.org.uk/node/1674

range of multi-disciplinary records. Contact and discussion was also held with prison based staff, staff from health settings, social work services and advocacy.

Key Findings

Older prisoners and provision of social care

The prisoner had spent many years in custody. Risk assessments identified him as being a high risk given the nature of his past offence and ongoing challenging behaviour at times. He was a prisoner who also required support with personal care including washing, dressing and assistance with meals.

The issue of long term prisoners ageing while in prison custody is one that has been previously highlighted and documented both by the Scottish Prison Service (SPS) and Her Majesty's Inspector of Prisons.[6] The number is increasing and prisoners are living longer.

We welcome the fact that this challenge has been recognised and the Health and Justice Collaboration Board at Scottish Government has developed an integrated health and social care work stream and has recently published a report, *Integrated Health and Social Care in Prisons, Tests of Change Findings and Recommendations (Social Work Scotland)* (A Bavidge).[7]

The particular prison setting was not the best environment for this person. Alternative prison units were considered but these too were not thought to be suitable for a range of reasons. As well as alternative prison sites, different hospital settings, psychiatric facilities and care homes were considered. We were told that almost 30 facilities were approached with no setting able to meet identified security, health and social care needs.

The health and social care needs of such prisoners should be a primary determinant of where they live, but such accommodation can be limited. As identified earlier, with the increasing number of older prisoners, this situation will become more prevalent.

We are aware that this issue has already been raised by HMIPS in their report:

Who Cares? The Lived Experience of Older Prisoners in Scotland's Prisons July 2017, Strang D HMIPS.[8]

Discussion with SPS has revealed that they are reviewing the prison estate with medium to longer term plans to build newer, environmentally appropriate facilities.

Prison based social work

Discussion with prison based social work staff detailed their distinct role and remit. This role focused on assessments of risk, particularly in relation to re-offending, preparation of reports for a parole board/tribunals, and through-care planning for those subject to statutory supervision upon release. It was explained that they are not experienced nor funded to deliver adult community care social work services. Instead, in these instances they require to link with their counterparts across all 32 authorities.

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[6] https://www.prisonsinspectoratescotland.gov.uk/publications/who-cares-lived-experience-older-prisoners-scotlands-prisons

[7] https://socialworkscotland.org/reports/integrated-health-and-social-care-in-prisons-tests-of-change-workstream-findings-and-recommendations/

[8] https://www.prisonsinspectoratescotland.gov.uk/publications/who-cares-lived-experience-older-prisoners-scotlands-prisons

A debate exists in relation to whether the prison based social work role should be extended. The Bavidge report suggests *"the role of social work within prisons more widely, should be reviewed to establish and promote a more cohesive approach to social work in prisons in the future"*. We support this review.

Liaison with the parole board

We found that due to assessed cognitive impairment, the individual was less able to follow proceedings at parole board hearings. In addition we were advised that the board was unable to appoint someone to represent him to ensure that his past and present wishes were expressed, as they had no powers within their remit to do so.

The introduction (by social work services) of advocacy services was key initially in ensuring that the prisoner's views were heard. The situation was eventually overcome by an application by the local authority for a welfare guardianship order under the Adults with Incapacity (Scotland) Act 2000. Following this the guardian was able to instruct a solicitor.

This solution however, was not a quick process and took some time to complete. The rights of the individual were therefore not fully exercised during this gap in representation.

We have discussed this situation both with the Parole Board in Scotland and Scottish Government. Both are aware of this gap and they have confirmed that discussion has been ongoing and plans are in place to address this issue by a review and change in Parole Board Rules. A public consultation on wider issues in relation to parole and the Parole Board is also planned in 2022.

Case summary 2

Introduction

Contact was made with the Commission via our telephone advice line by a court-appointed welfare and financial guardian, who told us about her mother, who was living in a care home, sustaining a fractured femur which necessitated admission to hospital and surgery. The welfare guardian raised concerns with us both in relation to the incident which led to the fall, and the subsequent processes which resulted from this incident.

The guardian's concerns focused on what she perceived to be deficiencies in organisations' responses and misunderstanding of the legislation in place to protect vulnerable adults who are unable to protect themselves. The guardian believed that her mother had been let down and was worried about other vulnerable adults lacking capacity to speak for themselves, relying on the same professional services for their care, treatment and protection.

Investigation

What we did

Following discussion and some preliminary enquiries with services, the Commission identified the need to investigate further.

The Commission called for copies of all relevant reports from the local authority who led the adult support and protection process. Having considered this information, we sought further clarification on key points where we identified gaps in practice which may have enhanced the outcomes both for the vulnerable adult and for her welfare guardian.

Similarly we spoke with other key players where appropriate, most notably Scottish Public Services Ombudsman(SPSO)to discuss their conclusions which we deemed to be an error in law.

Our aim in all of the above was to identify key learning points which could result in service improvement for all agencies, including the Mental Welfare Commission.

The incident

The incident occurred at night when care was being delivered by three night shift staff – one senior care home staff member and two agency staff.

Initially the injury was reported by care home staff as an unwitnessed fall, but this information was later changed to describe a scuffle that had ensued where the vulnerable adult fell and sustained a fracture to her femur.

An extract from the hospital's Emergency Department's notes on admission based on a verbal report from the same member of care home staff was that the adult had "been fighting and fell backwards".

The incident was reported on a Providers Notification Form, initially on the basis of the unwitnessed fall and updated a week later in light of more information elicited from the same care home worker.

The care home worker was employed by a private agency. Following the incident, the care home contacted the employing agency and asked that this worker did not return to the care home, pending further investigation. The agency carried out an internal investigation and concluded that the staff member required additional training in dementia awareness, moving and handling, and incident recording, and was cleared to continue to work on a sessional basis.

The care home reported the incident to both social work adult protection processes and to their own organisation's safeguarding team, although again there were discrepancies noted between both of these reports.

Finally, it was noted that while the vulnerable adult was awaiting an ambulance, one of the agency staff remained with her and the senior care home staff member interviewed the remaining member of staff in the office. There is no record of how ongoing care was provided to the remaining 28 care home residents during this time and there was no record that this had been considered during any of these processes which followed.

Additionally, one staff member accompanied the resident to hospital, and there is no record of how care in the residential care home was supplemented to cover for this reduction in staff.

Throughout the documentation we saw evidence of hesitation in informing the welfare guardian of the detail of the incident, and the changing picture of the detail as the reporting process progressed.

Key Findings

The care setting

The Scottish Social Services Council (SSSC) Codes of Practice ('the Codes') set out:

> *"The standards of practice and behaviour expected of everyone who works in social services in Scotland…."*

In setting out these standards, the codes are a tool for employers and for workers to use to think about how they can continually improve their practice. The codes let people who use social services and carers know what they can expect from the workers who support them.

In light of this we would expect that staff deployed in a specialist dementia unit to have the knowledge, skills and training commensurate with this role and it is incumbent on the management of any care facility to satisfy themselves that they employ staff who are equipped and trained to fulfil the requirements of the role. Additionally, staff must ensure that they are familiar with the individual needs of people to whom they are providing care.

Accurate records of incident/accident reporting within care homes is a crucial element of good quality service provision and staff require to be confident in their recording processes and the status of these records as a legal document. This incident was initially recorded as an unwitnessed fall, a picture which changed significantly over the following week and it appeared that these two different versions of this report were presented to different agencies simultaneously for consideration.

Care homes require to ensure that all staff understand the importance of recording incidents, not simply as an internal record but as potential evidence in criminal and/or adult support and protection processes.

The welfare guardian had explicitly informed the care home of her statutory role but this was not duly recognised, understood and observed by the care home. The guardian should have been fully appraised of the incident, as well as the care home's subsequent management of care post incident. Their reluctance to do so in this instance appears to be borne out of a poor understanding of the role and the rights inherent in the guardian's role rather than any wish to withhold information per se.

The adult support and protection investigation

Following the incident, a decision was taken by the health and social care partnership (HSCP) to conduct initial inquiries under section 4 of the Adult Support and Protection 2007 Act (ASP). The welfare guardian had provided photographs of bruising which she felt potentially evidenced grab marks on her mother's wrists, but these were not considered as part of the section 4 inquiry as far as we could ascertain from records. The section 4 inquiry concluded that the three point test for intervention under ASP was not met and the referral was closed.

There was a view that since the adult was unlikely to return to the care home where the incident occurred, she was not at risk of harm. What did not seem to feature was the fact that there remained concerns about her overall care and treatment in that care home and by extension the care and treatment of other vulnerable adults still residing within this setting.

Whilst it is often a single incident which alerts the need for inquiry or investigation, there is a danger that section 4 of the 2007 Act is used exclusively over what might be a more appropriate legislative framework and our recommendation in these instances is for a more

blended approach, taking into account the potential for the use of section 33 of the Mental Health(Care and Treatment)(Scotland) Act 2003 (the 2003 Act) or section 10 of the 2000 Act which could encompass adults whose personal welfare is at risk (s10) or "some other deficiency of care and treatment (s33). In essence, each Act may act as a gateway to other acts to ensure the vulnerable adult is protected. Linear approaches to the suite of protective legislation have the potential to create risk and miss opportunities for broader curiosity.

Further actions were taken to pass concerns on to other agencies, for example, referrals were made to the Care Inspectorate and to the Scottish Social Services Council in respect of the care provided within the care home and the fitness to practice of the worker involved in the incident. Each of these agencies conducted their own investigations into the aspects of the case which was relevant to their remit, but at no time was there a formal consideration of these individual processes and the potential for interaction between them.

It can be argued that the prompt closure of the ASP process, and the failure to consider concerns under any other legislation, failed to afford the opportunity to ensure that all conclusions were shared and considered collectively and therefore resulted in remaining discrepancies in the outcome. For example, the Care Inspectorate upheld a complaint from the welfare guardian that there was a lack of care plan documentation and risk assessments for individuals experiencing stress and distress, while the section 4 inquiry notes that care plans were adequate.

A lack of a joined up approach to sharing information and concerns has been a common theme in our published investigation reports over the last 10 years, and is repeated in this case too.

Complaints

To the Care Inspectorate:

> The Care Inspectorate (CI) conducted an investigation following a complaint from the welfare guardian and upheld four out of six areas of the complaint.

To the local authority:

> There was a delay in responding to the adult protection referral, which resulted from a misunderstanding in relation to where this responsibility lay. The individual was placed out of area, and the initial referral was routed to the placing authority rather than the authority in which she was habitually resident.
>
> The Code of Practice for the 2007 Act is clear that "references to a council in relation to any person known or believed to be an adult at risk mean the council for the area where the person is currently located" (ref: Adult Support and Protection revised Code of Practice 2 May 2014)
>
> We have been informed that adult protection policies within the HSCP have now been updated, the process of which had started prior to the date of this incident.
>
> However, the placing authority had also failed to notify the receiving authority of the existence of a private welfare guardian. The Adults with Incapacity (supervision of Welfare Guardians etc. by Local Authorities)(Scotland)Amendment Regulations 2014 require that private welfare guardians are subject to supervision unless a decision has been taken and notified of a variation or cessation of local authority duties. It

transpired that no supervision or support had been offered by the placing authority nor had this responsibility been negotiated and transferred to the receiving authority.

It is important that HSCPs review their AWI/ASP processes to ensure that where an incapable adult is moved out of their own area, formal transfers of care between HSCPs are confirmed as appropriate and that the responsibility for formal notifications required by legislation are attributed to the allocated worker.

To the Scottish Public Services Ombudsman:

Given the welfare guardian's view that there had been a failure on the part of the local authority to address three specific issues within the local authority complaint she escalated these to the Scottish Public Services Ombudsman (SPSO). These were:

- Failure by the council to consider the full range of their statutory duties i.e. the potential to consider the use of Section 10 AWI to further investigate her mother's circumstances,
- The council's failure to notify the Mental Welfare Commission of this investigation, given it related to an adult who was subject to an order under AWI and
- A failure to fully consult with her as welfare guardian.

These views were rejected by SPSO who concluded that the local authority had appropriately met their obligations under the 2007 Act.

Additionally, they concluded that Section 10 of the AWI 2000 Act was not appropriate as this related only to the supervision of private guardians. This is legally incorrect – the supervision of guardians **is** covered by this section but it also empowers the local authority to

"Investigate any circumstances made know to them in which the personal welfare of an adult seems to them to be at risk."

Finally, they did not accept her assertion that the Commission needed to be notified.

The welfare guardian continued to dispute this outcome and requested that this preliminary decision be reviewed. Following a review process within the SPSO, the original decision was upheld, again referring to section 10 of AWI 2000 Act as relating only to the supervision of welfare guardians and the case was closed.

We (the Mental Welfare Commission) have since made contact with the SPSO and offered a view about their interpretation of section 10 of the AWI 2000 Act. On the basis of this, the SPSO have since reviewed and revised their response. This has offered the welfare guardian a positive conclusion to her complaint.

Within the process, it was recognised that closer working relationships between the SPSO and the Commission might have resolved this sooner and prevented the need to seek a judicial review. The Commission is able to offer informed views on the application of mental health legislation and practice. There is a memorandum of understanding already in place between the two organisations, and this has been reviewed and strengthened to provide a more seamless and timely response to situations where mental health is the subject of the SPSO's considerations.

Impact on the welfare guardian

It is important to note that the welfare guardian has specific knowledge and training in safeguarding legislation and practice and would have viewed herself as well equipped to act to protect her mother's welfare as she became less able to do this herself.

The welfare guardian's experience, however, did not support this. She found it difficult to navigate through the complex landscape of the full range of, and interplay between, organisations who subsequently became involved in her mother's care. Despite her robust understanding of the legislation and the legal authority conferred on her as an appointed welfare guardian, she reports that she struggled to be duly consulted, included and informed in processes which sought to support and protect her mother.

She is convinced that her mother's life ended prematurely as a direct result of the injury sustained in the fall and the subsequent invasive surgery. She feels that her decision not to return her mother to the original care home heralded a diminution of the issues identified and that the quality of the subsequent investigation was reduced as a result. She is left with a feeling that she failed her mother at a point where she needed her most and this has been difficult for her to accept.

The guardian has given her permission for the details of her experience to be shared. Her hopes for the process undertaken by the Mental Welfare Commission is that some of the issues identified can be shared more widely, HSCPs can consider their processes and their engagement with welfare guardians and the public can have confidence that when things go wrong, social services workers are skilled and equipped to deal with issues swiftly, transparently and professionally.

Conclusions

The Commission is keen to ensure that our independent investigation work continues to:

- Deliver local accountability;
- Involve families and carers in a meaningful way;
- Be informed by standards and guidance based on good practice;
- Be characterised by openness, honesty and transparency;
- Provide clear, accessible and timely reporting;
- Focus on shared learning.

The Commission awaits Scottish Government feedback in relation to proposals regarding expanding our role to the investigation of deaths of those subject to detention and those relating to homicides as discussed earlier in this report. We also acknowledge feedback in relation to perceived gaps in investigation and learning relating to those not detained, in particular, people with a learning disability.

We welcome the Scottish Mental Health Law review which is underway and, in the meantime, we will continue to improve upon our work and deliver shared learning arising from our statutory responsibility to make enquiries and investigate.

Appendix 1

Published investigations by year (see https://www.mwcscot.org.uk/publications)

Name	Year	Gender	Nature of mental disorder*	Notified to by	Areas of concern & focus of investigation	No of recommendations made
Ms ST	2019	Female	Learning disability	Service provider	Delayed hospital discharge , issues with Self Directed Support, poor communication with family , lack of dispute resolution	4 recommendations with sub sets amounting to 17 in total.
Mr QR	2017	Male	Mental illness depression	Crown Office & Procurator Fiscal Service.	Poor discharge plans, lack of leadership and staff supervision, second opinion medicals.	6
Ms OP	2016	Female	Post-natal depression	Scottish Ministers	Poor pathways for perinatal care, poor recording in primary care records, and lack of medications review.	12 including recommendation for a clinical network
Ms MN	2016	Female	Asperger's Syndrome	NHS Board formal notification	Transition between differing health boards and between primary and secondary care, poor risk management, lack of specialist care.	7
Mr JL	2014	Male	Mental illness	GP/ social worker	Poor supervision for staff , lack of knowledge re capacity /AWI issues ,poor ASP knowledge	17
Mr GH	2014	Male	Mental illness	Family member	Poor communication between MH services and family	Case study learning points
Ms FG	2014	Female	Not known	Scottish Ministers	Poor access to out of hours crisis care	Case study/ learning points identified.
Ms DE	2014	Female	Mental illness depression	Associate medical director	Adverse impact on patients in relation to DWP medical assessments.	13
Mr EF	2014	Male	Learning Disability	NHS Board formal notification	Poor communication between primary and secondary care, poor physical health care screening for LD, issues with capacity and consent.	none
Mr S	2014	Male	Learning Disability	Sherriff from local sheriff court	Inter-agency disagreement with no resolution, poor staff supervision, lack of care plan reviews, lack of capacity assessments.	4
Ms AB	2013	Female	Dementia	Mental Health Officer	Poor medication prescribing and audit, lack of AWI knowledge and local training, remote location, poor ward environment.	7

Mrs CD	2013	Female	Emotionally unstable personality disorder.	Nursing manager within prison.	Lack of crisis services, including brief interventions, withholding treatment in light of poor patient behaviour.	8 including 3 to Scottish Government
Mr & Mrs D	2012	Male and female	Learning disability	Senior Social Worker	Poor case recording, lack of AWI procedures and knowledge of AWI law, lack of staff supervision, role of CLDT.	15 including recommendations to Law Society and Office of Public Guardian.
Mr N	2012	Male	Mental Illness - psychosis	Family member	Review use of suspension of detention, poor care plans and lack of support audit of risk docs. Required.	5
Mr O	2012	Male	ADHD	Family member	Poor access to drug and alcohol services , issues with observation policy , lack of discharge letters	5

*As per the Mental Health (Care & Treatment) (Scotland) Act 2003

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