mental welfare commission for scotland

Closure report

Investigation into the care and treatment of Mr TU

Homicide by a person in receipt of mental health services

May 2025

Our mission and purpose

Closure report

Investigation into the care and treatment of Mr TU – Homicide by a person in receipt of mental health services

Executive lead:
Alison Thomson – Head of Death in Mental Health Detention & Homicide Reviews

Investigation team:
Dr Ruth Ward, Caroline Walker supported by the MH Homicide Review and the Commission Investigations Team.

Date of executive leadership team approval of investigation:
14 September 2021

Date of commencement of investigation:
Letter sent to leaders of HSCP A to advise of decision to investigate 1 December 2021

Date of publication of investigation report:
9 March 2023

Date of closure report:
May 2025 (not completed within the 15-month KPI standard)

Purpose of a closure report
The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned.
The report must summarise the findings and recommendations made in the themed visit/investigation report and identify the organisations and individuals to whom the recommendations were made.
The report should also identify the follow up actions and activities of the Commission in gathering in responses to the recommendations, and once in, identify how these responses were evidenced, assessed for impact and their success measured.
The report should assess whether the activity was worthwhile in terms of impact, resource commitment and outcomes and met organisational standards and expectations.

Summary of recommendations made in the investigation report and the organisations and the individuals asked to respond

The investigation into the care and treatment of Mr TU was conducted under s.11 of the Mental Health (Care and Treatment) (Scotland)Act 2003. Section 11 gives the Commission the authority to conduct investigations and make recommendations as it considers appropriate, including where an individual with mental illness, learning disability or related condition may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

This particular investigation was part of a pilot project whereby the Scottish Government asked the Commission to develop a model for independent investigation of care and treatment in the event of a mental health homicide. A proposed model was identified and a report submitted to Scottish Government in March 2022. The Scottish Government is continuing to consider these proposals.

The Commission was first notified about Mr TU's case in April 2020. This notification was received from the psychiatrist that had contact with Mr TU two days before his release from prison and prior to the subsequent homicide. Mr TU was admitted to inpatient forensic mental health services under a Criminal Procedure (Scotland) Act 1995 assessment order in January 2019 and had a further brief admission under the care of general adult services in May 2019. Mr TU spent most of 2019 in prison, having been rearrested and imprisoned following liberation in May and again in September 2019. In December 2019, Mr TU was on remand in Prison A and was unexpectedly liberated by the court with no support package in place and no accommodation. On the evening of his release, Mr TU fatally injured a man who had offered him overnight accommodation at his flat.

The investigation sought to identify what lessons could be learned from the experience of Mr TU, for the Scottish Government, local authorities, health boards and health and social care partnerships across Scotland, as well as those organisations directly involved in his care. Liaison also took place with family members of the victim and Mr TU.

Recommendations to HSCP/NHS A

The following six recommendations were made to local services and were noted to be comprehensive and challenging with the aim of improving existing systems. We noted that the service not only focused on the specific recommendations but committed to reviewing a number of systems and processes not identified by our review. There was a strong commitment to work alongside partners and we noted that senior leaders from the service were actively involved.

1. HSCP/NHS A should provide training to ensure material risks identified in risk assessments are addressed, as far as is possible, by relevant risk management plans and staff are aware of the links between violence, substance misuse, non-compliance, and non-engagement.
   Our investigation identified that whilst many aspects of the care Mr TU received from NHS A services were of a high quality, we found that there were other aspects of that care, in particular how risks were assessed and managed, which if acted on, may have mitigated the risk of violence when he was discharged from inpatient care in June 2018. This included risk assessment and risk management planning, a multi-disciplinary approach to discharge planning and linking his substance misuse to subsequent increased violence and poor engagement with services.
   The service responded to this recommendation by comprehensively reviewing its learning and development opportunities in relation to risk assessment across the health and social care partnership and updated appropriately. This included a re-emphasis on risk assessment in adult support and protection training, multi-agency public protection arrangements (MAPPA) and a focus in multi-risk assessment conferences (MARAC).

2. HSCP/NHS A should carry out a review of the risk assessment and risk management paperwork and undertake an audit to ensure that processes are understood and followed.
   Linked to recommendation one the service reviewed and updated its risk paperwork and conducted an audit of how this is used in relation to the Care Programme Approach; the service updated prompt sheets and guidance across all of the paperwork and also ensured that access to risk assessment tools was widely available. The review was implemented across health and social work services, including in-patient units.
   Electronic records were also updated.

3. HSCP/NHS A should carry out a review of the discharge planning paperwork process and undertake an audit to ensure that discharge planning processes are understood and complied with.
   The service undertook a review of its admission and discharge policy and set up a short life working group to monitor its progress.
   We were pleased to note that the updated policy aimed to include new information on how and when to include family members in discharge planning and ensuring that the patient being discharged has access to appropriate accommodation. The service advised us that they had taken the opportunity to revise the whole policy and would be regularly auditing its use.

4. In the absence of crisis or assertive outreach services, HSCP A should ensure that community care services are available to support discharge planning and to provide assertive follow up support for people who are difficult to engage with where necessary. The issues of poor compliance with medication and engagement with services were a feature within this investigation and we noted a number of opportunities where assertive outreach and attempts to engage Mr TU could have been made.
   The service has added in the concept of an assertive approach to its discharge policy. Prior to discharge early contact should be made with community mental health services, including community mental health teams especially if additional support services are required for individuals. The service also told us that they had also undertaken work in relation to non-attendance rates for out-patient services so that they can consider any gaps in provision and address these. Improvements in follow up combined with a robust discharge planning policy have been implemented.

5. HSCP/NHS A should design a protocol for when patients refuse consent to share information with relatives/carers; see the good practice guide, Carers & confidentiality (2018). This should include an indication of how frequently or in what circumstances this should be re-addressed and documented. It should also indicate the circumstances in which the patient's wishes may be over-ridden by services in the interests of safety either to the patient or to others.
   Mr TU's family member found it difficult to be involved in aspects of his care and in our view, held important information that contributed to his risk assessment. It highlighted the significance of gaining a family history and ensuring relevant contact from family is recorded. The service has produced a new policy document to this effect and ensured that this has been disseminated across its services. It has also added a new section to its electronic systems so that family views can be recorded.

The Commission has recently updated its Carers and Confidentiality guidance with particular reference to the issue of individual patients expressly stating that they do not want information shared with family members. This is a difficult area for staff but one that is regularly raised with us and has been a feature in a number of our recent investigations.

6. HSCP A should carry out regular audit of the quality of social circumstances reports as required by standard seven of the National Standards for Mental Health Officer Services.
   A social circumstances report (SCR) was completed by a MHO on Mr TU and while it included some elements of risk, did not encompass this sufficiently with no reference to offending or forensic issues. We recognise that SCRs can be an important tool in providing key information for multi- disciplinary teams and wished to emphasise this point.
   We have been updated by the lead for MHO services on this action who has undertaken regular audits of social circumstances reports. We have been advised that the audit tool itself has been reviewed and updated and now ensures that family and carer views are incorporated, along with a clear MHO statement on risk assessment including previous offending, forensic issues and any adult support and protection issues. A report detailing the positive outcomes of this audit has been forwarded to the Commission and we are pleased to note that the audit work will continue.

Recommendations to the Scottish Government

In addition, national recommendations were made to Scottish Government with particular reference to throughcare services and multi -disciplinary joined up working.

1. The Scottish Government and Community Justice Scotland should address the recognised gap for 'Throughcare' services for prisoners on remand.

2. The Scottish Government and Community Justice Scotland should consider innovative joint working/multiagency practices with NHS/social care/social work/Forensic Network to pilot a post-custody outreach service.

3. The Scottish Government's national mental health workforce strategy should take full account of the individual impact of lack of continuity of care as highlighted in Mr TU's case relating to recruitment and retention of consultant psychiatrists/senior medical staff in health boards.

4. There should be additional investment in resources for outreach for complex co-occurring mental health/substance misuse issues particularly where this is associated with the risk of violence.

5. The Scottish Government should work with services to implement the three day follow up post discharge standard to bring it in line with NCISH recommendations (72 hours).

Summary of responses (including decision as to whether they are satisfactory and how this decision was evidenced and measured)

The Commission received responses from Service NHS/HSPC A and the Scottish Government within agreed timelines. In the case of the Scottish Government these were received from the Minister for Mental Health and were detailed in nature. The full response was received in October 2023. Responses will be summarised here and not repeated in full detail given their comprehensive nature.

The responses were scrutinised by the Commission's investigation team and follow -up information sought to clarify aspects of the work undertaken. The Scottish government has made provision both by legislative change and additional resource to the issue of throughcare services and discussion on unexpected liberation from prison has been taking place at a national level.

Section 12 of the Bail Release and Custody (Scotland) Act 2023 includes a number of provisions focussed on engaging justice and wider public services in supporting individuals on their release from prison. These legislative duties include pre -release planning placed on partners such as justice bodies, local authorities and health boards. In addition, we are advised that the SHORE standards (Sustainable Housing on Release for Everyone) have been updated in 2024 and include a strategic action plan to look at the housing needs of prisoners, including unplanned release. The Scottish government also detailed their commitments in the national mental health strategy and commented on their budget proposals for 2023 /2024, which included tackling shortages in the mental health workforce and recruitment and retention of psychiatry staff. This is found also in the mental health and well- being workforce action plan. Commitment to both resource and finance are also made in relation to tackling the issue of substance misuse through the Drug Deaths Taskforce.

Summary of Commission follow up activity and actions (including dates)

Commission staff received initial action plans from the service in June 2023 with a further update in November 2023. We were able to track progress by provision of a standard template which asks the service to comment and evidence the impact of the work they have undertaken. Action plans have been received and updated regularly from the service, and we have continued to communicate with senior managers in relation to their implementation.

The area practitioner for the area has also been key in evidencing the implementation of the recommendations and updating the investigation team on local intelligence. Key changes have been noted through the local visiting programme to the area undertaken by the Commission. Discussion also takes place with key operational staff on a regular basis. All recommendations are now implemented.

Given the wider changes that the service is implementing, this work is ongoing and whilst most of the work is concluded we continue to monitor progress.

With regard to Scottish Government, we received a full response in October 2023 and regular consultation with our sponsor department continues.

The publication of the report has also identified learning both locally and nationally and the following actions have occurred:

- Mr TU's report was discussed at a regional Mental Health Officer (MHO) forum in May 2023. This was the area where the incident had taken place and staff were keen to reflect on the learning in the report. Amongst the issues discussed were the benefit of completion of social circumstances reports by MHO's, issues around joined up working and the challenges of an assertive approach when resources are limited.
- Mr TU's case and findings were also discussed at a learning event within the Commission in September 2023.
- Recommendations and associated learning were highlighted at a national joint adult support and protection stakeholders and Police Scotland meeting in October 2023.
- The findings and learning were also reflected upon at the Commission's end of year meetings with all HSCP's in 2023.
- We are advised that the prison situated in the relevant area has in conjunction with the Scottish Prison Service produced an operational procedure for their staff in relation to liberation and this includes unplanned liberation.

Summary of the impact of the investigation report with particular reference to media

This report was published with a news release on Thursday 9 March 2023. It was the first of the Death in Detention/Homicide Review project reports to be published. It gained widespread media coverage from Scottish and UK-wide media.

Media

Reactive media comments were given by Scottish Government, the Scottish Prison Service, an MSP who has supported the victim's family, and the sister of the victim.

BROADCAST MEDIA

Sky News covered the story using an exclusive interview with the sister of the victim, shared online.

BBC TV Scotland's flagship evening news programme **Reporting Scotland** (9 March) featured the story.

BBC News website ran the story headed '*Good Samaritan murder may have been prevented*' in an online article.

BBC Radio Shetland broadcast the story in its morning bulletin in a 1m15s story at 8.30am. **BBC Radio Scotland** included the story in its afternoon bulletins at 4.16pm and at 5.13pm.

STV North News at Six (9 March) broadcast the story in a 2m30s segment at 6.13pm. The story also ran as '*Good Samaritan murder may have been avoided*' on the STV website .

Print/online media coverage was extensive.

UK NATIONAL

From the UK national outlets - **the Times** ran the story with the headline *'Failings over death of Good Samaritan';*

The **Daily Express** with *"Cataclysmic failings" over freed killer'*.

The **Daily Telegraph** focused on *'Lack of housing blamed for ex-prisoner killing man;*

***Metro** had 'Killer of Good Samaritan 'had lack of support'*.

The **Sun** ran with *'GAPS IN SYSTEM' COST MY BROTHER HIS LIFE*; and also featured the story in its online edition *'We need changes 'My brother was murdered by crazed killer - he was allowed to wander streets due to broken system'*.

SCOTTISH NATIONAL MEDIA

From Scottish titles, the **Scotsman** led with the story and shared the story online.

The Herald's story was *'Psychotic patient killed man within hours of jail release'*; the online edition ran with *'Paranoid' cocaine user killed stranger within hours of release from prison'*.

The **Daily Record** reported it as '*Release fail a key factor in Alan murder'*.

LOCAL MEDIA

The Courier ran with '*Report on killer of 'Good Samaritan' finds lack of support after prison release'*.

Aberdeen Live reported the details of report.

The **Aberdeen Evening Express** focused on the reaction of the victim's sister: '*Sister says she'll sue after brother stabbed to death'*.

Social Media

Twitter (aka 'X')

The original tweet received 169 engagements (meaning it was liked, retweeted, clicked on, or otherwise interacted with). 95 users clicked on the link to the news story, seven users liked the tweet, and 10 retweeted it directly to their own followers. This makes it the most engaged tweet of that week (after the tweet for the MHA monitoring report).

Website

In the seven days following publication, the news story on the report was viewed 167 times, by 2.70% of users, making it the 6th most popular page in that time (the most popular being the home page, with 958 views, or 15.52% of users).

Mailing list

We sent the report to all 1,827 subscribers on our mailing list. It was opened 866 times in the first week, an open rate of 48.9%. Subscribers clicked through to the report 705 times, or 81.41% of those people who opened it, a very high rate which is similar to our other high-profile reports, beaten only by our reports on Scotland's mental health law review (30 September 2022) and *Ending the exclusion* (29 September 2022).

Conclusion

The investigation into Mr TU's circumstances was chosen with the aim of identifying learning and reviewing how incidences such as this can be undertaken nationally. The report identified some aspects of high quality care delivered to Mr TU in 2018 , however aspects of that care, including how risks were assessed and managed, the minimal involvement of Mr TU's nearest relative, which if acted on, might have mitigated the risk of violence, and the lack of consistency by medical staff is likely to have impacted on the assessment and management of risk.

Reviews of this nature are complex and emotive. We are grateful to all parties including both family members who communicated with us.

We have received clear evidence from services that the recommendations from the report have been acted on and addressed both by Scottish Government and HSCP /NHS A. We are aware that the service responded with a clear action plan which was regularly monitored through their own governance arrangements and involved senior representation. We were also pleased to note that some of the changes went wider than we had recommended.

The Commission continues to visit HSCP/NHS A as part of our routine visiting programme, and we will continue to monitor the positive changes that have been made.

Identify any out-standing actions and recommendations and any future activity or options to satisfy these, if any? (Identify learning points for future investigations/visits and things to do differently?)

We will continue our relationship with the Scottish Government in relation to the wider, national issues and to ensure these are implemented and monitored.

If you have any comments or feedback on this publication, please contact us:

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