mental welfare commission for scotland

Closure report

Investigation into the death of AB

May 2025

Our mission and purpose

Closure report

Investigation into the death of AB

Executive lead:
Alison Thomson, head of Deaths in Detention and Mental Health Homicide Reviews

Investigation team:
Deaths in Detention/Mental Health Homicide Reviews Team including Kate Fearnley, Ian Cairns social work officer, Dr Moira Connolly consultant psychiatrist, Paula John social work officer (investigations practitioner), Mark Manders investigations casework manager.

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:
3 August 2023

Date of closure report:
March 2025 (not completed within 15-month MWC 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 AB was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). S11 gives the Commission the authority to carry out 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 report was also part of the Deaths in Detention and Mental Health Homicide Review project, a pilot funded by the Scottish Government with the aim of devising a national review programme for deaths that occur in mental health detention and homicides where mental health services are involved. The project produced and published a proposal document in March 2022. The Scottish Government continues to consider these findings.

The AB report is an investigation into the circumstances leading up to the death of an individual (AB) with a moderate learning disability whose death occurred shortly after their detention under the Mental Health Act was revoked. AB was also subject to Adult Support and Protection (Scotland) Act 2007 (Adult Support and Protection Act) procedures.

The review of AB's care centred on the five-year period before their death during which time they had been the subject of three Adult Support and Protection Act investigations and had been twice detained under the Mental Health Act, the latter detention ending the day before AB's death.

This investigation into the care, treatment and support provided sought to identify what lessons could be learned from the experience of AB, their family, the Scottish Government, local authorities, health boards and health and social care partnerships (HSCPs) across Scotland, as well as those organisations directly involved in AB's care.

Recommendations to NHS A and local authority A

Recommendation 1:
NHS A and local authority A will be asked to review their processes for deciding on when to initiate a local learning review ensuring that these meet the recommendations of the new Scottish Government Guidance for Adult Support and Protection Committees.

A consideration in proceeding with the investigation was that neither the local authority nor the health board in this situation had undertaken any internal or independent review following AB's death. We felt that there were lessons to be identified and learned, and that services should be clear when a review was required and how staff are able to escalate concerns through their own systems. Publication of national adult support and protection learning review guidance had occurred in May 2022 and we were keen to understand how services would interpret this in the future.

Recommendation 2:
NHS A and local authority A will be asked to ensure that staff are aware of the importance of reporting to the Office of the Public Guardian (OPG) concerns about the appointment of an attorney by someone who may lack capacity to do so or be subject to undue influence, and of the local authority duty to investigate concerns about an attorney's exercise of functions. In addition, they will be asked to ensure that staff are aware of the ability of a person with an interest in the adult's affairs under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) to seek an order from the sheriff regarding the operation of a power of attorney (POA) or revocation of the POA.

The issues in relation to the creation of a power of attorney, an individual's capacity to do so, legal duties, and the application of the AWI Act were key factors in this investigation. AB had nominated CD as her POA, but question marks remained about her capacity to do so. The options to challenge and change this situation were not undertaken by relevant staff involved. Knowledge of the legal requirements and the role of the OPG did not appear well understood at that time.

Recommendation 3:
NHS A and local authority A will be asked to provide training and support for social work and health staff on adult support and protection under the Adult Support and Protection Act, including identifying an adult at risk when in hospital and the powers

available when there is difficulty with engaging with the adult who may be subject to undue influence. This is also to ensure that where there is inter-agency complexity and multi-site treatment provision a single person is made the nominated lead for the case.

The AB case involved a range of multi-disciplinary professionals across health and social care, and care and treatment occurred in a number of different settings. We noted that at key points of transition, elements of risk management were not communicated and led ultimately to a deterioration in physical health for AB. Staff appeared unsure of their remit and responsibilities under adult support and protection legislation and within a more general health care setting, limited knowledge of this and wider legislation led to delays in intervening. More could have been done to promote AB's safety during the inpatient stays by implementing consistent safeguards around visiting and better communication between services and ward teams about CD's influence on AB's care and treatment.

Recommendation 4:
NHS A and local authority A will be asked to ensure that where guardianship applications are discontinued in preference for less restrictive case management arrangements that risk management planning includes trigger-points when guardianship should be reconsidered.

The Commission's view following investigation, is that there was sufficient evidence for an application for welfare guardianship and while this was discussed early on, this plan was later changed and re-visited at a much later date. Ongoing work and intervention moved from an adult support and protection framework to that of a care management process and this did not include any contingency planning in relation to any increased risk. We felt that services in future should be clear on the rationale for adopting a least restrictive approach but also be able to be clear on when risk factors increase, and a higher level of intervention required.

Recommendation 5:
NHS A and local authority A will be asked to audit the effectiveness of their processes to monitor long-term conditions management for people with learning disabilities.

AB experienced a long-term condition and engagement with health services was generally poor other than when a crisis would occur. There was a history over a number of years which evidenced this poor level of contact. The amount of pressure and interference that CD brought to bear had also been previously documented. Services did not apply this knowledge or past

experience and could have adopted a more assertive approach with regards to follow-up and intervention in relation to physical health care.

Recommendation 6:
NHS A will be asked to review medical records procedures in relation to the Mental Health Act, including in general hospitals to ensure that the requirement to submit documents to the Commission is consistently met.

When reviewing our own records as part of the investigation period we noted that formal legal paperwork had not been forwarded to the Commission. This had no bearing on the outcomes for AB but warranted local attention.

Recommendations to the Scottish Government

Scottish Government will be asked to review the existing systems and processes for obtaining second medical reports ahead of applications for guardianship orders and instigate steps to improve access and monitor the impact of improvement processes.

We have been aware not just in the circumstances of AB, but also through wider national intelligence that gaining a second medical report for a welfare guardianship order application can be difficult. In particular, rural areas where there are limited resources have raised this issue with us. We are aware that Scottish Government have been looking at this and considered its impact through consultation on the Adults with Incapacity Amendment Act which closed in October 2024. The consultation responses have been published and work is ongoing.

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

The Commission received responses from NHS A and the Scottish Government within agreed timelines. Prior to publication we had met with the service in May 2023 to discuss the recommendations and provide clarity on the responses we expected.

We also met with the service lead for adult support and protection in July 2023 to discuss progress in relation to practice developments. Action plans were submitted to us and responses scrutinised by the Commission's investigation team. Updates have been provided since this time and all recommendations are now complete.

Work on identified learning points will continue to be monitored by the Commission's local area practitioner and by the Commission's visiting programme.

We have assessed the work received by review of additional audits, training materials and templates of revised paperwork that have been provided by the service. This work has evidenced a strong commitment to review a number of systems across health and social care with an emphasis on joint working and clear leadership. We note this integrated approach to addressing the recommendations, learning from this incident and seeking improvement.

We also noted that prior to publication of AB's report in 2023, a great deal of work had been undertaken in relation to adult support and protection in terms of policies, best practice, and learning and development. Multi-agency procedures had been developed which included guidance on working with self-neglect and non-engagement. This also aimed to engender a stronger culture of integrated services to work together. In this regard the service has produced its own learning review procedures, in line with national guidance, developed an escalation process and provided awareness for its staff on these. There is an emphasis on disseminating learning from reviews and ensuring that this is shared across the service.

Training pathways and a review of staff capacity to be able to undertake learning reviews in the future has also been considered.

The issue of how learning reviews work alongside adverse event reviews undertaken by health boards, is also addressed with a review of current local procedures and inclusion of risk trigger points as to when a review should be commissioned.

Given the learning identified from AB's investigation we are aware that processes are now in place to address the failure to instigate learning in 2019.These include more robust governance involving the Chief Officer's Group and a subcommittee of the adult support and protection committee. In line with recommendation 3 we also note that multi-agency Adult Support and Protection Act training is now in place and the training materials revised. Numbers of staff completion rates were sent to the Commission for reference.

Within our report we stated:

"A missed opportunity was the lack of action once it was realised that AB had granted power of attorney in favour of CD. Had concerns about this been taken forward, the involvement of the OPG or courts would have brought greater scrutiny to CD's behaviours unencumbered with balancing concerns about AB and CD's engagement with services and the risk of them moving out of the area"

The granting of a POA document and the delay in challenging this by services resulted in serious consequences for AB. With reference to recommendation 2 we note that the local authority has produced guidance in relation to these matters and included advice on the investigative role of the Office of the Public Guardian within its adult support and protection procedures. Awareness sessions for staff were also developed as were changes to electronic recording systems. We are pleased to note these changes and recommend that the service continues with raising awareness of POAs across both local authority and health staff.

The additional issue of applications for welfare guardianship orders and ensuring governance around when and when not to proceed has been addressed by the service in relation to a local AWI Act procedure.

Long term condition management for people with learning disabilities was highlighted by the Commission in recommendation 5 and was a key issue in the investigation. This forms part of a national strategy and we noted that the service has undertaken a pilot project and subsequent audit, which it now aims to implement.

Effective notification to the Commission of Mental Health Act paperwork was requested in recommendation 6, and local developments have occurred to streamline this to ensure responsibilities are met.

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

As detailed above the Commission received responses to its recommendations within agreed timelines, and prior to this had met with senior staff on two occasions. Action plans were forwarded and scrutinised by the investigations team and appropriate follow up undertaken. This included requests for clarification of certain aspects of work and evidence of completed tasks. Copies of revised documents, policies and templates were also forwarded. All six recommendations have been followed up.

We recognise that the AB case identified a number of areas that needed review, and we commend the services for taking these on board comprehensively. We note that adult support and protection practice and procedural developments have advanced considerably in the area from the time period when AB was initially referred (2014 to 2019).

This was a complex and challenging situation for all the professionals involved. We recognise it was a very difficult balance between the expressed will and preferences of AB and the concerns about the nature of their longstanding relationship with, and influence from, CD and the impact of these factors on AB's care and treatment.

Staff who we spoke to were reflective in relation to their own actions and experiences and we acknowledge their cooperation in the report process.

When the Commission undertakes investigations under s11 of the Mental Health Act, the learning identified may also be relevant across Scotland, further activity has therefore included:

- AB's case was presented at the ASPire national conference organised by IRISS and Scottish Government on 20 February 2024 to a range of multi-agency professionals with an interest in adult support and protection. Feedback was positive with many professionals commenting that the findings and identified learning echoed individual cases in their own practice.
- AB's case was presented to the NHS /Adult support and protection health leadership group on 26 April 2024, staff here were keen to hear how safeguards could be implemented in a general health setting.
- AB's case was presented to a local mental health officer forum on 10 June 2024 with an emphasis on the interaction between the 3 key pieces of legislation, 2000, 2003, and 2007 Acts.

- A presentation was made to the Chief Social Work Officers' (CSWO) course at Caledonian University, Glasgow with AB used as a case example to illustrate decision making and the role of the CSWO in relation to welfare guardianship.
- The findings were also shared at a learning event within the Commission in September 2023 and reflected upon at end of year meetings with services.
- Sheriff training programme December 2023.

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

Media

This report was published anonymously with a news release on Thursday 3 August 2023. It was the second of the Deaths in Detention/Homicide Review project reports to be published. The report gained coverage from Scottish and UK media; it was one of the highest hitting in relation to non-Scottish local media online, taking the Commission's name to new outlets.

Much of the coverage came from Press Association's copy. In total, the story ran in 147 media outlets across the UK and two outlets in Ireland, as the web links below demonstrate. This shows the reach of the Commission's work and the interest in this particular report.

National Scotland, UK, Ireland and specialist publications

Vulnerable patient died after being 'isolated from family for years' (Web) STV - 03/08/2023
Steps were not taken to protect a vulnerable Scot who died while under the influence of another person, an investigation has found.

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) The Independent - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were "not taken".

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) Daily Mail UK - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were not taken.

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) Herald Scotland - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were not taken.

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) AOL UK - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were not taken.

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) Yahoo News UK - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were not taken.

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) Asian Image - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were not taken.

Mental welfare body says steps 'not taken' to help 'vulnerable' person who died (Web) Ireland Live - 03/08/2023
An investigation has found steps to protect a vulnerable Scot who died while under the influence of another person were not taken.

Local Scotland and UK publications
There were ten pages of links related to media organisations

Social media

Twitter (aka 'X')
The original post received 280 engagements (meaning it was liked, reposted, clicked on, or otherwise interacted with). 166 users clicked on the link to the news story, fifteen users liked the post, and twenty-four posted it directly to their own followers. This made it the most engaged post of the year to date.

Website
In the seven days following publication, the news story on the report was viewed 293 times, by 5.13% of users, making it the fourth most popular page in that time (the most popular being the home page, with 869 views, or 15.22% of users). This is notably higher than average compared to our other reports and publications.

Mailing list
We sent the report to all 1,810 subscribers on our mailing list. It was opened 276 times in the first week, an open rate of 23.29%. Subscribers clicked through to the report 124 times, or 44.93% of those people who opened it, an above-average rate which is like our other reports (such as local visits).

Conclusion

The AB case was identified as having significant potential for local and national learning given that they died unexpectedly, had a learning disability and had been detained under the Mental Health Act just prior to death.

No significant adverse event review (SAER) or significant case review (SCR) (at that time, now a learning review) was carried out locally following AB's death to determine what might have gone wrong or whether their experience identified any learning for services involved in the provision of care, treatment and protection.

The Commission's investigation produced six recommendations which have been followed up and responded to and which the services involved have committed to bring about change. We are in receipt of action plans to this effect and are confident that these are being monitored at a senior level.

The identified learning has generated discussion on a wider level as demonstrated by the activity detailed above and we hope that the publication will continue to be of use to professionals to effect improvements in the future.

Identify any out-standing actions and recommendations and any future activity or options to satisfy these, if any?

There are no outstanding actions.

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

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