mental welfare commission for scotland

Closure report

Investigation into the care and treatment of GH (2023)

Homicide by a person in contact with mental health services at the time of the offence

July 2025

Our mission and purpose

Closure report

Investigation into the care and treatment of GH (2023). Homicide by a person in contact with mental health services at the time of the offence

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

Investigation team:
Dr Ruth Ward Consultant psychiatrist; Carolin Walker Nurse consultant; MH Homicide Review team;
Mark Manders investigations casework manager

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

Date of commencement of investigation:
Letter sent to leaders of HSCP A & HSCP B to advise of decision to investigate 9 December 2021

Date of publication of investigation report:
30 November 2023

Date of closure report:
26 May 2025 (completed out with the 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 GH was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 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 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 related homicide. A proposed model was identified and a report submitted to the Scottish Government in March 2022. The Scottish Government is continuing to consider these proposals.

The Commission was first notified about GH's case by local services through the Commission's notification scheme four months after the homicide occurred. The GH report was an investigation into the circumstances leading up to a homicide which was conducted by GH on an unrelated person previously known to them. GH's care and treatment was difficult to manage and involved them moving between two health board areas, which compromised the continuity of care, treatment and support. A joint significant adverse event review (SAER) was completed by both area services.

The Commission carried out an investigation into this case because it was clear that the SAER had not included either the family of the victim, the perpetrator, or the perpetrator's family in the local investigation. This was because the SAER was commissioned whilst criminal proceedings involving GH were still underway and therefore contact with the family or perpetrator could have prejudiced court proceedings. Involving the families and the perpetrator is an important aspect of this investigation by the Commission and subsequently informed the Commission's proposals to Scottish Government.

The investigation into GH's care, treatment and support sought to identify what lessons could be learned from the experience of GH their family members, for the Scottish Government, local authorities, health boards and health and social care partnerships across

Scotland, as well as those organisations directly involved in GH's care. As part of the pilot project, the investigation looked at how mental health homicides are reviewed nationally in Scotland. Both GH and the victim's family were consulted as part of this process.

Recommendations for HSCP/NHS Area A

1. HSCP/NHS Area A should ensure that the learning from this incident is shared with clinical staff.
   There were a wide range of recommendations and key learning points found throughout GH's investigation, including the risks associated with historical and current violence, lack of continuity of care across two geographical health board areas and insufficient account taken of GH's family's concerns by services. We concluded that it was of paramount importance that the findings from the GH report were shared with clinical staff.
   HSCP/NHS area A have confirmed to us that they have circulated both our report and a summary to all professional leads to disseminate the learning and cascade to all frontline staff. A summary of the report and identified learning was also circulated in the NHS Bulletin.
2. HSCP/NHS Area A should review risk management training and risk documentation in light of this incident. The findings from the recent audit of documentation of historical risk information in relation to GH should be shared with the risk management training team. An MDT approach to review and seek corroborative information from families about historical risk information during inpatient admissions should be operationalised.
   Through our investigation we wanted to establish how risks were assessed and managed, and whether family concerns had been sufficiently considered. We feel these aspects of care are closely interwoven. Taking families' concerns into account and involving them in care should be part of how risks are assessed and managed. Risk assessment and management and involving families in care are both important aspects of care and treatment and we note that NHS A have since reviewed and revised their clinical risk policy. Clinical risk training and associated paperwork has also been changed and adapted. We have had the opportunity to read these materials.
3. HSPC/NHS Area A should design a protocol for when patients refuse consent to share information with relatives/carers. 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 overridden by services in the interests of

safety either to the patient or to others. For reference, the Commission has produced the good practice guide *Carers and Confidentiality*.
Listening to families and recognising their contribution to risk assessment was a key finding of the investigation. HSCP/NHS A have responded to this by producing a guidance document for staff on this issue, a leaflet to be shared with families and a 7-minute briefing. Again, we have been sent these materials and noted evidence of progress.

4. HSPC/NHS Area A should ensure that there is clarity about the designated RMO for all patients, at all times.
   Continuity of care was a key factor within this investigation and there were gaps in provision and a lack of clarity in RMO responsibility at times. It is noted that this was during the Covid 19 pandemic and changes had been made to the service at this time . NHS A have acted on this recommendation and improved aspects of referral paperwork when transition occurs between services. RMO cover at times of planned or unplanned leave has also been clarified across the service.
5. HSPC/NHS Area A should ensure that CMHT protocols for working with primary care include the procedure to follow up with referrers where a decision is made not to progress a referral from primary care.
   NHS A have revised their CMHT standing operating procedure to ensure that communication and referral pathways are clear.
6. HSPC/NHS Area A should carry out an audit of timeliness of medical discharge letters for inpatient ward A and other acute admission wards against local standards and address any failings.
   Refer to 7 below.
7. HSPC/NHS Area A should carry out an audit of immediate discharge letters from inpatient ward A and other acute admission wards and address any failings.
   In reference to both recommendations above we detailed that follow up and effective discharge planning were required. NHS A have completed new discharge letter guidance to all staff and have undertaken an audit , which they will build into the process.

Recommendations for HSCP/NHS Area B

1. HSCP/NHS Area B should ensure that the learning from this incident is shared with all clinical staff.
   There were a wide range of recommendations and key learning points found throughout GH's investigation, including the risks associated with historical and current violence, lack of continuity of care across two geographical health board areas and insufficient account taken of GH's family concerns by services. We concluded that it was of paramount importance that the findings from the GH report were shared with clinical staff.
   The service confirmed that the learning has been shared with appropriate staff in addition to the development and delivery of education materials and training around court liaison for clinicians. The service has also developed a standard operating procedure in relation to mental health and court liaison clinical referrals, which aligns with recommendation 4 below.

2. HSCP/NHS Area B should ensure that clinical staff have access to violence risk management training within 12 months of the publication of this report.
   We clearly found throughout GH's care, the risk of future violence was not assessed within HSPC/NHS Area B and we highlighted that the service should design a protocol when patients refuse consent to share information with relatives/carers. 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 overridden by services in the interests of safety either to the patient or to others. For reference, the Commission has produced the good practice guide *Carers and Confidentiality*.
   Listening to families and recognising their contribution to risk assessment was a key finding of the investigation. We found that there was no documented discussion with GH about violent behaviour towards their nearest relative and how this could be mitigated. There was no consideration of whether to over-ride GH's refusal to allow information sharing with family.
   In response to this recommendation, HSCP/NHS B robustly evidenced that violence risk management training is undertaken, which is embedded into mandatory training for all clinical staff in the service, which is audited and monitored on a monthly basis.

3. HSCP/NHS Area B should provide appropriate training for approved medical practitioners (AMPs) required to cover for court duties in Area B, including use of the Criminal Procedure (Scotland) Act 1995.
   Our investigation highlighted a lack of knowledge in relation to the court processes and procedures in GH's circumstances, which resulted in this recommendation. HSCP/NHS B has undertaken significant improvement actions around court liaison processes following the significant adverse event review[1] (SAER). HSCP/NHS B clearly evidenced in their response that they have developed and delivered court liaison training to all Approved Medical Practitioners with the incorporation of the Criminal Procedures legislation.
4. HSCP/NHS Area B should audit and address the timeliness of letters to the Crown Office and Procurator Fiscal Service (COPFS), general practitioners and CMHTs following assessment by the Court Liaison service.
   Aligned with HSCP/NHS B's court liaison improvement work, the service responded with clear evidence of improved processes and on-going monitoring through an audit process and robust governance, including proactive actions relating to communications with the COPFS, General Practitioners (GP) and forensic community mental health teams (FCMHT).

[1] "An adverse event is defined as an event that could have caused, or did result in, harm to people including death, disability, injury, disease or suffering and/or immediate or delayed emotional reaction or psychological harm". When a significant adverse event occurs the NHS will undertake a review known as a significant adverse event review to identify learning and increase safety. A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland last accessed May 2025.

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. Scottish Government should review violence risk management training for general adult psychiatrists across Scotland in view of the learning issues identified in two health boards in this report.
2. Scottish Government should consider an appropriate structured risk assessment tool such as OxMIV, the University of Oxford forensic psychiatry risk tools for assessing the risk of violent offending for high-risk groups (see section 3.2) presenting to general adult psychiatry services.
3. Considering the different digital record systems across mental health services in NHS Scotland, the Scottish Government should set standards for the safe transfer to, or management of patients who present to other health boards, including minimum standards for information sharing.
4. Scottish Government should work with services to ensure all patients are given an immediate discharge letter on leaving inpatient services. This should include details of follow up which should be within 72 hours of discharge.
5. Scottish Government should work with relevant stakeholders to review and share any learning on how different service models impact on continuity of care.

The Scottish Government responded to reinforce their commitment to addressing risk through the delivery of the core mental health standards with particular reference to ‘ assessment, care planning, treatment and support’. In terms of ensuring people access follow up by services on leaving inpatient services, the Scottish Government highlighted the application of mental health standard ‘moving between and out of service’ and evidenced the significant improvement digital and data strategic work, which includes the intention to deliver an electronic and integrated health and social care record. These important developments remain in progress and the Commission continues to follow up improvement work with Scottish Government and with services through our local visit programme.

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

The Commission received responses from HSCP/NHS A, HSCP/NHS B and the Scottish Government within agreed timelines.

In the case of the Scottish Government these were received from the Minister for Social care, mental wellbeing and sport and were detailed in nature. The full response was received in May 2024. 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. Summary details as are those noted above.

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

In addition to meeting and follow up with the services involved and follow up contact with GH following publication of the report, the Commission included reference to the GH report in the following external engagement events:

- East Renfrewshire Adult Support and Protection Committee 22 August 2024
- Care Inspectorate Mental Health Interest Group 6 August 2024
- North Lanarkshire Mental Health Officer Forum 1 February 2024
- Mental Health Professional Nurse Leads Business meeting 9 January 2024

Summary of the impact of the investigation report with particular reference to media as at 30 November 2023

Media

This report was published anonymously with a news release on Thursday 30 November 2023. It was the fourth of the Death in Detention/Homicide Review project reports to be published. The report gained coverage from BBC Radio Scotland:

BBC Radio Scotland FM - Thu, 30 Nov 2023 07:36:05 GMT - Good Morning Scotland
Good Morning Scotland, BBC Radio Scotland FM - 30/11/2023 07:36:05
"Mistakes were made" - that in a nutshell is the conclusion of a report published this morning by the Mental Welfare Commission.

Social Media

Twitter (aka 'X')

The original post received 81 engagements (meaning it was liked, reposted, clicked on, or otherwise interacted with). 53 users clicked on the link to the news story, four users liked the post, and seven posted it directly to their own followers. This was the second-most-successful post of the month (after the report on the role of police officers in mental health support).

Website

In the seven days following publication, the news story on the report was viewed 161 times, by 2.35% of users, making it the 10th most popular page in that time (the most popular being the home page, with 1093 views, or 15.94% of users). This is above average compared to our other reports and publications.

Mailing list

We sent the report to all 849 subscribers on our mailing list. It was opened 161 times in the first week, an open rate of 26.14%. Subscribers clicked through to the report 46 times, or 28.57% of those people who opened it, a slightly-above-average rate which is like our other reports (such as local visits).

Conclusion

The investigation into GH's circumstances was chosen with the aim of identifying learning and reviewing how significant events such as this can be undertaken nationally. The report identified learning required in relation to some aspects of care delivered to GH including how historical and current risks were assessed and managed, the lack of listening to the family as they attempted to raise their concerns and the sharing of information between in patient and community services as well as across geographical areas, which if acted on, might have mitigated the risk of violence.

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

We have received clear evidence that the recommendations from the report have been acted on and addressed by Scottish Government and HSCP /NHS A and HSCP/NHS B. We are aware that the services responded both initially and with follow up action plans which were regularly monitored through their own governance arrangements and involved senior representation and leadership.

The Commission continues to visit HSCP/NHS A and HSCP/NHS B 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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