mental welfare commission for scotland

Closure report

Investigation into the death of Mrs F (2024)

July 2025

Our mission and purpose

Closure report

Investigation into the death of Mrs F

Executive lead:
Arun Chopra, former executive director (medical) and Suzanne McGuinness, executive director (social work)

Investigation team:
Lesley Paterson, Sheena Jones and Margo Fyfe with project support from Mark Manders

Date of executive leadership team approval of investigation:
16 August 2022 (with a start date of February 2023)

Date of commencement of investigation:
Letter sent to leaders of HSCP A to advise of decision to investigate 10 November 2022

Date of publication of investigation report:
2 May 2024

Date of closure report:
July 2025 (completed within 15-month Commission 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 Mrs F was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). 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.

Mrs F's case was referred to the Commission by her family following concerns they had about her care, treatment and assessment in the Mental Health Assessment Unit (MHAU) in NHS A. Mrs F died by suicide two days after her assessment and discharge from the MHAU.

This investigation into the care, treatment and support provided sought to identify what lessons could be learned from the experience of Mrs F and her family for health boards and health and social care partnerships across Scotland, as well as those organisations directly involved in Mrs F's care. Liaison took place with members of Mrs F's family, who have been updated throughout this investigation.

Recommendations to NHS A

The following three recommendations were made to local services and NHS A and were noted to be comprehensive, with a clear focus on supporting service improvement and improved governance in practice.

Recommendation 1: Embed guidance on confidentiality and carers into relevant operating procedures

NHS A must ensure that mental health staff have a clear understanding about their responsibility to listen to and involve families and carers. This guidance should be embedded in their service operating procedures and supported by supervision and training. Mental health staff should receive training in confidentiality, in keeping with legal duties and guiding principles. Training should include consideration about how and when it may be appropriate to meet with families where there is no or only partial consent.

Our investigation identified that Mr F was involved in and fully informed of the outcome of his wife's mental health assessment, risk assessment and risk management planning at the emergency department (ED). He was however, not involved in the outcome of

Mrs F's mental health assessment, risk assessment and risk management planning at the MHAU. MHAU staff reported that they felt unable to involve Mr F as when asked, Mrs F had not given consent to share her information with her husband.

Listening to the concerns of families and carers is a vital part of mental health assessment, risk assessment and risk management processes. It does not require staff to break a person's confidentiality and does not require a person's explicit consent. Involving families and carers should be the expectation. Whilst it is right that consent should be sought from people to share information with others, this should not act as an impediment to listening to their concerns; and where possible involving them in care planning and safety planning. From reviewing practices and interviews with the MHAU staff involved with Mrs F, our investigation highlighted that there was a clear training and development need for mental health staff working within the MHAU with regards to their obligations to patients, families and carers.

NHS A responded to evidence a range of robust improvements in relation to embedding carers and confidentiality guidance across the service, which included a review of the MHAU operational policy, which was updated to include the Commission's *Carers, consent and confidentiality good practice guidance* for staff and was shared with all staff through local clinical governance groups with senior management oversight. In addition, a 'Confidentiality and Consent: Best Practice Guide' has been developed and distributed across NHS A mental health services in addition to forming part of staff induction. Information is also now on display in MHAU sites informing families and carers that they can be involved in the assessment process with the consent of the patient and can share concerns in the absence of consent. Board-wide posters have been developed and distributed to service managers for onward distribution in all mental health sites to inform families and carers that they can be involved in assessment with consent of patient and can share concerns in the absence of consent.

A Board-wide carer's information leaflet on 'Consent and Confidentiality' has been developed and currently awaiting completion via the Clear to All Team. Once complete, this will be distributed across NHS A mental health sites.

Recommendation 2: Review assessment and clinical risk screening and management documentation and processes
NHS A must review their assessment and clinical risk screening and management processes to ensure that they are in keeping with current and expected practice.

We found that the brief assessment tool and clinical risk screening and management documentation which recorded Mrs F's assessment in the MHAU had incomplete sections. This raised a question about the robustness and quality of the assessment process and also as to whether the MHAU documentation is consistently completed as identified in the relevant service operating procedure. We explored to what extent assessment documentation was completed and what audit processes are in place to monitor completion. Incomplete assessment paperwork was not considered in the Significant Adverse Event Report[1] (SAER) process. The Mrs F investigation also identified that further work was required to ensure that the assessment tools are fit for the purpose that they are designed for, including the recognition and recording of complex presentations.

NHS A responded to this recommendation and advised that the mental health and risk management training programme was reviewed, with a standard for frequency of training for all staff across mental health services implemented. Clinical risk assessment training was reviewed, and updated training was developed in June 2023. The programme continues to be rolled out to all staff across NHS A. In addition, NHS A circulated a mental health service clinical risk management policy 7-minute briefing to all staff. NHS A's clinical risk support document to support staff recording assessments on EMIS was also issued to all mental health staff.

Recommendation 2 and recommendation 3 are inextricably linked and the actions taken by NHS A set out below, also relates to the improvements in relation to recommendation 2.

Recommendation 3: Review Mental Health Assessment Unit Service Operating Procedures and assurance processes.
NHS A must review their service operating procedures for the MHAU to ensure that it reflects current and expected practice. Particular attention should be paid to the supervision, training, and governance processes (including audit processes) in the MHAU to ensure that MHAU staff have the support, supervision and training to undertake their clinical duties.

Our investigation identified issues relating to information sharing between departments (emergency department and MHAU) and in the MHAU impacted on the MHAU staff having all the available information at the right time. Issues with information sharing

[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.

between departments had been identified in the SAER process, with appropriate actions taken to address this. These included the requirement that all information must be sent to MHAU and reviewed prior to a person being assessed at the MHAU.

We found additional issues relating to when and how referral information was documented and shared in the MHAU; this issue was not considered through the SAER process. We found that the referral documentation was completed post assessment by staff who did not take the initial referral. We concluded that this further impacted on the assessment undertaken within the MHAU and highlighted possible gaps about the effectiveness of NHS A's supervision, training and governance processes and clinical practice. In particular, Mrs F's situation identified that staff should have an awareness and understanding of how self-harm/suicidal thoughts are related to any possible mental illness. From our investigation, we found that there appeared to be a lack of awareness of the relationship between complex clinical presentations and associated suicidal thoughts/intent.

Supervision and clinical governance processes (including audit) should be in place to ensure that the MHAU staff are working as intended and in line with local policies and their professional standards of practice. The service responded with a wide range of actions undertaken including a review of NHS A wide induction pack, used for all staff working within mental health services, to provide assurance that mandatory training is undertaken and discussed in supervision, including mental health and risk management training. Service wide and MHAU induction process documents were reviewed. We saw evidence of clear links between essential reading, Learnpro mandatory training and a role specific approach. In addition, the service evidenced a robust approach to improving practice as outlined below:

- Annual core audits of MHAU assessments and plans are being undertaken by the professional nurse leadership team. A mental health combined care assurance audit tool has been undertaken for the MHAUs in March 2025 with good results.
- Senior management have developed and implemented a supervision tracker and supervision log for all clinical staff working in the MHAU and this is audited quarterly. All lead professions have been asked to review and update supervision guidance which will be included as part of the audit programme.
- Monthly teaching sessions to be delivered to, or available to, all staff in the MHAU. These should include mental health assessment, risk assessment, assessing suicide, and identifying psychosis. We were shown the ongoing rolling 12-month teaching programme which had been developed to include the recommendations.

- MHAU operating policy for the MHAU has been reviewed and updated to reflect supervision and training requirements for staff. As part of the review, all standard operating procedures[2] (SOP) across mental health services will include supervision and training requirements.
- MHAU induction pack for staff includes guidance on assessing suicidality with a requirement to review this within supervision. The MHAU induction pack has been updated to include all relevant and related guidance.

[2] A standard operating procedure is a document which provides detailed instructions for staff in relation to specific work-related tasks.

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 within agreed timelines. The responses were scrutinised by the Commission's investigation team and follow up information sought to clarify some aspects of the work undertaken.

We were provided with evidence of a detailed and comprehensive approach to responding to recommendations which covered standard operating processes, staff training, supervision processes, patient information, as detailed above. We sought clarity and additional information, where required, which NHS A provided on request. We scrutinised and considered the range of resources and information shared with the Commission to date. We found NHS A's response to be comprehensive and detailed, with all aspects of the recommendations addressed.

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

Between March 2024 – April 2025 the investigation team undertook a range of follow up activities, which included meeting with the service, correspondence between the Commission and NHS A for clarity and follow up; liaison with the Crown Office and Procurator Fiscal Service[3] (COPFS) with updates, contact with Mrs F's family to ensure they were updated of progress and follow up actions by the Commission in relation to the assessment process as outlined on page 12 of the Mrs F report.

Formal and informal training processes as part of Commission's activities were undertaken including a presentation to North Scotland Higher Trainees Teaching.

[3] The COPFS has a role to consider whether to conduct their own investigation in the event of a sudden or unexplained death and were notified of the circumstances in relation to Mrs F.

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

This report was published with a news release on Thursday 2 May 2024. It a examined the care and treatment of Mrs F, a woman who died by suicide two days after being discharged from a mental health assessment unit in Scotland.

Media

Broadcast

BBC Radio Scotland included the report in news bulletins at 6am (one-minute segment) and 8.30am (25-second segment) and included an interview with the Commission in a 4m43s segment at 7.49am.

Print

The Herald (2 May) carried the story on its front page (“*Missed opportunities over preventing dinner lady’s death*”) with details inside.

Online

The investigation was carried online by:

School dinner lady in 'avoidable' suicide over food allergy (Web)
Herald Scotland - 02/05/2024
A school dinner lady took her life after becoming convinced that she had harmed a child with allergies by mixing up the food bags given to pupils.

Mental health unit 'missed opportunities' to help woman (Web)
BBC - 03/05/2024
A Scottish mental health assessment unit "missed opportunities" to help a school dinner lady who killed herself two days after being discharged, an investigation has found.

COMMENTS CARRIED BY THE MEDIA

From the **Commission**, Dr Arun Chopra was quoted from our news release:

> *"This was a tragic situation for Mrs F's family. As well as the specific service involved, we want mental health crisis services across Scotland to read our investigation, and to consider the lessons than can be learned from it.*
>
> *"Mental health assessment units have a critical role to play in our health service, yet we found missed opportunities in the mental health unit assessment in this case.*
>
> *"One vital issue is that staff must have a clear understanding of their responsibilities to families, especially when they come to hospital with someone who is unwell. Whilst it is right that consent should be sought from patients to share information with others, this should not act as an impediment to listening to their concerns; and where possible involving them in care planning and safety planning. Staff must listen to them because they know the person and know what has happened. Mr F was not listened to.*
>
> *"We also found there was a focus in the mental health assessment unit on risk assessment – meaning whether Mrs F was of harm to herself or others at that moment. However, a risk assessment must always be part of a full assessment to identify whether a person is seriously mentally unwell. The focus on risk led to Mrs F being sent home into the care of her GP rather than being identified as seriously mentally unwell."*

Social media

Twitter (aka 'X')

The original tweet received 161 engagements (meaning it was liked, retweeted, clicked on, or otherwise interacted with). 46 users clicked on the link to the news story, 16 users liked the tweet, and 16 retweeted it directly to their own followers, including Monica Lennon MSP. This makes it the most-engaged tweet of that week (and second most-engaged of the previous three months, after the tweet for a new AWI learning module).

Specific comments appeared from:

SAMH

> *"We agree with the Commission's conclusion that families and carers should be involved wherever possible in mental health assessment and treatment processes.*
>
> *Our thoughts are with everyone who has been affected by this case."*

Change Mental Health

> *"We strongly welcome the recommendation of the @MentalWelfare that families and carers should be involved wherever possible in mental health assessments and treatment processes. Read more from our CEO, @nickmward, below:"*
>
> *"We strongly welcome the recommendation of the Mental Welfare Commission that families and carers should be involved wherever possible in mental health assessments and treatment processes.*
>
> *We work hard to support the carers of those with mental illnesses acro0ss Scotland, and firmly believe that listening to families and carers must be a vital part of mental health assessments.*
>
> *The NHS must now ensure that staff have a clear understanding about their responsibilities to consult with families and carers and our thoughts are with everyone affected by suicide.*
>
> *Nick Ward, CEO Change Mental Health"*

LinkedIn

The original post gained 36 clicks to the news story, 11 likes, and six reposts.

Website

In the seven days following publication, the news story on the report was viewed 411 times, by 5.9% of users, making it the 5th most popular page in that time (the most popular being the home page, with 1066 views, or 15.4% of users).

Mailing list

We sent the report to all 1412 subscribers on our mailing list. It was opened 341 times in the first week, an open rate of 24.7%. Subscribers clicked through to the report 113 times, or 33.1% of those people who opened it, a number and rate which are both above our other recent reports.

Conclusion

This was a tragic case for Mrs F and her family.

When Mr F first contacted the Commission, he was very clear that he wanted to ensure no other family experienced the trauma and the loss that he and his family did.

Through this investigation, we highlighted our concerns about aspects of the mental health assessment, and the assessment and management of risk which took place in the MHAU, as outlined above and raised by Mrs F's family. Whilst the service involved carried out a SAER, which we would expect, we found that key factors around the care and treatment of Mrs F were not addressed during this process. We followed this up with the service. Following on from our investigation, we note that there is clear evidence that the three recommendations made within the investigation report were acted upon and addressed by NHS A. A detailed action plan is in place, and we will continue to monitor progress against this and seek assurance through ongoing contact with NHS A. In addition, progress against these action points will continue to be monitored though our routine local visit programme to ensure that the improvements in practice not only continue but become embedded in practice.

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?)

Activity currently in progress.

The Commission welcomed NHS A's robust response to the Mrs F's recommendations, with an additional activity still in progress at the time of writing relating to NHS A wide carer's information in relation to 'Consent and Confidentiality', which is currently being finalised. We look forward to the issue of the information.

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

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk