mental welfare commission for scotland

Investigation into the care and treatment of Mr TU

Homicide by a person in receipt of mental health services

Investigations

March 2023

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

Investigation into the care and treatment of Mr TU

Homicide by a person in receipt of mental health services

This report is an investigation into the circumstances leading up to a homicide conducted by a man, Mr TU, who had been in touch with mental health services prior to this tragic incident.

We acknowledge and appreciate the cooperation of all the individuals, organisations and staff who assisted us with this investigation.

The subjects of this report have been anonymised as is our practice in our published investigation reports.

As many professionals were involved in this case, we have provided a glossary as an appendix explaining their roles.

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Executive summary

Mr TU was 32 years old when he had four relatively brief admissions to psychiatric hospital between March and June 2018; he was diagnosed with drug induced psychosis. On each admission to hospital, he was transported there by the police and on three of these admissions he was in possession of a potential weapon. On each admission, Mr TU presented with paranoid delusional beliefs and was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act). There was increasing concern about the risk of future violence, however Mr TU was then not seen by NHS clinical services for a six-month period between June 2018 and January 2019.

Mr TU was admitted to inpatient forensic mental health services under an assessment order of the Criminal Procedure (Scotland) Act 1995 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 he was on remand in Prison A and was liberated by the court with no support package in place and no accommodation. On the evening of his release, Mr TU killed a man who had offered him overnight accommodation at his flat.

Mr TU was diagnosed as having episodes of drug induced psychosis, possible post-traumatic stress disorder (PTSD) (partially resolved) and probable narcissistic personality disorder over the course of his care in 2018 and early 2019. Later in 2019 he was thought to meet criteria for an anxiety disorder whilst in prison.

Mr TU was particularly vulnerable to the effects of taking substances, with the subsequent development of psychotic symptoms which were associated with increasingly violent behaviour. Lots of advice was given to Mr TU about the link between his alcohol and drug misuse and his violent behaviour. Superficially he appeared to have insight, however he repeatedly failed to engage with services or to comply with prescribed medication which may have helped to address this. Mr TU consistently stated that his main problem was PTSD and that he had not received support to manage this. Mr TU's apparent limited understanding of the link between illicit substance misuse and his mental health together with his ambivalence to his nearest relative's involvement in his care made supporting him more difficult.

Whilst the four admissions to Hospital A in 2018 predate the homicide by 18 months, at the time of discharge from hospital in June 2018, Mr TU was recognised to pose a risk of violence. The majority of the concerns raised by the victim's family and by Mr TU's nearest relative is with regard to the care given by clinical services in 2018. This investigation has therefore reviewed Mr TU's care and treatment from his first admission to psychiatric hospital care in March 2018 up to the date of the homicide in December 2019.

Key findings

The lack of accommodation provided for Mr TU on his unexpected release from prison in December 2019 is likely to have impacted on the outcome of this incident. It is however noted that even where accommodation was available following previous discharge from

hospital/liberation from prison, violent or potential violent incidents quickly led to readmission or re-arrest.

Whilst many aspects of the care Mr TU received from NHS A services in 2018 were of high quality, the investigation found that there were aspects of that care, in particular how risks were assessed and managed, which if acted on, might have mitigated the risk of violence to this individual when he was discharged from inpatient care in June 2018. This included:

- ensuring contact with substance misuse services as an inpatient to try to actively engage Mr TU with this treatment;
- comprehensive, multidisciplinary discharge planning which included assessment of Mr TU's home and of his mental state when visiting his home prior to discharge;
- consultation with other medical staff and/or formally requested a second opinion where there was a difference of view between doctors and the Mental Health Officer about diagnosed mental illness and the possibility of need for compulsory treatment under the 2003 Act and risk management;
- communication with Mr TU's new care team prior to a transfer of care after discharge;
- consideration of more assertive follow up given the series of previous failed discharges;
- assistance with accommodation as early as possible during the admission to hospital.

The investigation also found that:

- the concerns raised by Mr TU's nearest relative were not documented nor fully taken into account and that Mr TU's nearest relative was not as fully involved by services as they should have been in 2018;
- Mr TU's care by NHS A was made more difficult by his lack of insight into the impact of illicit drug misuse on his mental state, his ambivalence to his nearest relative's involvement and the lack of continuity of senior medical staff in 2018;
- whilst in prison Mr TU was seen by criminal justice social work and by forensic psychiatry prior to court and there was an opportunity to consider other sentencing options which may have engaged Mr TU in some form of therapy, but this did not happen.

Conclusions

The investigation concluded that, following Mr TU's unexpected release from prison in December 2019, although a support package and accommodation may have reduced the likelihood of further offending, evidence from a planned liberation in September 2019 indicated that even with a comprehensive support package in place and with accommodation provided, Mr TU rapidly re-offended, was rearrested and returned to prison. However, if Mr TU had been offered accommodation in December 2019 this is likely to have reduced the risk to the specific victim who invited him to his home because of his lack of accommodation.

The organisation of 'Throughcare' services for prisoners is complex, involving several agencies. The provision of Throughcare services is under review by the Scottish Government together with Community Justice Scotland. It is anticipated that a new model for care will be in place by April 2024. A gap in services for prisoners on remand was previously identified in the Commission's themed visit report, *Mental health support in Scotland's prisons 2021* (published April 2022).

SHORE (Sustainable Housing on Release for Everyone) standards do not address this issue at all. The Scottish Government is leading a review of these standards with an estimated completion date of 2024.

Prison A has undertaken to develop a standardised approach to the management of remand prisoners who are unexpectedly liberated from prison.

Many aspects of the care Mr TU received from NHS A services in 2018 were of high quality. There were however aspects of that care, including how risks were assessed and managed and the involvement of Mr TU's nearest relative, which if acted on, might have mitigated the risk of violence when he was discharged from inpatient care in June 2018. There was a lack of consistency of senior medical staff. Reviews took place outwith the usual MDT structures. Both of these factors are likely to have contributed to a lack of longitudinal assessment and associated risk management. The Mental Welfare Commission's (the Commission) visits to NHS A had previously reported on difficulties recruiting to senior clinical posts and the impact on continuity of care.

However, whilst the risk could have been mitigated at that time, further violence could not have been prevented with any certainty.

Learning points for all mental health providers

Learning points are not formal recommendations but points of best practice to be taken into consideration by all MH providers

- In recognition of the complexities involved, the Commission produced good practice guidance in relation to drug induced psychosis (*Drug induced psychosis and the law*, 2022) which states:

  > *"Use of, or dependence on, alcohol or drugs does not in itself constitute mental disorder. Mental illness that results from drug or alcohol use, or accompanies it, is a mental disorder under the 2003 Act. Based on all the available evidence, we consider that drug induced psychosis is a mental illness. The suspicion that psychotic symptoms may have resulted from drug use should not, in itself, be a factor in deciding whether or not this criterion for determining the use or not of the Act is met."*

- All MDT staff should be aware of the links between violence, substance misuse and non-compliance and non-engagement with services.
- All staff should be aware that discharge from hospital is a high risk point in care and this should be reflected in comprehensive, inclusive discharge planning.

- All staff should take full account of implications of discharges from hospital on a Friday afternoon where there are limited supports available at weekends.
- Services should ensure that where there is disagreement, senior medical staff should be aware of the process to seek further opinions and to raise formally when this is required. The Care Programme Approach (CPA) should be considered where a person is unable or unwilling to engage with care, putting themselves or others at risk OR where the MDT have not agreed a collective way forward to manage risk or promote a person's wellbeing. This approach ensures a clear care plan and care coordinator. Its use has been advocated by the Commission (*Preparation of care plans for people subject to compulsory care and treatment*, 2021).
- All staff should be aware of the importance of "*consulting with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans*". (*Safer services: A toolkit for specialist mental health services and primary care*, The National Confidential Inquiry into Suicide and Safety in Mental Health, NCISH/The University of Manchester, 2022).
- Nursing staff should be reminded that all family contacts should be documented, and any concerns raised by the family should be documented and discussed at MDT reviews.
- Where staff have concerns about patient care they should discuss this with senior staff and where appropriate seek advice from the Mental Welfare Commission.
- There is an implicit requirement in the 2003 Act to have the mental health officer and responsible medical officer work together to communicate in advance of a tribunal. In this case there was a difference of views between the mental health officer, as applicant, and the responsible medical officer about whether the individual had a diagnosed mental illness which met the criteria for detention.

Recommendations

Recommendations for HSCP/NHS A

To ensure that recommendations are addressed, these will be subject to formal follow up and review by the Commission with the agencies they are directed to.

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.
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.
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.

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.
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.
6. HSCP A should carry out regular audit of the quality of social circumstances reports as required by standard 7 of the National Standards for Mental Health Officer Services.

Recommendations for Scottish Government

The purpose of the SHORE standards should be to ensure that everyone has suitable accommodation to go to on the day that they are released from custody. The gap in these standards should be addressed by the Scottish Government in its review of these standards.

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).

1. Introduction

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

This investigation seeks to identify what lessons can be learned from the experience of Mr TU, not only for the health, social work and prison services involved but also for all other services and interested parties across Scotland.

The Commission was first notified about Mr TU's case in April 2020. This notification was received from the psychiatrist who had the last contact with Mr TU two days before his release from prison and prior to the subsequent homicide on 7 December 2019.

NHS A commissioned a review of care in March 2021, and the finalised report was completed in August 2021. The NHS A SAER (significant adverse event review) identified good practice by NHS A's mental health services but expressed concern about what they viewed as the sudden liberation of Mr TU from prison prior to the homicide.

The Commission carried out an investigation into this case because it was clear from the SAER's focus on medical notes that there had been no involvement of affected families or of Mr TU and because the homicide may meet the criteria for a Mental Health Homicide (the criteria have yet to be confirmed by Scottish Government).

1.1 Background

Mr TU apparently used cannabis from around the age of 18 on a recreational basis and thereafter used cocaine in a similar way. Aside from the prescription of an antidepressant for a short time 10 years previously with which he did not comply, there appear to have been no significant issues with Mr TU's mental health, until his presentation in 2018. This presentation in 2018 is noted to have coincided with an escalation in his intake of cocaine, alcohol and anabolic steroids.

Mr TU was referred by his GP to mental health services in February 2018 when he was 32 years old. He had consulted his GP saying he was experiencing distressing symptoms as a result of traumatic events he experienced whilst on a holiday in 2017. He was due to be seen by a consultant psychiatrist in the community at the end of March 2018 but was admitted to hospital two weeks before this appointment, being taken to hospital by the police after they found him in the street, causing concern brandishing a snow shovel. Mr TU was said to be delusional and aggressive and was considered for transfer to the intensive psychiatric care unit (IPCU) but there were no beds. Mr TU denied the use of illicit drugs or drinking excessively at this time. He was detained under the 2003 Act under a short-term detention certificate

(STDC) and required 2:1 nursing observation and rapid tranquilisation medication on two occasions. Mr TU's mental state settled quickly however, without further medication and the STDC was revoked. Prior to discharge Mr TU was seen by the responsible medical officer (RMO) with his nearest relative and girlfriend. Mr TU's nearest relative said that his drinking was an issue and that he took drugs, including cocaine and diazepam when he was drinking. Mr TU was discharged after a six-day admission with arranged outpatient follow up and a referral to substance misuse services (SMS). At that point there was no clear diagnosis, but it was felt that a drug induced psychosis or post-traumatic stress disorder (PTSD) were possibilities.

Mr TU was re-admitted to hospital four days after discharge (in March 2018). He had contacted the police himself as he was concerned that there were people after him, and he was found by the police outside his home, with a baseball bat. He was punching holes in the walls of his flat believing that there were people in the pipes. Mr TU admitted to the use of both alcohol and cocaine. He was discharged just over two weeks later after the STDC was revoked, with a plan for follow up in the community by the community mental health team (CMHT), support for alcohol misuse and a plan for possible cognitive behavioural therapy (CBT) for PTSD symptoms.

However, Mr TU was admitted to hospital for the third time the day after discharge, again being brought to hospital by the police, and again being detained under the 2003 Act. Mr TU was delusional about intruders in his flat and had been trying to create smoke using the toaster as a possible deterrent to the intruders. On admission he was verbally abusive and threatening and was treated with antipsychotic medication. On one occasion he admitted taking a significant amount of cocaine during the admission and was seen by acute medical services. His paranoid symptoms again appeared to resolve quickly, the STDC was revoked and the diagnosis on discharge, eight days after admission, was of drug induced psychosis. He declined a referral to the substance misuse service, but a follow up appointment with a psychiatrist after discharge was arranged, but he did not attend. He was advised to continue with antipsychotic medication on discharge but did not comply with this. Mr TU said he would continue private CBT for his PTSD symptoms.

Mr TU's fourth hospital admission in 2018 was at the end of April, eight days after his previous discharge. Again, he was taken to hospital by the police after he had entered a neighbour's flat armed with a screwdriver, as he believed there were people in that flat who posed a risk to him. He was again detained under the 2003 Act, and because of the level of agitation he was displaying he was moved from the general admission ward, which was an open ward, to the intensive psychiatric care unit (IPCU). Mr TU was aggressive and threatening, and assistance by the police was required on two occasions. He was given rapid tranquilisation medication. He was treated with antipsychotic medication and as his mental state settled, he was transferred back to an open, unlocked ward. Mr TU admitted the frequent use of cocaine. There were documented concerns about the "imminent and tangible" risk of violence and how this could be managed if he continued to use cocaine in the community. During this admission there were issues with consistent RMO cover and Mr TU was seen by several different consultant psychiatrists. An application was made for a longer period of detention under a compulsory treatment order (CTO) by a consultant providing cover. The mental health officer

(MHO) continued to support the application at the Mental Health Tribunal and expressed concern about the lack of a "continuing, consistent" assessment of Mr TU's mental health because of the changes in consultant cover, however the RMO (Psychiatrist A, who was not the original consultant who made the application) gave evidence that, in his view, Mr TU did not meet the criteria for a CTO as he did not have a mental illness. The Mental Health Tribunal accepted the updated evidence from this RMO and refused the CTO application. Mr TU therefore became an informal patient and was now homeless having given up his flat earlier in the admission.

Mr TU remained on low dose antipsychotics and was seen for a more detailed assessment of PTSD by Psychiatrist A. There was thought to be some evidence of PTSD, but this was believed to be improving. Mr TU was also thought to meet criteria for a narcissistic personality disorder however he was discharged from hospital on 1 June, less than one week after the tribunal decision not to grant a CTO. At this time the MHO was on leave and no attempts were made to contact other social work staff. Mr TU said he would probably stay with family or friends until he could organise private rented accommodation for which he had the means. The discharge plan was for outpatient follow up within seven days, substance misuse service follows up and Mr TU would seek private psychology support. There were no records to confirm that Mr TU had ever received this private service despite this being referred to, at previous discharges.

Mr TU did not attend two arranged follow-up appointments and did not return to the ward to pick up his medication on discharge. As Mr TU had no fixed abode, and text messaging had not got through, no further follow up could be arranged. Contact with NHS services was lost until January 2019.

Mr TU was arrested in June 2018 for carrying a knife in a public place; he was intoxicated. He was further arrested in October for assault outside a bar, and again in November when he was arrested for Breach of the Peace, resisting arrest, and assault on bar door staff.

Mr TU reported he stayed with friends and also self-funded a placement in a private residential rehabilitation facility for about a month between June and December 2018. He refused access to NHS staff of any records relating to this stay when he was admitted to the assessment ward in December 2018.

Mr TU was admitted to hospital from prison under an assessment order (AO) granted by the court, under Section 52D of the Criminal Procedure (Scotland) Act 1995 in January 2019. The reason for this admission was to establish whether Mr TU had an underlying psychotic illness such as schizophrenia. He remained in hospital under an AO for four weeks, during which time he received a comprehensive multi-disciplinary assessment. Diagnosis was of drug-induced psychosis now resolved; PTSD largely resolved. There was no evidence of an underlying psychotic illness. He was advised about the risks associated with continuing to use illicit drugs, and arrangements were made to provide follow-up support either in the community or in prison, depending on the outcome of his court appearance. He did return to prison, and there was follow up by the prison based mental health team.

Mr TU was released from prison at the beginning of May 2019, and the day after his release he was admitted to hospital. He had been assaulted in a fight in a bar. He had been drinking

and using cocaine and was admitted to a general hospital for treatment of his injuries. He was transferred to the psychiatric hospital he had previously been admitted to in 2018, as an informal patient (i.e., not detained under the 2003 Act), due to concerns about thoughts he was expressing about harming both himself and the person who had assaulted him. He was in hospital for five days, then left the ward and returned later the same day, apparently having been drinking alcohol. He displayed aggressive and agitated behaviour, but as there was no assessed evidence of an acute mental illness, he was allowed to discharge himself from hospital. He was arrested the following day, remanded in prison, and follow up from prison mental health services was once again arranged.

Mr TU remained in prison from May until December 2019, apart from a brief liberation from prison in September. On this occasion Mr TU was liberated with a comprehensive support package and with arranged homeless accommodation, however he was involved in a fight after drinking alcohol on the day of his release, was re-arrested and returned to prison the next day. During this seven-month period Mr TU had regular contact with the prison consultant clinical psychologist and was reviewed regularly by forensic psychiatry. He saw the psychologist and psychiatrist in early December 2019, and both found him to be well on prescribed medication for anxiety disorder, with no evidence of illicit drug use within the prison. It was noted that he was due to return to court but that he expected to remain in prison after this court appearance.

On 6 December Mr TU appeared in court and was liberated with no arranged support or accommodation. He was conveyed back to prison after liberation to collect his belongings and medication, and he was reported to be distressed by the decision to release him from custody which had not been anticipated nor planned for. Mr TU subsequently reported that he had spent some time walking around the city centre and at some point, was offered and consumed cocaine. He went to a club where he met the victim, previously a stranger to him. Subsequently, having apparently failed to secure overnight accommodation elsewhere for Mr TU, they went to the victim's house where the homicide occurred.

1.2 Focus and lines of enquiry

The terms of reference for this investigation were:

- To examine the care and treatment provided to Mr TU by mental health and social work services between March 2018 and the homicide in December 2019.
- To examine how risks were assessed and managed over this period. This will not include an assessment of Mr TU's mental state leading up to the incident or at the time of his court appearance and subsequent disposal.
- To consider and respond to questions raised by the involved families and by Mr TU (see Section 4 findings).
- To identify any lessons to be learned both locally and nationally.
- To make recommendations as appropriate.

1.3 Impact on victim's family

The following statement has been provided by the victim's family.

> *"Mr G was the youngest of three sisters and an older brother. On leaving school he joined his father's firm and served his time as a blacksmith structural engineer. He then went on to work in the oil industry where he was well thought of by his work colleagues.*
>
> *Mr G was a confident, sociable and very likeable guy, loved by so many for his fun-loving personality. His friends have described him as a 'generous loveable diamond who would walk into a room and it would light up'. He always had time to have a catch up with old friends he hadn't seen for several years. One friend said, if you met Mr G, he made such an impression you never forgot him.*
>
> *Mr G was late in becoming a father but when his son was born, he would say it was his greatest achievement and he finally understood unconditional love for someone. He was such a proud dad, he spent as much time as he could with his son.*
>
> *They loved their time together, whether going swimming or just hanging out, it was just so special to them both and their holidays to Spain and lots of trips they made around the UK.*
>
> *It is so poignant to all of us who knew Mr G that his kind thoughtful personality would cost him his life. The night he showed an act of kindness by exhausting all options to try and find this man he just met, a room on that cold December night. And because he could not find him any accommodation, he couldn't just leave him, so offered that he come back to his flat.*
>
> *He will never be forgotten by his family and friends and all whose lives he touched."*

1.4 Investigation process

The investigation team had access to mental health, social work records and health records for HSCP A/NHS A and HMP A (medical, nursing and allied professional) for the period from 14 February 2018 until 25 August 2021.

The investigating team had access to the NHS A Significant Adverse Event Review (SAER) report commissioned 15 March 2021 and had feedback from service manager A for inpatient and specialist services for NHS A mental health services with regard to their action plan following the SAER.

The investigating team also had access to NHS A's documentation titled *Admissions and Discharge Procedure, updated May 2019*, *Weekly MDT meeting acute wards*, *Weekly MDT meeting*, *Rapid Risk Assessment Version 6*, *Care Management Handbook v14, Nov 21*, *Care Programme Approach Guidance* and *Care Programme Approach Pack*.

The investigating team spoke to the Head of Justice, Scottish Prison Service (SPS) about Mr TU's liberation from Prison A on 6 December 2019 and contacted the policy manager (housing and welfare) at the Scottish Prison Service (SPS) with reference to the SHORE standards.

The investigation team met with the family of the victim.

The investigating team also met with the perpetrator (Mr TU) and with his nearest relative, to understand what concerns, if any, they had about the care given to Mr TU.

Having considered the records and the concerns about care raised by those most affected by the incident, the investigating team then met with those key individuals who were part of the process during the period identified.

The investigating team sought not to repeat interviews already held with involved staff for the Health Board SAER unless it was necessary to understand the events prior to the incident.

All interviews and meetings were conducted remotely using video links, because of Covid-19 restrictions.

Once the interviews had been conducted, the information was analysed using the following thematic headings:

- Findings area 1: care and treatment provided by NHS A
- Findings area 2: risk assessment and management by NHS A
- Findings area 3: unexpected liberation from Prison A
- Findings area 4: response to concerns raised by Mr TU, Mr TU's nearest relative, and victim's sister.

2. Findings area 1: examine the care and treatment provided to Mr TU by mental health and social work services between March 2018 and the homicide in December 2019

2.1 Care and treatment - good practice

In general, there was good care and treatment by inpatient services and by clinical staff in prison. There were detailed admission assessments and appropriate care of physical health issues. There was regular, detailed review by senior medical staff and their assessments were clearly documented. Discharge summaries and outpatient clinic letters were completed to a good standard. There were regular one-to-one sessions with nursing staff. Mr TU's nearest relative stated that nursing staff did listen to her and at busy times, called back as they said they would.

On admission to hospital under an assessment order (hospital admission five: 30 January - 27 February 2019) it is clearly documented that Mr TU refused to allow services to have contact with his nearest relative.

Mr TU was seen regularly by forensic psychiatry services in prison with well-documented prison appointments. Mr TU was also seen by substance misuse services (SMS) and from July to December 2019, there were regular (weekly) review appointments with Psychologist A who also co-ordinated a detailed care package for Mr TU when he was liberated as expected from prison in September 2019.

2.2 Care and treatment - observations by the Commission

2.2.1 Continuity of senior medical cover

During the four hospital admissions in 2018 there were several changes of responsible medical officer (RMO). Psychiatrist F was responsible for Mr TU's care for admissions one and two. Psychiatrist A took over RMO responsibilities on 13 April prior to Mr TU's discharge that day. After the third admission on 22 April, it was noted that the usual RMO was unwell, and it was not clear who would be covering. Psychiatrist B then reviewed Mr TU as duty and IPCU consultant, there was then a delay in transfer back to acute general adult wards because of a lack of RMO (27 April). Mr TU was then seen by psychiatrist G on 1 May and then again by Psychiatrist A on 2 May. Whilst Psychiatrist A was on leave, Psychiatrist C provided RMO cover (7 May); there is also a further review by Psychiatrist G, then again by Psychiatrist C on 14 May prior to Psychiatrist A's return on 17 May.

At interview, Psychiatrist A stated that as they were covering for medical leave and for another sector, reviews did not take place within the usual MDT structure and sometimes happened out of hours. Psychiatrist A said that usually, for inpatients from the catchment area, MDT reviews would include a nurse from the inpatient ward, CPN, a social worker or mental health officer if detained and an occupational therapist. Decisions regarding discharge and about the level of input required by the CMHT post discharge would be agreed at the MDT meeting

involving the CPN. Given the risks involved, Psychiatrist A had in the past included a police liaison officer at MDT reviews having discussed the issues with forensic colleagues and taken advice from his medical defence organisation. The fact that Mr TU was an out of sector patient for Psychiatrist A meant that after the first out-patient review, follow-up care would then be transferred to Mr TU's sector CMHT. Psychiatrist A said that the lack of consistency of care was a hindrance to a more comprehensive treatment and care package.

It was noted at the Mental Health Tribunal (MHT) held on 24 May following the application for a compulsory treatment order (CTO) that MHO A expressed concern that Mr TU had not had a "continuing and consistent" assessment of his mental health having been seen by a number of RMOs during his hospital admissions.

Mental Welfare Commission visit reports from NHS A had also highlighted longstanding difficulties in retention and recruitment to medical posts.

Continuity of consultant psychiatrist cover was clearly a challenge in Mr TU's case.

3. Findings area 2: examine how risks were assessed and managed over this period

3.1 Good practice – Risk assessment and management

Risk assessment documentation was completed on each admission to general adult psychiatry wards. During inpatient forensic care there were thorough multidisciplinary assessments using the Care Programme Approach (CPA). Documentation of both risk assessment and management was appropriately detailed in this setting.

There was awareness and concern about the risk of further violence by Mr TU in both general adult psychiatry and forensic psychiatry settings.

Clinicians were aware of the risk factors for violence, in particular of Mr TU's substance misuse. Involved clinical staff repeatedly counselled Mr TU about the link between substance misuse and violence and when well, it appeared that he had insight into this.

There were referrals to substance misuse services by both general adult and forensic services when Mr TU agreed to this.

Mr TU signed a 'drug use and violence contract' on 25 May 2018. It could be said that by doing so he superficially appeared to understand the links between drugs and his behaviour.

Most clinicians were concerned about Mr TU's history of non-engagement and non-compliance with either follow up or medication. Mr TU was readmitted to Hospital A in April 2019 for assessment but also with a stated aim of re-engaging him with support services.

Efforts to get collateral information were complicated by Mr TU's refusal to allow this on most occasions throughout care.

3.2 Observations by the Commission – risk assessment and management

3.2.1 Substance misuse

One of the key findings in the National Confidential Inquiry into Suicides and Homicides (NCISH) Annual Report 2017, is that "*in all four UK countries, most patients convicted of homicide also have a history of alcohol or drug misuse, between 88% in England and 100% in N Ireland. In other words it is unusual for mental health patients to commit homicide unless there is a co-existing problem of substance misuse.*"

The NCISH Annual Report 2018 states that one of the "*clinical measures most likely to prevent patient homicides and by implication reduce the risk of interpersonal violence is reducing alcohol and drug misuse.*"

Mr TU not only had an established history of drug and alcohol misuse but was recognised to have "a significant vulnerability to developing florid psychotic symptoms and significant agitation when using substances" (May 2019). In these circumstances, ensuring referral to

and engagement with substance misuse services (SMS) where possible should be an important component of any plan to mitigate risk and did not happen in this case.

Mr TU gave contradictory information about the pattern and extent of his drug and alcohol misuse throughout care. He was repeatedly advised by clinical staff about the links between substance misuse, the development of psychosis and violent behaviour. Superficially, he could appear at interview to have insight into this but despite counselling, he was ambivalent about accepting the advice of these services, changing his mind or failing to attend appointments offered to him. This pattern suggests that insight was partial, and this was clearly recognised by some clinicians.

Mr TU agreed to refer himself to SMS following his first admission to Hospital A in March 2018 but was readmitted to hospital four days after discharge. He was referred to SMS by inpatient services during his second admission but as his short-term detention certificate (STDC) was revoked, he was not seen in hospital by SMS before discharge and staff were advised that he could attend a drop-in centre in the community following discharge. He was readmitted the day after his second discharge, was counselled about the harmful use of cocaine but adamantly refused referral to SMS. His STDC was then revoked for the third time. During his fourth admission, Mr TU admitted to longstanding, frequent use of cocaine. A referral was made to SMS with Mr TU's agreement, but he was discharged before being seen by SMS and left with a plan for SMS follow up instead. He was further referred to SMS during his hospital admission under an Assessment order by forensic services in January 2019 and was seen by SMS for the first time in March 2019 at which time Mr TU said he did not want to further engage with the service.

Given the recognised link between Mr TU's drug and alcohol misuse and subsequent violent behaviour and the history of non-engagement with services, a more assertive approach which ensured that Mr TU was seen as an inpatient by SMS prior to revocation of his STDC during the third hospital admission and prior to discharge in the fourth hospital admission in 2018 may have helped engagement with this service.

3.2.2 Non-compliance and non-engagement

The NCISH Annual Report 2018 states that *"the risk of homicide by mental health patients is strongly linked to other factors in the clinical picture, namely the additional use of drugs or alcohol, and the loss of contact with services. Clinical measures most likely to prevent patient homicides and by implication reduce the risk of interpersonal violence are therefore reducing alcohol and drug misuse and maintaining treatment and contact in patients at risk of disengaging from services*." Research supporting this in 2020 found that *"almost all homicides were committed by patients who had a history of substance misuse and/or who were not in receipt of planned treatment. To prevent serious violence, mental health services should focus on drug and alcohol misuse, treatment adherence and maintaining contact with services."* (*Homicide by men diagnosed with schizophrenia: national case-control study*, BJPsych Open, 2020.)

Based on data collection over 20 years, NCISH have developed a list of 10 key elements for safer care for patients (*Safer services: A toolkit for specialist mental health services and primary care*, NCISH 2022). One of these elements is for outreach services:

"Community mental health teams should include an outreach service that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services. This might be patients who don't regularly take their prescribed medication or who are missing their appointments."

For Mr TU, there was a pattern of non-compliance and non-engagement with services together with rapid readmission and rearrests in both hospital and prison settings in 2018 and 2019 respectively. Mr TU stated that he would comply with medication and/or engage with follow up but did not.

On discharge from his third hospital admission on 13 April 2018, Mr TU was offered an outpatient appointment (OPA) six days after discharge. He was treated with antipsychotic medication, given advice about the use of drugs and there was a potential referral to SMS should he change his mind about accepting this. However, once again, Mr TU failed to attend the OPA and failed to comply with medication. He was readmitted eight days later (fourth admission). His presentation was described as "potentially highly dangerous" (Psychiatrist E, 16 May). In the social circumstances report (SCR) for the mental health tribunal held in May 2018, MHO A commented on the series of previous failed discharges. Psychiatrist C advised that there should be a CTO application to support discharge planning and Psychiatrist E commented on Mr TU's rapid return to drug misuse post discharge in the past. However, on discharge from hospital following the fourth admission, the plan for follow up was essentially the same as for the previous admissions i.e., an OPA in seven days' time, SMS support which Mr TU said he would attend and psychotropic medication. He was discharged on a Friday afternoon with no accommodation.

Given the previous history of non-compliance and non-engagement and the recognition of increased risk, it is reasonable to suggest that consideration should have been given to more assertive outreach to monitor Mr TU's progress, engage him in the treatment plan and offer additional support on discharge from hospital on the fourth occasion. The fact that he had no fixed address when discharged on a Friday afternoon made further follow up impossible once he had defaulted from OP review. Records confirm that Mr TU was discharged whilst MHO A was on leave, no contact was made with alternative social work staff. Mr TU did not return to the ward to pick up his medication after discharge.

In May 2019, Mr TU returned to prison seven days after being liberated having been arrested for behaving in a threatening manner and an alleged assault on a police officer on 10 May whilst on bail for previous offences. He was referred for a criminal justice social work report. Mr TU told the criminal justice team that he had PTSD but had been given no support to manage this. The criminal justice report recognised the increased seriousness, diversity and frequency of Mr TU's offending citing 10 offences, nine of them aggressive/violent in nature in the previous year. They advised deferring a sentence for a psychiatric report and suggested the use of a community payback order with a supervision requirement to try to engage him with supports although recognised that this would be difficult

He was also reviewed by forensic psychiatry who recommended psychology referral, SMS support and psychiatry review as required. This report stated that Mr TU did not need to be detained in hospital as "he is willing to engage on a voluntary basis". It is not clear whether the criminal justice report recommending the use of a community payback order to support

Mr TU's engagement with services was available to the psychiatrist writing the report. It would have been reasonable to consider other sentencing options which may have engaged Mr TU in some form of therapy, but this did not happen.

3.2.3 Discharge planning

Based on data collection over 20 years, NCISH have developed a list of 10 key elements for safer care for patients (*Safer services: A toolkit for specialist mental health services and primary care*, NCISH 2022). Discharge from inpatient services is recognised to be a high-risk point of care. One of the 10 key elements is for early follow up (within 72 hours) of discharge. The advice from NCISH states that *"a comprehensive care plan should be in place at the time of discharge and during pre-discharge leave."*

NHS A's *Admission and Discharge Procedure – updated May 2019* indicates under 'wellness planning', that there should be confirmation that the patient's accommodation is ready prior to discharge. There is a prompt to inform the carer or next of kin of discharge.

It was noted on admission two (17 March – 4 April) that Mr TU had punched holes and ripped insulation from walls in an attempt to find people there. He subsequently reported that he thought one of the neighbours was spying on him and the MHO was unsure about how he would react to his neighbours. Prior to his discharge from hospital on 4 April, Mr TU is reported to have had two periods out of the ward to visit his flat and he reported there were no issues. The following day the STDC was revoked, and he was discharged from hospital. There is no record of a home visit by staff to check the extent of any damage prior to admission and ensure that the flat was safe and habitable. There was no accompanied pass to ensure that Mr TU's previous paranoid beliefs about his neighbours were absent on his return to that setting.

On re-admission to hospital the day after discharge on 5 April (admission three), there were reports from the police that Mr TU had been burning paper in his toaster to smoke out people he believed were in his flat. Mr TU was discharged eight days later after his STDC had been revoked for a third time. There is no documented home visit prior to discharge on this occasion either. Once again there is no record of action taken to assess the flat or to ensure that Mr TU was sufficiently well to be discharged back to this setting.

Mr TU was re-admitted to hospital on 22 April on a fourth STDC, nine days after discharge (admission four). Mr TU stated to nursing staff on 29 April that he was going to hand back the keys of his tenancy because he was remorseful about entering the neighbour's house brandishing a screwdriver. There is no further mention of Mr TU's lack of housing in the clinical notes until 25 May when it is stated that the MHO will offer support with housing but is on leave. It is then recorded, prior to discharge on 1 June that Mr TU intends to stay with family or friends until he arranges his own accommodation. Mr TU's nearest relative however was not informed of his discharge from hospital. MHO A returned to the ward on 12 June and only then learned of Mr TU's discharge on 1 June without any accommodation.

Regarding admissions two and three, in view of the previous failed discharge(s), the reports of damage to Mr TU's flat and potential risk to neighbours, a home visit and accompanied pass prior to discharge to assess both the flat and to further monitor Mr TU's mental state prior to discharge would have been appropriate.

In some NHS board areas, crisis and assertive outreach teams are available to accompany patients on pre-discharge home visits, to assess both the home circumstances and the patient's mental state back in the home environment prior to discharge but HSCP A/NHS A does not have either a crisis or assertive outreach team. Such assessments are not the sole responsibility of specialist teams however, there are other models where members of the multidisciplinary team would similarly make home visits.

Regarding admission four, the need for discharge planning was recognised by Psychiatrist C (14 May) who discussed this with Psychiatrist E (the psychiatrist who would be responsible for community follow up). Given the history of failed discharges, the recognised increase in risk and the planned transfer of care to Psychiatrist E post discharge, it would have been important to have discussed plans for community follow up and transfer of care as part of the discharge planning process and to address Mr TU's homeless status as early as possible in the admission. This did not happen.

It is likely that the lack of a consistent RMO over the course of these four admissions, with reviews not carried out within the usual structure of an MDT or using a care programme approach, contributed to the difficulties with comprehensive, person-centred discharge planning.

3.2.4 Use of compulsory measures

During the fourth admission to Hospital A (22 April – 1 June 2018) there were different medical views about Mr TU's care and treatment. Psychiatrist C referred (7 May) to "splitting" of staff and there was also a difference of views about the use of the Mental Health Act. Psychiatrist C (14 May) thought there should be a CTO application to allow discharge planning and Psychiatrist E (16 May) who would be the consultant responsible for Mr TU's community follow up supported this view stating that there must be some uncertainty about whether Mr TU's illness is solely drug induced or he has an endogenous psychotic disorder that is exacerbated by drugs. In view of his lack of insight, Psychiatrist E stated it would only be possible to ensure satisfactory compliance with antipsychotic medication by use of depot medication.

MHO A made an application for a CTO and Psychiatrist C completed the first medical report (the second was by the GP). Psychiatrist A then reviewed Mr TU on 17 May and found no evidence of psychosis and "no evidence of mental illness during a prolonged period of observation in a contained environment" (forensic inpatient care, 10–23 May). At that time however, Mr TU was being prescribed a low dose of antipsychotic medication.

At the Mental Health Tribunal (MHT) on 24 May, MHO A reaffirmed their view that the criteria for a CTO were met. They also stated that they were concerned that Mr TU had not had a continuing and consistent assessment of his mental health having been seen by a number of RMOs during his hospital admissions. Psychiatrist A however stated that without the complication of drug misuse, they could detect no signs of mental illness and did not consider that Mr TU needed to be detained. After considering the evidence, the MHT accepted the updated evidence of the RMO which did not support the granting of a hospital-based CTO.

In a situation where there is a difference of view about care planning between senior medical staff or between disciplines within a MDT, particularly where there is recognised to be high

risk and an imminent transfer of care between RMOs, there should be clear mechanisms to seek a second opinion where needed. NHS A's Care Programme Approach (CPA) guidance suggests that this approach, which involves a multidisciplinary meeting, could be used where either, "despite the supports in place, the patient is unable or unwilling to engage with their support package, putting themselves or others at risk" OR "where the MDT have not agreed on a collective way forward to manage risk and promote the person's wellbeing".

Where these discussions do not take place, staff should discuss their concerns with senior staff. Where escalation is ineffective, it may be appropriate to discuss with the Mental Welfare Commission for Scotland.

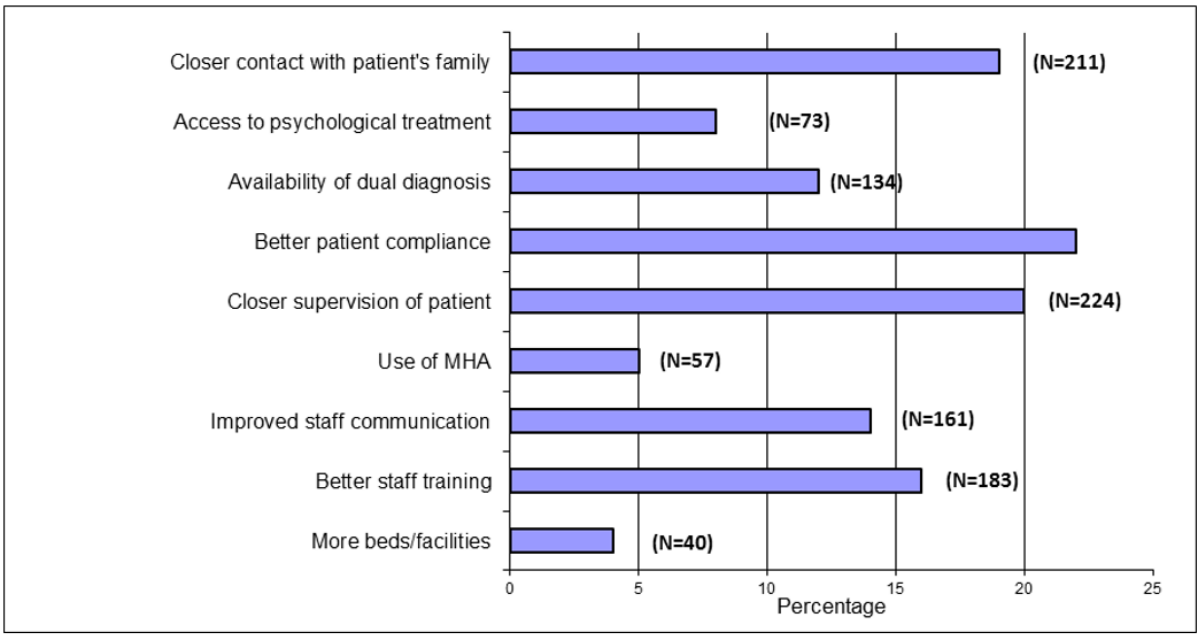
3.2.5 Involving the family

Based on data collection over 20 years, NCISH have developed a list of 10 key elements for safer care for patients (*Safer services: A toolkit for specialist mental health services and primary care*, NCISH 2022). One of these is with regard to involving the family:

> *"Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans.' 'Patients tell us they want their families to have as much involvement as possible in their assessment of clinical risk, including sharing crisis/safety plans with them. Clinicians tell us family involvement is vital to enhancing patient safety in mental healthcare settings."*

Feedback from clinicians following patient homicide (NCISH data made available to the Commission, May 2022) indicates that closer contact with the family is one factor frequently recognised to make a homicide less likely:

Figure: Factors which could have made homicide less likely in homicide cases between 2000-2016.



Involving families can help with risk assessment. In Mr TU's case, an example of this is the involvement of his nearest relative during admission one (13 March 2018). Mr TU denied taking illicit drugs or drinking excessively but his nearest relative, who was his named person at that time, told Psychiatrist F that his drinking was an issue and that he took drugs, including cocaine and diazepam when he was drinking.

Following the first admission, Mr TU did not wish his nearest relative to be named person and his nearest relative was informed by nursing staff that Mr TU did not want information about his care to be shared with them. Nonetheless Mr TU's nearest relative continued to visit him regularly and spoke to nursing staff about their concerns. However, Mr TU's nearest relative stated at interview that after the first admission, they were not given any information about discharges or planned support after discharge and only contacted to be asked if they knew where Mr TU had gone after he had been discharged. The initial discharge planning meeting was the only contact Mr TU's nearest relative had with a doctor, and could not recall having had any contact with anyone from social work during the period from March to June 2018.

Mr TU's nearest relative told us that mental health services did not appreciate how rapid and devastating the change and deterioration in Mr TU's mental health had been, and they were concerned that information shared about this was not fully taken into account. Mr TU's nearest relative was not sure if the information shared with nursing staff was recorded in the notes.

We could not find any documentation of Mr TU's nearest relative's concerns in nursing notes nor at MDT or other medical review meetings. It is documented in the social circumstances report (SCR) (1 May 2018) that Mr TU "does not wish any contact with his family". The report also states that it had been reported by medical staff to the MHO that Mr TU's nearest relative was frightened of him. Whilst there is no documentation in clinical notes of Mr TU's nearest relative's concerns, it seems from the SCR that some information was passed to medical staff about this and this was subsequently discussed with the MHO.

It is documented on 2 May by Psychiatrist A that during a mental health assessment with MHO A, Mr TU told Psychiatrist A he had given up the tenancy of his flat and would be staying with his nearest relative when he left hospital, and Mr TU agreed that the MHO could contact his nearest relative for collateral information. There is no corresponding entry in the MHO notes for this date and no documentation of contact with Mr TU's nearest relative or reasons why this did not happen.

There is no other mention in the case notes that Mr TU's nearest relative was frightened of Mr TU but on the day of discharge (admission four, 1 June) it is documented that Mr TU advised hospital staff that he planned to stay with family or friends until he arranged his own accommodation.

The Royal College of Psychiatrists *Standards for Acute Inpatient Services Working-Age Adults (AIMS-WA) – 6th Edition* (standard 2.44) states that *"Carers are involved in discussion about patient's care and treatment and discharge planning."* This is a type 1 standard (type 1: criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment - to meet accreditation, the service must achieve 100% of these standards).

Under the Carers (Scotland) Act 2016, each health board must ensure that, before a cared-for person is discharged from hospital, it involves any carer of that person in the discharge. In NHS A's *Admission and Discharge Procedure – updated May 2019* under 'wellness planning', there is a prompt for staff to inform the carer or next of kin of discharge.

Regarding discharge planning, Mr TU's ambivalence to staff contacts with his nearest relative complicated this process. At interview, Psychiatrist A said they were concerned that contact with family, even to receive information only, where the patient has explicitly stated they do not want the family involved, can damage the therapeutic relationship.

The Royal College of Psychiatrists *Standards for Acute Inpatient Services Working-Age Adults (AIMS-WA) – 6th Edition* (section 2.49) states that *"Teams follow a protocol for responding to carers when a patient does not consent to their involvement – to ensure their concerns are recorded."* This is also a type 1 standard.

Where permission is not granted, the Mental Health (Care and Treatment) (Scotland) Act 2003 *Code of Practice* (Vol. 1, Chapter 11) states that *"the MHO should weigh up the advantages and disadvantages of over-riding these wishes"* (of the patient, for their carer/relative not to be contacted).

> *"This is a judgement call which should be discussed with the patient's RMO and other members of the multi-disciplinary team. Decisions will be informed by the nature of the relationship between the patient and the carer or relative; the nature of the illness and the impact on the behaviour of the patient; and the perceived potential value of the views of the relative or carer."*

However, as there was knowledge that Mr TU's nearest relative had reported previously feeling frightened of him, this should have been taken into account in considering contact with them and in discharge planning, particularly given his stated intention, at one point, to live with them. The changes in consultant staffing, impact on continuity and lack of MDT structure for some reviews is likely to have made this more difficult.

- The Mental Welfare Commission also has guidance on this issue – *Carers and confidentiality* (2018);
- as does the General Medical Council – *Confidentiality: good practice in handling patient information - ethical guidance*;
- and the Scottish Social Services Council – SSSC Codes of Practice.

3.2.6 Social circumstances report, May 2018

The Mental Welfare Commission has recently updated its good practice guide, *Social Circumstances Reports* (2022) which states that:

> *"The Mental Health Act 2003: Code of Practice (Volume 1) highlights the importance of SCRs to RMOs in relation to assessment, participation of relevant others and future care planning.*

The SCR is an extremely important document which should examine the interaction of an individual's social and family circumstances with their mental health condition. It will comment on issues that the MHO feels will need to be addressed when planning care and treatment. It gives the MHO an opportunity to secure vital information from carers, who may play a crucial role in the future care and support of the individual. It is also an opportunity to offer information and support to carers.

Risk assessment and management plans should be considered as part of this process not just in relation to the compulsion itself and the 2003 criteria but also in terms of looking at alternatives to detention in hospital and how risk will be managed at home. The SCR should not be viewed as an end, but as part of an ongoing process of working with an individual, their carers, and the multidisciplinary team to assist the recovery of the individual.

An SCR will record and impart crucial information and will aid communication with the multidisciplinary team.

In discussions with RMOs, all RMOs stated that a good SCR, which includes detail on social and personal circumstances, is an invaluable tool."

The SCR completed in May 2018 briefly refers to risks but does not have any information about any offending or forensic issues. By the time the SCR was written, on 1 May 2018, there had been six adult protection concerns completed and sent to the local authority by the police. Four of these probably related to the situations when the police were involved and Mr TU was taken to hospital and detained, but at least two of them are likely to be related to other situations when the police were involved and sent police concern reports into the adult support and protection team. The SCR would have been more useful had this detail been included and fully taken into account.

The SCR notes information from medical staff that Mr TU's nearest relative was frightened of him and that he had (at the time of the report) refused consent to contact the family.

At a time when there had been a number of changes of RMO, the role of the MHO was particularly important in providing continuity, ensuring that family views were considered where possible and taking a pro-active role in advising Mr TU about accommodation issues once he had given up his flat. See section above on involving the family.

A separate issue is that the SCR was apparently accompanied by a letter to the Commission which asks the Commission to take notice of the report. There is no copy of this letter on the Commission's records, but there may have been an administrative error at the Commission which separated the letter from the SCR when it came into the Commission. Our good practice guidance does explicitly say that *"The Commission reads SCRs as soon as we receive them if directed to do so by a covering letter from the MHO."*

We ask MHOs to flag up to the Commission where they have specific concerns about a case. The contents of the letter on this occasion are non-specific, asking the Commission to note the contents of the SCR. It seems likely in this case that the MHO wanted to alert the Commission to the fact that there had been four detentions in hospital in a relatively short period of time.

3.3 Risk assessment and discharge planning documentation

NHS A's *Admissions to and Discharges from* document states that risks should be assessed, and a risk management plan completed within two hours of admission. There is a prompt in the 'MDT meeting' document to review risks and to document an updated plan.

Appendix 1 of the *Admission to and Discharges from* document states that when assessing risk, both historical and current risk factors are considered, risk assessment should be developed in collaboration with the patient, carer and others.

It would be helpful to have prompts to include relevant risk factors including substance misuse, non-engagement and non-compliance about risk of future violence and for space in the document to describe how the risk management plan will address these issues. Staff should have training to ensure they are aware of these risk factors.

The *Admissions to and Discharges from* document does include a prompt to complete a 'Consent to sharing information form' and the 'MDT review meeting' template includes a reference to 'Family considerations' which prompts staff to consider any child or family protection issues. It would be helpful if this could be expanded to include adult and public protection concerns and a review of consent to sharing information, particularly where this has been previously refused. NHS A should consider developing a protocol for responding to carers when a patient does not consent to their involvement – to ensure their views are heard and concerns are recorded.

The MDT review form prompts the user to consider whether the discharge is uncomplicated and to consider MDT discussion before discharge where there are more than six medications. There is a further prompt that when there are anticipated requirements for an increase in the care package or the patient/family are expressing concern about discharge, this is labelled a 'Complex Discharge' and a 'complex discharge plan' should be initiated. There is no further information about this.

There is also a checklist for discharges which includes confirming that the patient's accommodation is ready for discharge. There is no prompt to update the risk assessment prior to discharge in this checklist but Appendix 1 states that *"community health teams play a core role in support on discharge"*, *"Information on inpatient care and current risk assessment and management plan should be available to all involved in the discharge planning process,"* and that *"discharge planning incorporates current/ongoing risk assessment and management plans."*

NHS A should consider including previous failed discharges and transfer of care on discharge as additional indicators of a 'complex discharge' process which requires additional MDT discussion and planning.

4. Findings area 3: unexpected liberation from prison

Mr TU was seen by Forensic Psychiatrist B for review on 4 December 2019 when he was assessed to be free from any symptoms of anxiety or psychosis. Mr TU was a prisoner on remand at that time and he was then liberated from prison after a court appearance on 6 December 2019 (Friday). Mr TU was released without an arranged support package and with no accommodation despite the recognition by forensic services that substance misuse service input and the provision of housing were likely to reduce the risk of further re-offending. Mr TU had not expected to be released on 6 December but instead expected to receive a further custodial sentence and informed clinical services (forensic psychiatry and Psychologist A) of this.

After court, Mr TU was taken back to prison to collect his belongings but had no accommodation to go to. He was seen by a mental health nurse in prison before he left with his belongings. Medication at that time was Pregabalin, Buspirone and Diazepam for treatment of anxiety and Zopiclone to help with sleep. The nurse managed to arrange a seven-day prescription but said he was upset as he did not know where he would stay. Mr TU indicated he would present himself at housing where he had previously been allocated homeless accommodation, but that he did not know if they would be open (late on a Friday afternoon). The nurse emailed the psychiatrist who assessed Mr TU on 4 December, and they replied to say that they would try to establish contact with him later, although no specific plan/date was made at that time.

Mr TU subsequently reported that he had spent some time walking around the city centre and at some point, was offered and consumed cocaine. He went to a club where he met the victim, previously a stranger to him. Later, having failed to secure accommodation for Mr TU, they went to the victim's house where the homicide occurred.

NHS A's SAER found that system failure did contribute to the outcome due to the court "decision to precipitously liberate Mr TU from court on a Friday afternoon" without support and no accommodation to go to. The NHS A action plan was that NHS A should engage with any ongoing discussions with Prison A regarding care provision for vulnerable individuals precipitously liberated from prison.

The investigating team received feedback from NHS A service manager for inpatient and specialist services in April that the action plan had now been signed off as completed by NHS A. NHS A had met with Prison A management to discuss the learning from the SAER. *"A Standard Operating procedure is going to be created regarding communicating to the community services around prisoners getting released early from prison."* Prison A will now take this forward.

The investigating team spoke to the Head of Justice, Scottish Prison Service about Mr TU's liberation from prison A who commented that the SPS Throughcare Support Service was suspended on 13 September 2019. This was temporary in response to operational pressures which had necessitated redeployment of operational prison staff delivering the service. A commitment was made that this would be kept under regular review.

Community justice social work (CJSW) within each local authority area continue to provide statutory Throughcare services alongside voluntary Throughcare. Everyone remanded or sentenced to custody is entitled to a Throughcare service from community justice social work. Voluntary assistance applies to those who are not subject to statutory supervision.

Following the suspension of the SPS Throughcare Service, New Routes, Shine and Moving On PSPs, which provide voluntary Throughcare and mentoring services for those serving non statutory sentences, were provided with additional funding by Scottish Government (SG) to expand their services in order to maintain a comparable Throughcare provision for those leaving our care.

Community Justice Scotland and Scottish Government are currently exploring the provision of non-statutory, voluntary Throughcare and mentoring services across Scotland for individuals serving short term prison sentences of up to four years. The new model will not be in place until April 2024.

While SPS is aware that there are inconsistencies and service gaps for particular groups within the prison population who are not catered for through the current provision, these are being reviewed by Community Justice Scotland and Scottish Government.

The investigating team contacted Scottish Prison Service on 8 April 2022 with reference to the SHORE standards. These are the Scottish quality standards for the provision of housing advice, information and support for people on remand or serving a short-term sentence. On reviewing the SHORE standards, we could not find any reference to a standard for those prisoners whose release from prison is unexpected.

Scottish Prison Service responded that the SHORE Standards were developed collaboratively with a range of partners, including Scottish Government during 2017 for people in and leaving prison. A number of groups and organisations were consulted on the draft. During the SHORE consultation process, people being unexpectedly released was not highlighted as a specific issue. However, it was recognised at the time that there should be standards for people in other parts of the justice system such as On Arrest and At Court. These were identified as areas for future strategic development.

As part of the work to implement SHORE, SPS developed a data sharing agreement with local authorities, on behalf of community justice partnerships, which enabled us to share details of all admissions, liberations scheduled over the next 12 weeks, and liberations over the preceding week. Social work services also receive the liberation data. This assists them to sustain tenancies where possible and carry out preventative planning for those nearing liberation. All local authorities signed up to this prior to 30 April 2020.

However, it is recognised that those liberated unexpectedly do not appear on the scheduled liberation reports. SPS cannot predict when someone will be liberated from court or will receive a backdated sentence, which may require them to be immediately released on return from court the same day. While local authority housing and social work services will be aware that these individuals are in custody and should start engagement/planning at an early stage, they may not have been able to engage prior to release when this happens. The SHORE standards aim is to avoid people being liberated without anywhere to go but on the occasion that this does happen individuals are advised to contact the local housing office on release.

The Scottish Government currently chair the SHORE Review steering group, which includes SPS, and will shortly be undertaking a revision of the SHORE standards with partners.

The investigating team note that regarding Mr TU, accommodation issues had been recognised by forensic services during hospital admissions five and six as a modifiable risk factor for non-engagement and future violence.

Prior to Mr TU's earlier, planned release from prison in September 2019, Psychologist A had a leading role in co-ordinating a support plan for Mr TU:

> *From July 2019, Mr TU had weekly psychology appointments with an emphasis on developing a 'Staying well' plan, identifying issues to support a stable lifestyle e.g., housing, daily structure, identifying triggers to mental health deterioration and substance misuse and developing a strategy to support stability. An appointment was made with housing and there was planning for community psychology follow up post liberation in September.*
>
> *Mr TU was not keen to engage with psychiatry but initially did want to follow up with SMS. Psychologist A submitted an application for a community care grant, discussed with the prison GP regarding hypnotic medication for night-time anxiety at Mr TU's request, emailed and spoke to housing, sent a letter requesting accommodation to support Mr TU's attendance at community SMS and psychology appointments and arranged a job centre appointment.*
>
> *Psychologist A discussed a coping plan in the community with Mr TU. A care plan was completed in prison prior to liberation with clear actions to meet identified needs and to transfer supports to the community, including mental health and substance misuse services.*
>
> *A detailed liberation plan was drawn up with information about accommodation in local authority A, specifically how all supports were to be accessed, and information about community appointments with services. The plan notes that Mr TU was now unsure if he wished to engage with substance misuse services. Mr TU had an appointment with SMS in prison a week before his expected date of liberation. The use of Antabuse medication was discussed but Mr TU did not feel it would benefit him or prevent him from drinking alcohol. It was left open that he could consider this treatment option in the community.*
>
> *At the final psychology appointment prior to liberation, there remained uncertainty about whether housing would be offered to Mr TU by the local authority. The coping plan was reviewed, including a plan for the day of release and weekend to support managing the risk of substance misuse. Community psychology and psychiatry appointments were made for the next two weeks, a list of appointments was made for liberation including housing, GP, job centre, key collection for immediate accommodation. A benefits application was completed. Mr TU was now not keen to engage with SMS – nonetheless he was provided with information on telephone contact and SMS drop-in clinics in the community.*

Despite these interventions and detailed care package made available to Mr TU on his release, prison health records note that he was liberated from prison on 13 September to homeless accommodation and was re-arrested and returned to prison on 14 September after being involved in alleged assaults in a pub and offences towards police officers.

In the view of the investigating team, based on the events in September described above, even if Mr TU had been provided with accommodation and support on his release from prison on 6 December, there was still a high risk that Mr TU would have returned to substance misuse and potentially to further violence. However, the more specific risk to the victim might have been avoided if Mr TU had accommodation to return to that night.

5. Findings area 4: concerns raised by the victim's family, Mr TU (perpetrator) and Mr TU's nearest relative

5.1 Risk assessment

1. Mr TU had several very brief admissions to hospital within a short period of time in 2018 and he had been displaying threatening or aggressive behaviour before some of these admissions. Was the care given by the hospital appropriate?

The psychotic symptoms Mr TU was affected by in 2018 were linked to use of alcohol and illicit drugs and these symptoms were usually short lived – this is why Mr TU's symptoms appeared to settle quickly whilst he was in hospital and low dose antipsychotic medication may have contributed to this. Nonetheless, the investigation found that whilst there was a great deal of evidence of good quality care, there were learning issues around how risks were assessed and managed described in detail in this report.

2. Mr TU had missed follow-up appointments after discharge from hospital. Were the missed appointments followed up? "If a person has been violent with drug, alcohol, or mental health issues, they should be monitored for a length of time until they adjust into society. I would think even having to receive depot medication to make sure they are taking their medication."

Mr TU was readmitted to hospital shortly after the first two admissions. The investigation found that more intensive follow up of Mr TU should have been considered following the third and fourth admissions in 2018. Mr TU was ambivalent about taking medication and did not comply with medication post discharge. Giving medication against someone's will should only happen when that individual is detained under the Mental Health Act.

3. Prior to the fourth hospital admission in April 2018, the police were called at 5.00am as Mr TU was smashing a glass internal door with a screwdriver. Police arrived; then the on-call out-of-hours (OOH) primary care service. Both parties had been in the flat. Mr TU was left and went on to threaten his neighbour with the screwdriver.

Why did the police not secure his property? Why did the doctor not see he was obviously out of control? Why was he not taken in then by police for smashing an internal door with a screwdriver, a neighbour was concerned enough to call the police? What did the doctor do?

The Commission currently does not have a data sharing agreement with the police and so we could not investigate the role of the police at this time – this will be taken forward by the Commission as learning from this investigation.

The Commission will also ask that primary care services in Area A review the response by OOH services to this referral and inform the family of the outcome of its review.

4. When Mr TU was admitted to hospital on 7 May 2019 after he had been assaulted, he told staff that he would harm someone, but he was allowed to leave hospital despite having said this.

The investigation found that in the view of the clinical team at that time, Mr TU was not mentally ill and so was responsible for his actions. The police were informed of Mr TU's discharge and of his threats to harm others.

5. Why did the various authorities repeatedly fail to identify Mr TU was a serious threat to both himself and others?

The investigation found that there was awareness of the risk that Mr TU posed, in particular to others. Whilst there was learning identified during the investigation for mental health and prison services that may have partially mitigated these risks, the risk of harm to others could not have been removed completely.

Currently the Commission does not have access to data from police records and so were not able to explore communication and joint working between the police and mental health services. One of the reasons for this pilot investigation is to identify what needs to change in order for thorough multiagency investigations to be carried out. Ensuring that data can be shared between the police and the Commission is an area we have identified from this investigation.

5.2 Discharge from hospital and prison

6. When discharged from hospital following the second admission, Mr TU did not have a place to go to as he had been evicted from his flat. Was there social work involvement? Should this have happened?

Mr TU had accommodation to return to after the first three admissions but gave up his tenancy at the beginning of the fourth admission. He was discharged following the fourth admission without accommodation but said that he did have money to provide himself with private accommodation. Mr TU had also said to staff on at least two occasions that he intended to stay with his nearest relative, or between his nearest relative and friends until he could organise other accommodation. However, the investigation did find that there should have been further consideration of the lack of housing prior to discharge.

7. Mr TU said that after one discharge from hospital he had no accommodation to go to, and he ended up sleeping rough outside.

It is documented that on discharge from hospital on 1 June 2018, Mr TU was homeless, but that Mr TU stated he had the means to rent accommodation. Mr TU stated he planned to stay with friends or family until he arranged his own accommodation.

However, the investigation found that the clinical team should have further considered accommodation options for Mr TU prior to his discharge.

8. Inpatient assessment did not take full account of needs. On occasion, Mr TU was discharged from hospital too quickly, without account being taken of how unwilling he was to accept support and that he had been admitted repeatedly.

The investigation found that whilst there was evidence of good quality care, there were learning issues around how risks were assessed and managed and that more intensive support for Mr TU should have been considered by the clinical team particularly after the third and fourth admissions to Hospital A.

9. Mr TU was released unexpectedly from prison the day before the incident. He was apparently distressed about being released, and he had no accommodation to go to. Why did this happen?

The investigation has found that there are recognised gaps in 'Throughcare' provision for prisoners on remand. There is currently a review of these gaps in service provision underway by the Scottish Government and partners.

NHS A has been involved in discussion with Prison A about the learning from this incident. Prison A will review the process where there is unexpected liberation of prisoners and will introduce a standardised procedure to improve the support given at these times.

Evidence from a previous planned release when Mr TU was provided with accommodation and a comprehensive support package, suggests that even with support in place, there was a high risk of Mr TU re-offending.

10. There was an unexpected liberation from court without support; concern was expressed that Mr TU was liberated from court immediately prior to the incident when he was emotionally vulnerable and pleading for help with no support and with no bed for the night.

The investigation found that there are recognised gaps in 'Throughcare' provision for prisoners on remand. There is currently a review of gaps in service provision underway by the Scottish Government and partners.

Prison A will review the process for prisoners unexpectedly liberated from prison and introduce a standardised procedure to improve the support given at these times.

These issues are further addressed in the conclusions section of this report and in recommendations for the Scottish Government and others.

5.3 Treatment

11. Why was Mr TU being seen by a psychiatrist in prison if he wasn't mentally ill?

Whilst the hospital admission under an assessment order in 2019 indicated that Mr TU did not have an underlying psychotic illness, it would be usual practice given Mr TU's history to monitor his mental state and provide support as he required it in prison. In prison, Mr TU's symptoms were principally anxiety based and at the time he was liberated he was being treated for an anxiety disorder. The investigation concluded

that Mr TU was appropriately monitored by forensic psychiatry and psychology services whilst in prison.

12. At the time Mr TU was admitted to hospital from prison in January 2019 on an assessment order, he was told he would get psychology support if he went to prison but Mr TU states this did not happen.

The investigation found that Mr TU did not receive psychology support following his return to prison in February 2019 and his liberation on 3 May. However, Mr TU did have regular psychology support after his return to prison in May 2019 until the incident.

13. Regarding his fourth admissions in 2018, Mr TU said that he was very paranoid, and that he could have been given more support than he was offered each time he was discharged. In his view, during the periods he was in hospital there was more emphasis on making a diagnosis than on offering any help or treatment. He believes he was traumatised after events on holiday in 2017, but that staff in hospital had preconceived ideas about his symptoms.

The investigation found that Mr TU's care and treatment was of good quality in general and that account was taken of Mr TU's experiences abroad. Mr TU appealed against his detention in hospital on two of the four admissions and was keen for discharge as soon as possible during all four admissions. Following discharge, Mr TU was offered follow up by both psychiatry and substance misuse services following all four admissions however was readmitted following the first two admissions before these appointments. Mr TU also undertook to organise and to attend private psychology appointments following discharge after the third and fourth admissions. Mr TU refused follow-up by substance misuse services during his third admission and failed to attend outpatient follow up or to comply with prescribed medication following discharge from the third and fourth admission.

However, the investigation did conclude that more intensive support for Mr TU should have been considered by the clinical team after the third and fourth admissions to Hospital A because of the risk and the previous failed discharges.

14. Mr TU said that prior to his release from prison in 2019 he had requested Antabuse but that this had not happened.

It is documented that the use of Antabuse was discussed with Mr TU in September 2019 prior to his release from prison but that he did not feel it would benefit him or prevent him from drinking. It was left open to Mr TU to consider this treatment option following liberation.

5.4 Family involvement

15. The service did not take full account of family concerns. Mental health services did not appreciate how rapid and devastating the change and deterioration in Mr TU's mental health had been, and information shared about this by Mr TU's nearest relative was not fully taken into account. Mr TU's nearest relative was not sure if the information shared with nursing staff was recorded in the notes.

The investigation team could not find any documentation of Mr TU's nearest relative's concerns by nursing staff. It was documented in the SCR that medical staff reported that Mr TU's nearest relative was frightened of him, but this did not appear to be taken into account when Mr TU was discharged from hospital, possibly to stay with his nearest relative.

The investigation concluded that the service did not take full account of Mr TU's nearest relative's concerns.

16. The service did not sufficiently involve family in care.

After the first admission, when Mr TU's nearest relative participated in a discharge planning meeting, they were not given any information about discharges or planned support and only contacted to be asked if they knew where Mr TU had gone after he had been discharged. This initial discharge planning meeting was the only contact Mr TU's nearest relative had with a doctor.

Mr TU's nearest relative could not recall having had any contact with anyone from social work during the period from March to June 2018.

The release of information by hospital staff to Mr TU's nearest relative was complicated by Mr TU's ambivalence to involve his nearest relative in his care. However, this was not documented systematically and an opportunity to discuss care with Mr TU's nearest relative prior to discharge in June 2018 was missed. If Mr TU's nearest relative's concerns had been taken full account of, the service should have over-ridden Mr TU's refusal to allow contact with his nearest relative at the point of discharge from hospital in June.

6. Conclusions

The investigation concluded that, following Mr TU's unexpected release from prison in December 2019, although a support package and accommodation may have reduced the likelihood of further offending, evidence from a planned liberation in September 2019 indicated that even with a comprehensive support package in place and with accommodation provided, Mr TU rapidly re-offended, was rearrested and returned to prison. However, if Mr TU had been offered accommodation in December 2019 this is likely to have reduced the risk to the specific victim who invited him to his home because of his lack of accommodation.

The organisation of 'Throughcare' services for prisoners is complex, involving several agencies. The provision of Throughcare services is under review by the Scottish Government together with Community Justice Scotland. It is anticipated that a new model for care will be in place by April 2024. A gap in services for prisoners on remand was previously identified in the Commission's themed visit report, *Mental health support in Scotland's prisons 2021* (published April 2022).

SHORE (Sustainable Housing on Release for Everyone) standards do not address this issue at all. The Scottish Government is leading a review of these standards with an estimated completion date of 2024.

Prison A has undertaken to develop a standardised approach to the management of remand prisoners who are unexpectedly liberated from prison.

Many aspects of the care Mr TU received from NHS A services in 2018 were of high quality. There were however aspects of that care, including how risks were assessed and managed and the involvement of Mr TU's nearest relative, which if acted on, might have mitigated the risk of violence when he was discharged from inpatient care in June 2018. The lack of consistency of senior medical staff and the fragmented nature of each psychiatrist's involvement in May 2018 is also likely to have impacted on the assessment and management of risk as reviews happened out with the usual multidisciplinary team (MDT) support structure. The Commission's visits to NHS A had previously reported on difficulties recruiting to senior clinical posts and the impact on continuity of care.

However, whilst the risk could have been mitigated at that time, further violence could not have been prevented with any certainty.

6.1 Learning points

- In recognition of the complexities involved, the Commission produced good practice guidance in relation to drug induced psychosis (*Drug induced psychosis and the law*, 2022) which states:

  > *"Use of, or dependence on, alcohol or drugs does not in itself constitute mental disorder. Mental illness that results from drug or alcohol use, or accompanies it, is a mental disorder under the 2003 Act. ... Based on all the available evidence, we consider that drug induced psychosis is a mental illness. The suspicion that psychotic symptoms may have resulted from drug use should not, in itself, be a factor in deciding whether or not this criterion for determining the use or not of the Act is met."*

- All MDT staff should be aware of the links between violence, substance misuse and non-compliance and non-engagement with services.
- All staff should be aware that discharge from hospital is a high-risk point in care and this should be reflected in comprehensive, inclusive discharge planning.
- All staff should take full account of implications of discharges from hospital on a Friday afternoon where there are limited supports available at weekends.
- There should be clear mechanisms to seek a second opinion where needed. The Care Programme Approach (CPA) should be considered where a person is unable or unwilling to engage with care, putting themselves or others at risk OR where the MDT have not agreed a collective way forward to manage risk or promote a person's wellbeing. This approach ensures a clear care plan and care coordinator. Its use has been advocated by the Commission (*Preparation of care plans for people subject to compulsory care and treatment*, 2021).
- All staff should be aware of the importance of "*consulting with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans*".
  (*Safer services: A toolkit for specialist mental health services and primary care*, The National Confidential Inquiry into Suicide and Safety in Mental Health, NCISH/The University of Manchester, 2022).
- Nursing staff should be reminded that all family contacts should be documented, and any concerns raised by the family should be documented and discussed at MDT reviews.
- Where staff have concerns about patient care they should discuss this with senior staff and where appropriate seek advice from the Mental Welfare Commission
- There is an implicit requirement in the 2003 Act to have the mental health officer and responsible medical officer work together to communicate in advance of a tribunal. In this case there was a difference of views between the mental health officer, as applicant, and the responsible medical officer about whether the individual had a diagnosed mental illness which met the criteria for detention.

7. Recommendations

7.1 Recommendations for HSCP/NHS A

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.
2. HSCP/NHS A should carry out a review of the risk assessment and risk management paperwork and undertake an audit to ensure processes are understood and followed.
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.
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.
5. HSCP/NHS A should design a protocol for when patients refuse consent to share information with family/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 over-ridden by services in the interests of safety either to the patient or to others.
6. HSCP A should carry out regular audit of the quality of social circumstances reports as required by standard 7 of the National Standards for Mental Health Officer Services.

7.2 Recommendations for Scottish Government

The purpose of the SHORE standards should be to ensure that everyone has suitable accommodation to go to on the day that they are released from custody. The gap in these standards should be addressed by the Scottish Government in its review of these standards.

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).

8. Appendix: Glossary of terms

2000 Act: see 'AWI'.

2003 Act: the Mental Health (Care and Treatment) (Scotland) Act 2003.

Assessment order: an order granted by the court under the 1995 Act remanding an individual to be detained in hospital after charged with an offence.

AWI: the Adults with Incapacity (Scotland) Act 2000

CPSA: the Criminal Procedure (Scotland) Act 1995.

CTO: compulsory treatment order granted for up to six months in the first instance under the 2003 Act.

HSCP: health and social care partnerships. There are 31 health and social care partnerships in Scotland. Each health and social care partnership works towards a set of national health and wellbeing outcomes. All partnerships are responsible for adult social care, adult primary health care and unscheduled adult hospital care. Some are also responsible for children's services, homelessness and criminal justice social work.

IPCU: intensive psychiatric care unit provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation.

MDT: a multidisciplinary team is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users.

MHTS: the Mental Health Tribunal for Scotland discharges its functions through panels of three members: a legal member (who acts as Convener), a medical member and a general member. The judicial arm of the Tribunal is supported in its functions by the staff of the Scottish Courts and Tribunals Service (SCTS).

Named person: a named person is someone who can look after your interests if you are cared for or treated under mental health legislation.

SCR: a social circumstances report is a document prepared by a mental health officer within 21 days of a person being detained under a STDC that provides an account of the circumstances of the person who is detained under a STDC. Other detention events also can require the preparation of an SCR; the most common detention requiring this is a STDC. These reports provide information about the interaction between a person's mental disorder and their personal and social circumstances, the MHO's views on the use of compulsory powers, the alternatives that might be available to compulsory treatment and other relevant factors that might help an RMO and treatment team in delivering care and treatment to the individual and the Commission in discharging its duties under the Act.

STDC: short-term detention certificate granted for up to 28 days under the 2003 Act.

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