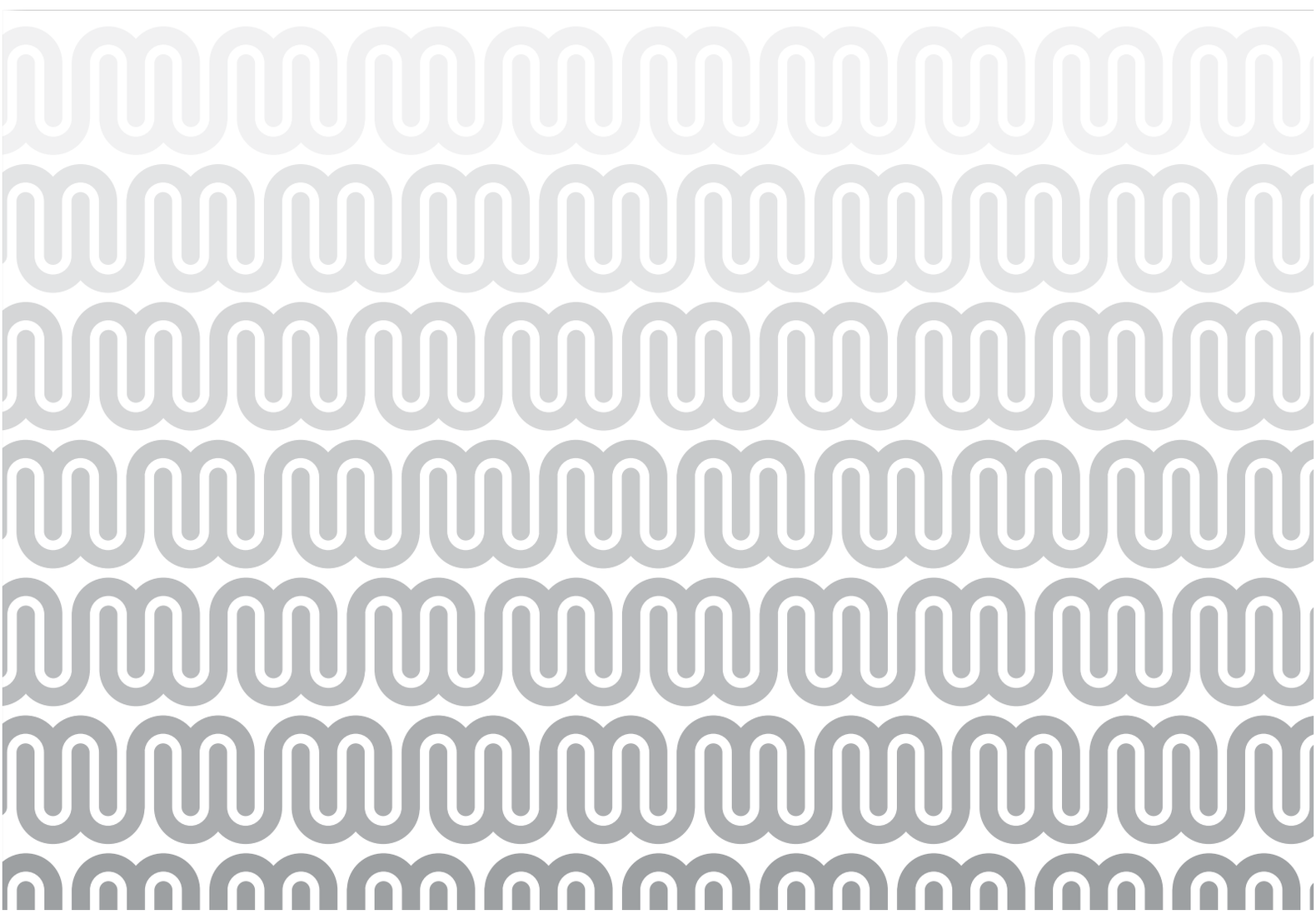
mental welfare
commission for scotland

Investigation into the death of AB

Investigations

August 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

This report is an investigation into the circumstances leading up to the death of an individual (AB) with a moderate learning disability whose death occurred shortly after their detention under the Mental Health (Care and Treatment) Scotland Act 2003 was revoked. AB was also subject to Adult Support and Protection (Scotland) Act 2007 procedures.

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

The subjects, geographical location and other features which could identify individuals have been anonymised in order to protect confidentiality in relation to vulnerable individuals, both living and deceased. However, relevant local authorities and health boards as well as Police Scotland are aware of the identity of the individuals and have been made aware of the Commission's report, findings and recommendations.

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

Contents

Executive summary

AB was a middle-aged adult with mild to moderate learning disability who died in an orthopaedic rehabilitation ward the day after their detention in hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003 ended. AB had a number of ongoing serious physical health issues for which they had received treatment. AB's final admission to hospital followed a fall from which there had been a debilitating fracture. AB's rehabilitation from this injury was compromised and AB died from organ failure secondary to sepsis associated with skin ulceration.

This review of AB's care centres on the five-year period before their death during which time they had been the subject of three Adult Support and Protection (Scotland) Act 2007 (the ASP 2007 Act) investigations and had been twice detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act), the latter detention ending the day before AB's death.

The first adult support and protection (ASP) investigation began in 2014 when concerns for AB first came to light. It emerged AB had become estranged from their family in the 1990s and left their home area in the company of a friend, CD, who subsequently presented to agencies and authorities as AB's relative and carer. There were difficulties taking forward the initial ASP investigation. Recognising that AB had already moved area with CD, social work were concerned that they would move again and attempts to find out more about AB would be limited further. Social work concluded there was insufficient information to confirm if AB was an adult at risk of harm and a letter was sent to their family advising there were no acute concerns but that no further details could be disclosed.

A second ASP investigation ran for an eight month period between 2015 and 2016. This followed almost immediately after concerns were raised about another individual with whom CD had contact and alleged to be the individual's carer. This person, XY, also cut ties with their family. This second ASP investigation concluded that AB was a vulnerable adult who might be unable to safeguard themselves and was at risk of harm. It proved difficult to find a place of safety and arrange a removal order under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) in order to fully assess AB's circumstances. During this period of investigation, AB's physical health required prioritisation before plans for an unannounced home visit could be progressed. This visit was thwarted due to AB having been admitted urgently to an acute hospital high dependency unit due to acute illness. While AB was an inpatient, ward staff expressed concerns about CD's odd and sometimes hostile behaviour. CD was said to interfere with the potential for AB to engage fully with the ward staff around their treatment plan to the extent that CD was found to have brought in unsuitable food, brought their pet into the ward and encouraged AB to refuse personal care. An emergency ASP professionals meeting agreed further assessment was necessary given the evidence of apparent neglect or self-neglect. Plans were developed for AB's admission under a short term detention certificate (STDC) to the local psychiatric hospital. AB discharged themselves from the acute hospital against medical advice and the detention in the psychiatric hospital learning disability unit was initiated six days later when an inpatient bed became available. In the meantime, a solicitor engaged by AB and CD challenged, by letter, the

need for visits by social workers and the social work department's grounds for questioning CD's care of AB.

AB spent just over four weeks in the psychiatric hospital learning disability unit. The solicitor engaged by AB and CD made a formal complaint about the admission and appealed the STDC, although this was unsuccessful when heard by the Mental Health Tribunal. Observations of AB at this stage were that they were accepting of medication but had no knowledge of what foods they should be eating. CD was found to have been bringing in unsuitable food to AB. The ward staff arranged for required health related assessments to be carried out and observed that AB was more hostile towards them and resistant to their care after visits from CD. A case conference in the latter half of AB's detention considered the potential for seeking a compulsory treatment order (CTO) or a guardianship order. AB's lack of capacity in relation to managing their physical health condition, personal care and the investigation of an acute health concern was confirmed by the consultant learning disability psychiatrist (who was also AB's responsible medical officer - RMO). The inpatient team noted the relationship between AB and CD was such that there were potential risks to AB if separated completely from CD. A recommendation was made that joint living with a degree of supervision might be the best way forward. There was concern about the role of CD as AB's named person under section 255 of the 2003 Act but, as the STDC was not followed with a compulsory treatment order (CTO), no further steps were taken to formally remove CD as named person. There were difficulties with a welfare guardianship application as the necessary second medical opinion along with that of AB's RMO could not be obtained during the inpatient period under the STDC. AB would not speak with the GP who visited, the ward junior doctor was inexperienced, and a request made by the RMO to other colleagues was not taken up. Once the STDC expired and AB was discharged, AB's care plan followed the ASP protection plan which had been drawn up. However, it quickly became apparent this wasn't working. Although by the middle of 2016 at an ASP case conference when it was agreed that AB met criteria as an adult at risk of harm, the decision was taken to discharge AB from ASP, suspend the guardianship application, and switch to multi-disciplinary review under the Care Programme Approach (CPA). The view was it was better to maintain supervision of AB's circumstances in a low key way involving fewer rather than more professionals. Neither AB nor CD attended any CPA meetings and their solicitor continued to correspond with social work on their behalf saying they felt hounded. AB's case was closed by social work in the middle of 2017 after positive updates from the primary care nurse, housing officer and GP.

Just over a year later, AB was admitted to the acute hospital orthopaedic ward having sustained a fracture in a fall. AB required transfer to an orthopaedic rehabilitation hospital but objected to this, although the move took place after a multi-disciplinary team meeting at which the necessity of the transfer was re-affirmed. For the first week in the rehabilitation ward, AB evaded or refused assessment by the onsite doctor. CD, who was by this stage AB's financial and welfare power of attorney (PoA), frequently removed AB from the ward and AB missed out on opportunities for physiotherapy. Interference with AB's medication and physical healthcare also occurred, although it remained uncertain who was responsible for this. Towards the end of 2018, AB was detained under a STDC following the intervention of liaison psychiatry in response to the deterioration in their physical and mental health. CD had been granted PoA at least a year before then and the plan was to involve CD in all discussions unless they were uncooperative.

The situation deteriorated and by early 2019 AB was made a specified person[1] under the 2003 Act, visiting restrictions were imposed on CD and evidence continued to emerge that CD was thwarting AB's much needed treatment. This familiar pattern persisted before an application for a compulsory treatment order (CTO) was made and granted on an interim basis and fully granted a month later. A local authority guardianship application was granted on an interim basis five days before AB's death. In the intervening weeks AB's physical health continued to fluctuate. AB's family were with AB in those final days having been contacted by social work.

Police Scotland were involved throughout all three ASP investigations. In the final days of AB's life, they took CD into custody on account of the behaviours reported by staff in the acute hospital. After AB's death, the procurator fiscal decided against prosecuting CD on charges of culpable and reckless conduct due to insufficient evidence of criminal intent. No significant adverse event or significant case review was carried out locally.

The purpose of this review was, in the absence of any other form of review, to examine in detail the care, treatment and support AB received in the five year period prior to their death with particular attention to their limited engagement with necessary physical health care and with other support services. Attention was also to be given to the adult support and protection processes, consideration of the use of welfare guardianship and the role of the PoA for AB under the Adults with Incapacity (Scotland) Act 2000 (AWI). The intention was to identify if there were any deficiencies of care and/or support of a systemic nature which could have contributed directly or indirectly to their death and from which lessons could be learned and recommendations for improvement made.

We interviewed a number of professionals involved with AB's care and support over the five year period of review. We accessed social work records, psychiatric notes, learning disability team notes, nursing and psychology records from January 2014 up to and following AB's death in early 2019.

The investigating team had access to mental health act paperwork both in the clinical records and in records held by the Commission. There were calls from health and social work to the Commission for advice and to inform the Commission of AB's death and of the actions taken at that point. We also viewed relevant policy and procedure documents for the health and social care partnership.

We spoke to AB's family representative at the outset of the investigation. They told us of AB's background and initial years with them before they saw the marked change when AB became associated with CD and subsequently relocated from their home area. They had concerns for AB's welfare because of their known learning disability and vulnerability to influence. They had tried to find and reconnect with AB but were unsuccessful. They described their concerns about AB's treatment and care. They found it difficult to understand why CD was so readily accepted as AB's carer and that they were not consulted.

[1] The designation of 'specified person' status to an individual detained in hospital under the 2003 Act enables authorising of restrictions on the individual's correspondence, use of telephones and also in relation to safety and security in hospitals

Key findings

Findings: Rights, risks and safeguards

- Had a welfare guardianship order been in place at an earlier stage, it might have proved possible to more effectively balance protecting AB and supporting both AB and CD.
- More could have been done to promote AB's safety during the inpatient stays by implementing consistent safeguards around visiting and better communication between services and ward teams about CD's influence on AB's care and treatment.

Findings: Impact of non-engagement with services

- The difficulty in engagement, and concern that AB and CD might leave the area, together with practical difficulties associated with assessing AB's capacity may have swayed decision-making away from proceeding with guardianship processes.
- AB's unwillingness to engage made capacity assessment difficult but no less important.

Findings: Learning from experience and communication

- AB was put at unnecessary risk because there was no learning from previous admissions. Professionals focussing on building engagement may have been too ready to believe the situation had changed for the better rather than recognise the re-emergence of unhelpful patterns.

Findings: Use and understanding of legislation

- The Commission's view is there was sufficient evidence for an application for a welfare guardianship order in 2016. This became more evident when there was no engagement by CD and AB in the CPA process.
- The inability to identify a second doctor timeously for a capacity assessment was a system failure.
- Care and treatment providers had the option to challenge CD's appointment as attorney through the Office of the Public Guardian, given the longstanding concerns about CD's care of, and influence over, AB and because the position as an attorney posed an added barrier for staff when considering how to respond to behaviours which put AB at risk of harm.
- The decision to make AB a specified person was appropriate but could have been enacted more promptly.
- Whilst adult support and protection legal interventions may not have fully addressed all concerns in this complex situation, we saw little recorded discussion of the concept of undue pressure, a lack of use of chronologies, and inconsistent protection plans and decision making.

- There was potential for use of Section 315 of the 2003 Act when CD's risk to AB became more overtly evident in the acute inpatient unit and at the point when Police charged CD with reckless conduct.
- There was potential for use of Section 317 of the 2003 Act which makes the obstruction of a person authorised in the Act a criminal offence. This could have been considered in relation to CD during AB's hospital admissions, for instance in 2019 under a CTO and at other times when treatment was authorised under the Act.
- At times we observed a lack of working knowledge by key professionals on aspects of the three key pieces of legislation and how they interacted.

Findings: failure to carry out a local review

The agencies providing care and support for AB had the option of raising the circumstances of AB's death with the adult protection committee with a view to conducting a significant case review (ASP learning review). This could have recommended further action including joint working with the NHS significant adverse event review process, which given AB's recent detention and difficulties with treatment provision, could also have been enacted.[2]

Conclusion

Although complex, there were several decision points over the five-year period reviewed when services were aware of concerns that AB could be at risk. Action taken at these times in response to improvements did not take into account previous learning. The focus was on immediate management rather than on longer term planning to secure AB's safety and health.

2 https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx

Recommendations

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.

NHS A and local authority A[3]

1. NHS A and local authority A will be asked to review their processes for deciding on when to initiate a local learning review ensuring that these meet the recommendations of the new Scottish Government Guidance for Adult Support and Protection Committees. [4]
2. NHS A and local authority A will be asked to ensure that staff are aware of the importance of reporting to the Office of the Public Guardian concerns about the appointment of an attorney by someone who may lack capacity to do so or be subject to undue influence, and of the local authority duty to investigate concerns about an attorney's exercise of functions. In addition, they will be asked to ensure that staff are aware of the ability of a person with an interest in the adult's affairs under AWI to seek an order from the sheriff regarding the operation of a power of attorney or revocation of the PoA.
3. NHS A and local authority A will be asked to provide training and support for social work and health staff on adult support and protections under the ASP 2007 Act, including identifying an adult at risk when in hospital and the powers available when there is difficulty with engaging with the adult who may be subject to undue influence. This is also to ensure that where there is inter-agency complexity and multi-site treatment provision a single person is the nominated lead for the case.
4. NHS A and local authority A will be asked to ensure that where guardianship applications are discontinued in preference for less restrictive case management arrangements that risk management planning includes trigger-points when guardianship should be reconsidered.
5. NHS A and local authority A will be asked to audit the effectiveness of their processes to monitor long term conditions management for people with learning disabilities.
6. NHS A will be asked to review medical records procedures in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003, including in general hospitals to ensure that the requirement to submit documents to the Commission is consistently met.

Recommendations nationally

7. Scottish Government will be asked to review the existing systems for obtaining second medical reports ahead of applications for guardianship orders and instigate steps to improve processes and monitor the impact on speed of access to medical reports across health boards, and health and social care partnerships.

[3] Whilst recommendations 1-6 are made to health board A and local authority A; the role of the health and social care partnership as the delivery arm is also critically important. Please see glossary page 54.

[4] Adult support and protection: learning review guidance - gov.scot (www.gov.scot)

Learning points

Learning points are not formal recommendations but points of best practice to be taken into consideration by all providers of mental health care, treatment and support.

- The concept of undue pressure introduced in the ASP 2007 Act can present dilemmas for professionals during the course of adult support and protection investigations. Such a dilemma occurred in this case. The Scottish Government's Code of Practice[5] details undue pressure. Public bodies (NHS boards and local authorities) may want to focus on undue pressure as part of their ASP learning and development programmes, particularly on what evidence of undue pressure can be presented to a court when seeking a protection order.
- Similar considerations apply to **coercive control or undue pressure**. In such situations the control exercised over a vulnerable person may render them **unable** to take or action decisions that would protect them from harm. It is therefore important to understand the person's decision-making processes. This should include an understanding of any factors which may have impinged on, or detracted from, their ability to make and action free and informed decisions to safeguard themselves. In these circumstances an affected person should be regarded as unable to safeguard themselves.
- Solicitors, when consulting with clients seeking to grant power of attorney, must fully consider their client's capacity to do so, if there is any undue influence or vulnerability and the proposed attorney's ability to fully comprehend their role. The Commission addressed this issue in a report published in 2012 *Mr and Mrs D*. In response the Law Society of Scotland introduced guidance for solicitors which remains current[6] [7]. The guidance for Rule B1:5 of the Law Society of Scotland Rules, notes that whilst the solicitor must satisfy themselves that a client has capacity, "if there is any doubt as to a client's capacity to instruct in a particular case (for example a client may have a profound learning disability), input should be sought from an appropriate professional".
- With the implementation of Mental Health (Scotland) Act 2015, named persons must be nominated and individuals need to have capacity to make a nomination[8]
- There is no absolute right to be allowed to visit an individual in hospital but this is balanced against the rights of the patient e.g. Article 8 ECHR – 'Right to respect for private and family life'. A statutory provision which could be used to prevent access by a visitor in a situation such as in this case is a Banning Order under section 19 of the ASP 2007 Act. This would be time-consuming but could be achieved. The health board could also go to court to seek an order under common law to prevent visits, and could seek an interim interdict pending a full case hearing.

The Care Programme Approach (CPA) to meeting health and social care needs for people with complex mental health problems or learning disability benefits from the agreement and participation of the individual involved if it is to meet the person-centred objectives associated

[5] Adult Support and Protection (Scotland) Act 2007: Code of Practice (www.gov.scot)
[6] Continuing and Welfare Powers of Attorney | Law Society of Scotland (lawscot.org.uk),
[7] B1.5: Vulnerable Clients Guidance | Law Society of Scotland (lawscot.org.uk)
[8] Mental health law in Scotland: guide to named persons - gov.scot (www.gov.scot)

with CPA, in addition to effecting multidisciplinary and multi-agency collaboration. CPA has no legislative basis but can be a useful framework for multidisciplinary work when a legislative framework such as the 2003 Act is in place. Care is required not to exclude individuals from other legislative processes which might be warranted and afford greater protection by more formalised risk management processes.

1. Introduction

This investigation into the care and treatment of AB was conducted under Section 11 of the Mental Health (Care and Treatment) Scotland Act 2003 by the Mental Welfare Commission for Scotland (the Commission).

Section 11 gives 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 or related condition may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

AB's case was identified for further investigation in September 2021 when the Commission's Deaths in Detention review team identified deaths of people with a learning disability as an area that required attention[9].

AB was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) for a number of weeks until the day before their death.

AB was a middle-aged adult with a mild to moderate learning disability who died in 2019 in an orthopaedic rehabilitation ward, following a fall in which they sustained a fracture. They had serious physical health issues and there were concerns about the involvement of the friend who presented variously as a relative and carer while AB was in hospital.

Just before AB's death their carer, CD, was charged with culpable and reckless conduct towards AB while in hospital, a charge that was subsequently dropped due to lack of evidence to support criminal intent. Concerns under the Adult Support and Protection (Scotland) Act 2007 (ASP 2007 Act) had been raised in the past in relation to the actions of CD towards both AB and towards another individual, XY. Concerns were raised again during AB's final hospital admission.

No Significant Adverse Event Review (SAER) or Significant Case Review (SCR) was carried out locally following AB's death, although an externally commissioned learning review of ASP processes had been conducted locally following XY's death some years before.

The Commission decided to investigate AB's death, and the wider context of their situation in the five years before their death. We wanted to find out whether AB received the right care, treatment and support, and whether there were any systems issues which could have contributed directly or indirectly to their death.

The specific terms of reference for the review were;

- To examine in detail the care, treatment and support that AB received in the five year period prior to their death.
- With particular attention to: AB's limited engagement with physical health care and with learning disability services; adult support and protection processes; consideration of welfare guardianship under the Adults with Incapacity (Scotland) Act 2000 (AWI).

[9] Full details can be found at; Deaths in detention reviews | Mental Welfare Commission for Scotland (mwcscot.org.uk)

1.1. Focus and lines of enquiry

The purpose of this investigation was to investigate the care, treatment and support given to AB by the NHS, local authority and health and social care partnership from early 2014 until their death in 2019, particularly:

- The use of the AWI 2000 Act including the reasons for not following through the application for a welfare guardianship order in 2016.
- The decision-making processes in relation to the balance between respecting privacy and the right to choose and the duty to safeguard and protect under adult support and protection legislation.
- The actions taken to address the serious issues with interference in AB's hospital care during their orthopaedic admission in November 2018.
- Whether appropriate interventions were timeously considered.
- Why there was no local significant case review or significant adverse event review following AB's death.
- Why notification requirements on revocation of AB's detention were not followed.
- To identify any lessons to be learned both locally and nationally.
- To make recommendations as appropriate.

1.2. Investigation process

The investigation team had access to social work records, psychiatric, learning disability, nursing and psychology records from January 2014 up to and following AB's death in 2019.

We accessed the local authority adult support and protection procedure documentation, and the NHS board's Interagency Policy and Procedure for the Support and Protection of Adults at Risk of Harm, the NHS board Policy for the Management of and Learning from Adverse Events and Feedback and the Mental Health and Learning Disability Services review.

We spoke with a family representative to identify family concerns.

Having considered the records, we interviewed the following professionals involved in AB's care:

- Consultant learning disability psychiatrist;
- Clinical psychologist;
- Social worker 1, who was council officer[10] 1 during the ASP processes in 2014-15 and 2015-16, mental health officer (MHO 2) for a short period in March-April 2016, and care manager from April 2016 to August 2017;
- Senior care manager;
- Mental health officer 1;
- We received written responses to questions from MHO 3 (who was also care manager 2);

[10] Section 53 1 of the 2007 Act defines a council officer as an individual appointed by a council under section 64 of the Local Gov (Scotland) Act 1964 .

- We received a written response to questions from the transition lead at the health board for information from acute NHS notes at the rehabilitation hospital. We also wrote to council officer 2.

The Commission's investigation team comprised:

- a Deaths in Detention Project investigations officer;
- a Deaths in Detention Project consultant psychiatrist;
- a Deaths in Detention Project nursing officer; and
- a Commission-based social work officer.

Once interviews were conducted, the information was analysed using a content analysis model, using the following thematic headings:

- Rights, risks and safeguards;
- Impact of refusal to engage and challenges to ASP investigation processes and capacity assessment;
- Learning from experience and communication;
- Use and understanding of legislation.

We also considered the failure to carry out a local review.

1.3. Impact on AB's family

We spoke with AB's family about their background and views of what happened. The following is a summary of what they told us.

AB's family lost contact when AB and CD left the area in which AB grew up in 1996. They were reunited only when AB was dying, 23 years later. They had longstanding concerns about the influence of CD, and held CD responsible for AB cutting themselves off from family.

We were told that AB grew up in a large, close family with warm, loving and supportive relationships and 'wanted for nothing'. AB attended mainstream school before they moved to one with additional support for their learning disability, so lacked friends in their local area.

In an affidavit in the appeal of a criminal case in which AB was a witness, their relative described AB's friendship with CD. Their relative had initially been pleased AB had found a friend. Soon after, CD moved into a flat close by and AB moved in. AB's relative felt that CD 'brainwashed' AB, who soon stopped speaking to their relative and would shout abuse at them in the street. AB stopped seeing their nieces and nephews, whom they had previously 'doted on'. AB was being pushed around in a wheelchair by CD, although they had no mobility difficulties. A solicitor's letter was received by AB's relative falsely alleging that they had assaulted AB and CD.

AB and CD disappeared in 1996. AB's relative tried to trace them and heard they had changed their name. Years later AB's relative discovered they were living in another area of Scotland with CD. The relative was concerned for their welfare because of their learning disability and vulnerability to influence. AB's relative travelled to the area and was informed by the church attended by AB and CD that they presented themselves as relatives. AB's relative learned that AB had been a witness in a trial, held the previous week. AB's relative did not believe they were capable of giving evidence independently and was concerned because they were very easily influenced. It was contact from a solicitor in this unrelated case which led to the first adult support and protection investigation into AB's welfare.

AB's family told us they have concerns about the treatment and care received and questioned why they were not consulted about their care. They found it difficult to understand why CD was accepted as AB's carer and decision-maker.

Background details

2014-2015 details of first ASP investigation, February 2014 – March 2015

In February 2014 concerns were raised with social work about AB who was estranged from their family and moved away from their home area in the 1990s with CD.

The two claimed to be siblings, and AB had changed their name to that of CD's deceased sibling. After some years AB's relative became aware of their whereabouts and was concerned about their welfare and the impact CD had on AB's behaviour and wellbeing. This concern was passed to social work with assistance from an intermediary.

An adult support and protection (ASP) inquiry was opened in February 2014. A social worker was appointed as council officer[11] and a full ASP investigation began in August 2014. This coincided with an ASP investigation into the case of another individual (XY) who CD was carer for. There were difficulties taking forward the investigation because AB and CD refused to engage with the council officer, and their solicitor challenged the social work department's authority to interview AB at home.

Both AB and CD changed general practitioner (GP) during the process. AB's management of their long-term medical condition was not good and they did not attend outpatient appointments. An assessment order[12] was considered but not pursued. ASP investigation minutes noted that AB did not appear unhappy though CD appeared to have some degree of control over AB. There was no recorded discussion of the potential for 'undue pressure' under the 2007 Act. It was feared that if an assessment order was applied for this could result in AB and CD leaving the area. Professionals concluded there was insufficient information to confirm AB was an adult at risk of harm and a letter of response to AB's relative advised that social work had no concerns about AB but could not disclose details.

Second ASP investigation, September 2015 – May 2016

In August 2015 concerns were again raised about XY who had become estranged from their family since CD became involved with them and falsely claimed to be a relative. When XY died further inquiries under ASP were carried out in relation to AB. Concerns included their learning disability diagnosis, capacity to make decisions about their complex medical needs, defaulting on appointments, using a wheelchair despite not needing one, limited understanding of their situation, changed identity, and never being seen alone by professionals.

[11] The role of council officer is defined under section 53 (1) of the Adult Support and Protection (Scotland) Act 2007; this is usually a registered social worker, but can be an occupational therapist or a nurse.

[12] Section 11 of the Adult Support and Protection (Scotland) Act 2007 'allows a council to apply to a sheriff for an assessment order. This allows a council officer to take a person from a place being visited under section 7 in order to allow a council officer, or any council nominee, to conduct a private interview, or a health professional to conduct a medical examination in private.' https://www.gov.scot/publications/adult-support-and-protection-revised-code-of-practice/pages/11/

In November 2015 ASP-involved professionals decided that AB was a vulnerable adult who might be unable to safeguard themselves and was at risk of harm. The ASP-involved professionals applied for a removal order under the 2003 Act [13] to assess AB's capacity to make decisions about treatment and where they lived. The GP told council officer 1 that AB habitually failed to attend appointments and had last attended the long term conditions clinic in 2010. When last seen by the GP for a prescription CD led the discussion as AB didn't wish to speak.

The removal order proved difficult to arrange. Professionals involved considered ways to meet both AB and CD informally before moving to compulsory measures. Plans were postponed when AB needed an urgent scan, which they attended, though did not permit adequate examination. In mid-March an ASP professionals meeting heard a summary of their hospital and GP notes from the consultant learning disability psychiatrist. Staff present learned that AB was diagnosed with a learning disability from an early age; most hospital doctors believed AB lacked capacity to make medical treatment decisions and had asked CD to assist; CD had asked AB to leave hospital against medical advice. Summary GP notes included many instances of failure to engage and of CD insisting that AB had capacity to consent to medical procedures or of CD giving consent on AB's behalf with no legal authority to do so. There were many indications of poor self-management of a long term medical condition. The meeting agreed AB was an adult at risk of harm and planned an unannounced home visit to consider short term detention under the 2003 Act to allow assessment in hospital separate from CD.

Hospital admission 1: March – April 2016, acute hospital - high dependency unit

Just before the unannounced visit AB was admitted to a high dependency ward for treatment of their long term medical condition and an infection. The Council Officer visited AB in hospital but CD asked them to leave and AB would not speak.

Ward staff had concerns about CD's odd and hostile behaviour. CD would not leave AB which made it difficult for them to engage with AB and assess their capacity for decision-making. CD told staff that AB had been to university and worked from home. CD said they were siblings but could not say where each was placed within an alleged sib ship of 12. Staff closely monitored CD's behaviour which included aggression to staff, telling AB to swear at them and which to trust; bringing a pet into the ward, bringing in food inappropriate for AB's medical condition and encouraging AB to refuse personal care. Ward staff limited CD's visits from 2pm until 8pm but CD still Face Timed AB until late.

A mental health officer (MHO1) interviewed AB alone on 31 March in the ward but AB said very little. They noted the acute care team's concerns. On the same day an emergency ASP professionals meeting agreed there was evidence of neglect and planned a short term detention under the 2003 Act for AB after discharge from the medical unit. There would be a ban on visits by CD for the first week.

[13] Section 293 of the Mental Health (Care and Treatment) (Scotland) Act 2003 allows for a sheriff to make an order for someone at risk to be removed to a place of safety and detained there for up to 7 days.

The consultant learning disability psychiatrist advised that detention would allow AB to be made a specified person under the Mental Health Act 2003[14] so that staff could control use of AB's phone. The detention was to allow assessment of their learning disability, capacity for medical decision-making and personal care requirements. Social work notes indicated that a welfare guardianship order under the Adults with Incapacity Act (AWI) was to be considered and an attempt was made to assess AB alone without undue pressure from CD.

On 5 April AB discharged themselves against medical advice. The next day a warrant was obtained (under S.35 (1) and S.35 (4) of the 2003 Act) for access and medical assessment, but detention was postponed to 11 April because the receiving ward was fully occupied. In the interim, social workers planned to make direct contact to ensure AB's safety. They tried several times without success, before they visited with police for a welfare check on 10 April. AB and CD's solicitor wrote alleging they were distressed by staff banging on the door and querying the need for visits and the grounds for questioning CD's care of AB.

Hospital admission 2: April 2016–May 2016, detained under 2003 Act in learning disability psychiatry ward

In early April 2016 AB was detained on an emergency detention certificate (EDC) from an NHS facility out of hours. AB's emergency detention was followed by use of a STDC. During interview AB claimed to have been to university, denied their actual family history and chose not have independent advocacy. Visits from CD were restricted to 30 minutes a day. Their solicitor made a formal complaint to the health and social care partnership and appealed the STDC.

Ward staff observed that AB was compliant with medication but had no knowledge of what they should eat. There were concerns that CD was bringing in inappropriate food. AB was referred to dietetics, speech and language therapy, and occupational therapy. Staff noted that AB became more hostile, resistant, and wanted to go home after CD's visits.

Eight days later staff gave AB the wrong medication. CD was upset and told staff AB was unwilling to accept medication from nursing staff. A room search found non-hospital issue medication and food. AB had a mobile phone and was contacting CD.

The consultant learning disability psychiatrist advised that AB could make their views known within the limits of their learning disability, although AB didn't understand the negative consequences of their actions on their physical health and would put pressure on CD to bring in preferred snacks and drinks.

Three days later an ASP professionals meeting focussed on risk management in case AB's appeal against the STDC was successful at the Mental Health Tribunal. Concerns and priorities included AB's physical health and the need for radiological investigation; their capacity to consent to treatment; contact with CD and how free AB was to make decisions about their family; and plans to apply to revoke CD's status as named person. The clinical

[14] This enables authorising of restrictions on individual's correspondence, use of telephones and also in relation to safety and security in hospitals. See also section 5.4.

psychologist recorded that in their opinion AB's trust of CD meant CD needed to be involved in any approach.

The ASP professionals group planned a case conference for six days' time. If detention was overturned on appeal by the tribunal, welfare guardianship was to be taken forward. A draft welfare guardianship order application was drawn up and sent to the RMO. There was no intention to seek a compulsory treatment order (CTO) as the criteria for detention were not thought to be met.

During AB's admission they were assessed as having limited ability to manage their long term condition. It was recorded that CD supplied AB with inappropriate food and non-hospital issue medication, was verbally aggressive to staff and threw items of clothing at them, which made AB verbally aggressive. Actions in response to these difficult to manage behaviours included regular multidisciplinary team (MDT) meetings involving social work, and the review, update and sharing of care plans.

The consultant learning disability psychiatrist certified AB's lack of capacity in managing health, personal care, and investigation of an abdominal mass. They also recommended that AB and CD continue to live together with the least intrusive support due to their longstanding relationship, CD's provision of support to AB, and the risk of separation traumatising both. They thought AB's lack of understanding put their health at risk and CD's problematic behaviour was an emotional response to the situation.

On 26 April MHO 2 withdrew an application to remove CD as named person as there was no plan to seek a CTO and to prevent the stress to AB and CD of another tribunal. The ASP investigation record of 5 May noted ongoing difficulties interviewing AB, CD denying access to AB, instructing solicitor's letters, and concerns from nursing staff about CD's behaviour. When visits from CD were restricted and supervised, AB's health condition was better controlled and they were more accepting of support. The ASP investigation meeting concluded that AB met the ASP three point test for an adult at risk of harm[15] and recommended further assessments, continuing the welfare guardianship application, and exploring AB's family's views on welfare guardianship. It also noted that if AB was discharged home, their health would continue to be mismanaged and support at home obstructed. It recommended a case conference and reconsideration of applying for a CTO, as AB was at risk of critical illness that could have fatal consequences.

A case conference was held on 6 May. The community-based health team's view was AB and CD could manage AB's treatment at home, although AB had limited understanding and held unhelpful beliefs about how to self-manage. The GP acknowledged AB's lack of engagement for a concerning infection in 2015, and for routine care. The consultant learning disability psychiatrist advised the relationship between AB and CD was complex and interdependent. The clinical psychologist could not conduct a formal assessment but agreed they should be supported to live together, in joint accommodation. As the psychiatrist felt there were no grounds for extending detention, the case conference drew up an ASP protection plan for AB's

[15] The Act defines adults at risk as adults who are unable to safeguard their own well-being, property, rights or other interests, are at risk of harm, and because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

return home. The plan included weekly visits, agreement with CD not to provide inappropriate foods and monitoring of this, housing assessment, health appointments support and a welfare guardianship order application. A second medical report on capacity was needed but AB refused to see the GP who visited them on the ward. AB's family were not asked for their views on guardianship.

After discharge on 11 May 2016

AB was discharged on 11 May when the STDC expired, with the ASP plan in place. Support was initially provided by the ward senior charge nurse, with a plan to introduce the community learning disability nurse. Identified risks included urinary incontinence, inconsistent health condition management and refusal to engage or attend appointments, with risk of fatal consequences. The guardianship application remained pending, and challenge from CD and AB's solicitor was anticipated. It was suggested that local authority legal services should meet with the solicitor and gain agreement from CD to professionals' input to AB and if successful, withdrawal of the guardianship application.

The ASP protection plan did not work. CD refused entry to the district nurse and neither AB nor CD would engage with the senior charge nurse. CD threatened to change their GP and leave the area as they felt they were being blamed. A second doctor to assess capacity for the guardianship application was not arranged and the usefulness of meeting AB and CD's solicitor was questioned as was AB's incapacity on the grounds they had shown their refusal to meet with the GP by locking themselves in a toilet. The social worker spoke by phone to CD and briefly to AB in early June; both said all was fine. They attended a health clinic, where CD did most of the talking. On 15 June CD registered AB with a new GP, refused to tell the social worker which one and did not allow the social worker to speak to AB.

On 21 June 2016 an ASP case conference agreed that AB was an adult at risk of harm but discharged them from ASP and suspended the guardianship application due to improved engagement, perceived reduced risk to AB, and fears that AB and CD might otherwise leave the area. There was also concern about third-party reports of CD's vulnerability. Care Programme Approach (CPA)[16] was initiated as a less formal means of engagement, with a CPA meeting booked in six weeks. The aim was to sustain contact in a low-key way, involving fewer professionals. Engagement remained difficult. Social workers tried three times in late June to contact AB, but AB was abusive on the phone.

AB and CD did not attend the first CPA meeting on 27 July 2016. The new GP reported seeing AB twice and had no concerns. AB did not attend the long term conditions clinic but the nurse

[16] The Care Programme Approach (CPA) is "a way of ensuring that people with complicated health and social care needs have care plans which reflected their needs for ongoing care, treatment and supervision and that this is fully coordinated. […] Important elements include patient and carer involvement in the agreement and review of the care plan", multidisciplinary involvement and "a care plan which addresses the patient's needs and is clear as to which professional is responsible for which action point and when it should be reviewed. The patient should agree to the plan and have a copy." https://www.tsh.scot.nhs.uk/Person%20Centred/Docs/Care%20Programme%20Approach%20-%20CPA%20Policy.pdf

was told over the phone by CD how AB was doing. The two did not respond to attempts by the housing officer to address their unsuitable housing.

The letter inviting AB and CD to the next CPA meeting on 30 November resulted in correspondence from their solicitor saying they felt 'hounded', did not understand what CPA was and did not wish to meet. The social worker responded, explaining that AB had been discharged from the ASP process but their vulnerability meant their case remained open for monitoring and support, and asked to meet with AB and the solicitor to discuss this.

The CPA meeting on 30 November heard that AB had attended the GP who had no concerns about their health. Housing reported complaints from neighbours about AB and CD's unpleasant behaviour. CPA was discontinued because AB did not attend. There was poor representation from across the relevant disciplines. AB's case was kept open by social work and monitored via liaison with GP, primary care nursing and housing.

In late February 2017 social work were told that AB had, in October 2016, granted both financial and welfare power of attorney (PoA) to CD. In email discussions questions were raised about whether AB had capacity to do this but no action was taken. Information from the 30 November 2016 CPA meeting was reconsidered, as were letters from the solicitor for AB and CD asking social work to cease contact. Around the same time, the social worker responded to a police enquiry triggered by contact from the family of XY. Police were assured that AB's case remained open but when telephoned by social work they would hang up or shout abuse, and that letters were followed up by a response from their solicitor asking for contact to stop. Police were told erroneously that AB remained subject to CPA. The social worker again sought updates from other agencies; the GP said that AB was unwilling for information to be disclosed, but they had no concerns about AB's appearance, health or interaction with CD. On the advice of a senior social worker, AB's case was kept open, until August 2017 when it was closed after positive updates from the primary care nurse, housing officer and GP.

Hospital admission - November 2018 to February 2019

Acute hospital – orthopaedic acute ward November to mid-December 2019

In late November 2018 AB sustained a fracture in a fall and was admitted for surgery. In early December, ward staff reported that CD was unhappy that staff gave personal care to AB and declined their help to get AB into a chair. CD was aggressive when staff intervened but was later reported as understanding their rationale. A liaison nurse contacted the social worker, who shared AB's history of self-discharging or being taken home by CD and requested an ASP referral if this happened. An MDT 'best interests'[17] multidisciplinary meeting agreed the need for AB to be moved for orthopaedic rehabilitation, a transfer which AB and CD objected to.

[17] A 'best interests meeting' in the context of learning disability services in Scotland is a multidisciplinary meeting. In England it is one where discussions about treatment of an adult are made in circumstances where it has already been established that an adult lacks capacity and cannot consent to or refuse treatment themselves, usually with reference to the Mental Capacity Act 2005. bma-best-interests-toolkit-2019.pdf

Orthopaedic rehabilitation unit - mid- December 2018 to February 2019

AB was given a side room so that CD could stay over, as had been the case at the acute hospital. CD told the senior care manager that AB was 'very bright' and managed their finances. The senior care manager thought this unlikely but noted that lack of engagement had made it impossible to assess AB's functioning when at home. Their stated view was that it was unlikely that AB had capacity to grant the PoA and that guardianship would have been more appropriate.

AB had three falls while with CD in the side room. Staff were concerned that CD had been mobilising AB and after the first fall advised CD not to do this. The two further falls were logged on Datix[18] and health staff reported ASP concerns to social work. CD continued to visit and stay in the room. CD was described as a distraction, as they went off the ward together for most of the day, meaning that AB missed rehabilitative physiotherapy. CD said that AB was not happy in hospital and wanted AB home for Christmas. A further ASP concern was raised in late December after CD took AB out of the hospital in a wheelchair and left AB at a bus shelter while CD went into their home. There were concerns over CD's interference with AB's medications, and denying access to AB for clinical review.

The care manager and social work senior care manager were concerned about increasing the risk to AB by enforcing measures such as ASP processes, referencing the risk of disengagement from NHS services and moving out of area noted in the previous ASP process. They agreed to continue visiting AB in hospital to assist the treating team address clinical concerns as a priority, and consider the need to formally reopen ASP processes. When the senior care manager visited on 20 December, the ward doctor advised this was the first time they had been allowed to examine AB, who by then had several pressure sores and other physical health concerns. A s47 certificate of incapacity under AWI was in place to allow treatment but AB and CD threatened to go home. The senior care manager explained to them why AB could not go home and the need for nursing observations by staff overnight. The rehabilitation consultant and MHO 3 contacted the Commission and were advised to look into CD's suitability to hold power of attorney, and consider applying for guardianship.

Third ASP investigation

On 21 December, an ASP professionals meeting discussed immediate safeguards including treatment under the s47 certificate and possibly detaining AB under the 2003 Act. It was explained to CD why AB needed to be in hospital for treatment and not taken off the ward, with the help of a social story[19] provided by speech and language therapy (SLT). Two days later CD took AB off the ward. On 24 December AB was detained under the 2003 Act. The STDC enabled assessment of the impact of physical ailments on AB's mental health, and the potential for serious and possibly fatal consequences if remained untreated. The intention was to involve CD, as welfare attorney, unless they were abusive. CD tried to remove AB shortly after the STDC was in place before CD then cooperated and accepted care and treatment for

[18] Datix is an electronic incident reporting system widely used in the NHS

[19] Social stories are a personalised, visual approach that: Describe a social situation or context in a way that helps people with developmental disorders to understand

AB. The ASP concern was discussed by the ASP professional team which decided on no further action as AB was detained.

In early January AB deteriorated. Concerns regarding refusal of care, impeded infection control and dietary intake were raised to senior nursing staff.

An ASP professionals meeting on 9 January heard that AB was refusing some medication and necessary nursing interventions with CD's support. AB was at risk of sepsis and death from ulcers because the dressings were being removed. AB had constipation which CD reported to be manually evacuating. CD claimed their solicitor told them the STDC was not valid and not to cooperate with staff. AB refused advocacy. Police were contacted when CD again attempted to take AB off the ward. Staff were concerned that CD's understanding of AB's health needs was impaired.

In discussion with colleagues, the mental health officer (MHO 3) considered if they were using the full range of legal powers available or whether they were holding back for an elusive therapeutic relationship. MHO 3 considered that as there was an imminent threat of death, more robust action was needed. It was agreed to make both CTO and guardianship applications and use specified persons measures to restrict CD's visits and influence on AB and to conduct a full ASP investigation. Visiting restrictions were imposed from the second week in January. CD could visit in the afternoon but was not allowed to stay overnight or bring in food or drink. Authority to restrict phone use was not put in place until mid-January.

AB fell three times in a two day period in mid-January and refused aspects of nursing care. The tissue viability team became involved; AB refused continence aids, their skin broke down and blood results worsened. Staff suspected that CD had removed bandages and smuggled in food. The learning disability acute liaison nurse recommended constant observations during visits from CD but this was not initiated. Two days after the falls, CD encouraged AB by phone to leave the ward. The boot intended to protect AB's skin had been removed. The next day hospital management decided to continue CD's visits as excluding them was felt to be detrimental to both AB and CD and the relationship staff had with them.

The following day AB showed improvement. AB and CD were provided with accessible information about the CTO application. The next day the call buzzer disappeared and foodstuff from outside hospital was found in AB's room. An incident report noted both AB and CD were unable to rationalise their behaviour due to cognitive impairment. More food was found in the room some days later. The learning disability acute liaison nurse again recommended constant observation during visits but was told there was not enough staff. A referral to the integrated community learning disability team noted AB's lack of progress in hospital due to the obstructive and secretive nature of both AB and CD, their denial of AB's learning disability and outlined future accommodation needs.

On 23 January 2019 a professionals' case discussion ASP meeting heard that AB's health was still poor and impacted on by the actions of CD. Staff had not yet controlled AB's phone use - AB would call CD until 4am, sleep late, and miss treatments. AB's necrotic heel deteriorated due to non-compliance with treatment and they were referred to a vascular surgeon. The rehabilitation consultant felt that AB did not need further medical intervention and could be cared for in the community once infection was controlled. The ASP actions considered

included guardianship or interim guardianship powers, depending on whether a CTO was granted.

An interim CTO was granted on 25 January. In late January there were further efforts to manage CD's behaviour using a clear protocol, explained in an easy read[20] letter. AB was to be discharged once infection cleared and guardianship, accommodation and an assessment of needs were in place. Ward staff were unable to fully supervise visits from CD and enquired about sourcing assistance but social work felt that the introduction of additional staff would be resisted. They continued with input from staff who were familiar to and tolerated by AB and CD.

By the end of January AB's infected foot had worsened. Discussion of a 'do not attempt cardiopulmonary resuscitation' (DNACPR)[21] plan took place with AB and CD and they were given bespoke easy read material to refer to[22]. Social work formally reopened the ASP screening process noting on-going concerns and agreed AB needed to remain in hospital and needed protection against CD's actions and influence. Professionals agreed that continued monitoring under ASP was necessary although opposed by CD (and therefore also AB).

The DNACPR was removed at the start of February; AB was still unwell but had improved and the behaviour protocol drawn up to manage CD's behaviour on the ward was working. On 5 February, council officer 3 noted AB's physical condition had deteriorated and asked about funding a support worker to supervise CD's visits. Supervision could not be provided by ward staff and the senior care manager suggested reducing visits so they could be supervised by familiar social workers. It was decided against imposing greater restrictions on visits as CD was extremely concerned about AB, was encouraging healthy eating and there was no direct evidence that CD was undermining AB's recovery or purposefully harming them at that point.

Two days later the vascular consultant advised that AB's infected lower leg should be amputated otherwise sepsis was likely. Speech and language therapy (SLT) provided easy read scripts to help the MDT explain these options to AB and CD. Amputation was scheduled for the following week.

Acute general hospital – from 10 February 2019 to the death of AB

On 10 February 2019, AB had a respiratory arrest and was transferred to the acute general hospital where DNACPR was put in place. The next day council officer 3 emailed guidance on AB's care to the medical registrar at the general hospital, explaining an interim CTO was in place, guardianship was being applied for and AB was an adult at risk of harm under ASP. They detailed concerns about CD's behaviour and the need for vigilance during visits. In addition, the senior care manager visited and discussed management of CD's behaviour with medical and nursing staff and gave a detailed written account of the legal situation. CD was reported as being no problem but had given AB an inappropriate drink. Staff allowed CD to stay overnight given AB's poor prognosis.

[20] 'Easy read' refers to the presentation of text in an accessible, easy to understand format.
[21] Further information on 'DNACPR' is available at www.scotland.gov.uk/dnacpr
[22] The acute service case file with details of this discussion was not accessed

The consultant liaison psychiatrist emailed social work to say a welfare guardianship order would be preferable to a CTO as a legal mechanism to limit undue influence from CD. However, it was decided not to apply for guardianship as AB's situation had altered significantly and CD had not obstructed medical treatment. Legal advice from the local authority was to consider the least restrictive option and compliance by CD and AB might be a barrier to the sheriff granting interim guardianship.

Three days later a CTO was granted by the Mental Health Tribunal which considered the risk of AB refusing treatment, seeking to self-discharge or having help from CD to disrupt treatment was still 'acute and significant'. The community learning disability nurse visited and heard that CD had stayed overnight, and closed the door and curtain. Despite the information provided by social work, ward staff were unaware of the agreed restrictions.

The next day, an ASP professionals meeting heard significant concerns about AB's medical condition. CD had become obstructive, brought in fizzy drinks and removed an oxygen tube. AB was in pain but CD had obstructed access to morphine. A full guardianship application was lodged and AB's family were contacted. It was agreed to seek interim guardianship powers and restrict CD's visits to safeguard AB and allow family access. CD's harm of AB was seen as a potentially criminal matter by the immediate treatment team and social work and officers from Police Scotland who had been present at the ASP meetings took CD into custody the next day.

Thereafter, AB's family visited and interim guardianship was granted to the chief social work officer with powers to consent to medical treatment and decide who AB should consort with.

A few days later CD appeared at court, charged with culpable and reckless conduct.

Subsequently, all active treatment was withdrawn from AB and palliative care initiated. AB died two days later with family present. The cause of death was multiple organ failure, systemic sepsis and contributory underlying medical conditions.

After AB's death

Following AB's death the procurator fiscal decided against prosecuting CD due to lack of evidence to support criminal intent. There was no significant adverse event or serious case review.

2. Rights, risks and safeguards

2.1. Balancing rights and risks

Throughout the period we looked at, there was a conflict between the expressed wishes of AB and CD and the efforts by professionals to assess and protect the safety and wellbeing of AB. Services tried to allow the pair to live their lives and make some choices but failed to adequately protect AB.

Professionals were faced with balancing different human rights. Respect for rights, will and preferences and supported decision-making (UNCRPD Article 12) and respect for private and family life (ECHR Article 8) were in potential conflict with AB's right to life (ECHR Article 2), freedom from exploitation, violence and abuse (UNCRPD Article 16) and the right to the highest attainable standard of health (UNCRPD Article 25).

Human rights were not discussed directly in these terms in the notes we saw but there was clear consideration at a number of points of the 2003 Act and AWI Act principle of the least restrictive option. AB was adamant throughout they did not want the involvement of social work in their life, did not think they had intellectual impairments or mental illness and wanted to be with CD. What was not clear was their capacity to understand specific health and care needs and to what level they were controlled or influenced by CD. There was evidence AB was confused about their own identity and relationship to CD.

The first ASP investigation was concluded with no further action on the basis that one of AB's previous GPs had determined AB had capacity in relation to treatment whereas another had assumed it (see section 5.3).

There was no formal assessment of AB's capacity for specific decision-making, despite acknowledging CD appeared to have undue influence over AB. AB failed to attend GP appointments and refused direct social work contact at that stage.

The Commission's view is that once it became evident that AB had a learning disability (assumed to be of mild to moderate degree), more weight should have been given to AB's potential vulnerability and a full capacity assessment carried out.

During AB's hospital stays, allowing CD to visit was upholding their right to a private and family life and was in line with AB's wishes. However, it also potentially risked their right to health and, ultimately, their right to life.

The Commission's view is that once it became evident that CD's actions were not of benefit to AB, swifter and more effective action was needed to supervise or restrict visits and maintain a sufficient level of oversight.

AB's right to a private and family life and their wishes were also upheld in the recommendations in April 2016 which were based on observations during the four week inpatient period, clinical records and discussion with staff. During AB's admission to the psychiatric hospital their trust of and dependence on CD meant CD needed to be involved in any approach and the recommendations of the consultant learning disability psychiatrist and the clinical psychologist was that AB and CD should be supported to live together in accommodation which afforded some oversight.

AB by this point had been assessed as lacking capacity in relation to managing their care and treatment. AB and CD were seen as being very important to each other and that AB was unlikely to engage with care and treatment in the absence of CD. Seeing them as a unit was seen as least restrictive and would preserve their right to family life.

The ASP investigation record on 5 May 2016 which recommended further assessments and welfare guardianship application noted 'significant evidence' that if AB were discharged home, their health would continue to be mismanaged and support at home obstructed. It recommended a case conference and consideration of applying for a compulsory treatment order (CTO), as AB was at risk of critical illness that could have fatal consequences. The case conference subsequently accepted on the advice of the consultant psychiatrist that the legal criteria for a CTO were not met.

The decision at the ASP meeting in June 2016 to suspend the welfare guardianship application in favour of the CPA approach shifted the balance away from seeking protective powers to decide how AB lived. Different views were expressed to us about how far to go in using a legal framework to guide support measures and whether AB and CD's joint living arrangement should continue – but in a more formalised setting.

The Commission's view is that with welfare guardianship in place, it might have proved possible to balance protecting AB and support the two to live together.

2.2. View of the relationship

During the first ASP process, concerns were raised about the influence of CD on AB, going back to the period in the 1990s when they first met. This continued to be of concern throughout the three ASP processes. The possibility that CD actively intended harm to AB was founded on factors such as AB's belief the two were siblings and CD's active interference in AB's hospital care, both directly, such as by bringing in unsuitable foods, removing AB from the ward and possibly interfering with dressings, and indirectly by encouraging AB to refuse treatment and personal care.

However, it is important to recognise the situation was not clear cut. When observed in the learning disability psychiatry ward under the STDC, their relationship was seen as 'inter-dependent' and if CD's role as an 'enabler' of AB could be redirected into a more appropriate supporting role then it could have been helpful. There was 'anxiety in the system' about CD, including their role in AB's estrangement from family but their attachment – seen as co-dependence – made this a challenging case.

There were also concerns about the parallels with the case of XY, who CD had also allegedly cared for.

The Commission's view is this was not a straightforward case of alleged harmer and victim; however, whether or not there was active intent on the part of CD to harm AB, there was evidence CD was not always competent at caring for AB, which resulted in significant and cumulative risks to AB's health. At the point in June 2016 when the decision was taken to suspend the application for a welfare guardianship order, and later when it was decided to discontinue the CPA process, AB remained at risk of harm by neglect of significant health

needs given their incapacity regarding treatment needs and the history of limited engagement with services. CD's role in AB's life also maintained the ongoing estrangement from AB's family.

Different services had differing views of the relationship and ultimately this did influence the intervention provided. These differences in how AB and CD were viewed should have prompted steps to discuss the issues further and collaboratively agree a way forward to protect AB bringing legislative steps into play as needed.

2.3. Risk that they might leave the area

The first ASP process was the first point at which concern was expressed that if a more assertive investigation of AB's circumstances was undertaken, AB and CD might leave the area, and AB would be lost to follow up. However, engagement was already poor and monitoring was limited. AB and CD had a history of impulsive responses; they moved areas in the past and changed GP when social work first enquired about AB's wellbeing.

This concern was reiterated at key points during the three ASP processes, and was a factor in the decision in June 2016 to suspend the application for welfare guardianship and monitor where possible and with least restriction. CD and AB resisted social work input and took offence to certain professionals' involvement.

After AB's admission with a severe complication of a long term condition in 2016, they were reported as really engaging with the primary care nurses over some weeks and that was seen as a route to balance the risk they would leave. This risk was also of concern to the treating team during AB's admission in the orthopaedic rehabilitation unit.

After concerns about interference with care and three ASP investigations, social workers still expressed concern about possibly increasing risk to AB by enforcing measures such as ASP procedures and the risk of their disengagement. Effective action to address CD's behaviour may have been delayed.

The Commission's view is undue weight was given to this concern. They were in a housing association tenancy, and apparently resistant to moving, even when offered more suitable accommodation. They were unlikely to be in a position to move without services being aware of their new location. If they had moved as CD sometimes stated they would, the case could have been transferred to their new area.

2.4. Balancing risks in hospital

By 16 January 2019, although there was already a substantial history of harm caused by CD's interference with AB's care, hospital management decided CD would not be asked to refrain from visiting. This was because not visiting was felt to be detrimental to both and to the relationship that staff had with them.

Although not explicitly stated, this decision was in line with AB's expressed wishes and their human right to a private and family life. However, it is not clear sufficient attention was given to balancing this with measures to keep AB safe.

Although restrictions on CD's visits were introduced, these had limited success and CD still interfered with bandages, smuggled in food and encouraged AB to leave the ward. The power to restrict phone use was in place but was not immediately acted on. On 14 and 21 January, the learning disability acute liaison nurse advised constant observations during visits but this did not happen as the ward did not have sufficient staff.

The suggestion of social work providing support workers to supervise visits was made on 29 January but was rejected on the basis it would be difficult for a worker to build rapport and if visits were reduced, they could be supervised by social work staff who were known to AB and CD and existing ward staff complement. A further suggestion of social work funding support workers to supervise came on 5 February but AB was by this time very ill and CD was very concerned and cooperating in AB's care.

It was felt that a support worker scrutinising the visit in the confined space of the side room would potentially impose too great a control on AB and CD who had an extremely close bond and vigilance could be managed in the absence of sufficient powers to fully block visiting.

In interviews, we were told social work were considering seeking guardianship powers to allow the local authority to take those decisions lawfully and the general hospital did not have enough staff to provide 24 hour supervision.

The Commission's view is options to keep AB safe during this period existed such as earlier use of controls on phone use, tighter enforcement of the rules for CD's visits and the supervision of these measures.

The general ward managers also had a responsibility to apply proportionate restrictions on CD as a visitor and supporter of AB.

If continued visiting at the scale it happened was deemed appropriate then the added resource needed to supervise contact on the ward could have been drawn from mental health or learning disability services given that AB was detained under the 2003 Act in an acute hospital setting.

3. Impact of non-engagement with services

3.1. Non-engagement with ASP processes

Difficulty in engaging with AB and CD was a significant issue in the first ASP process in 2014-15. Although it was acknowledged CD appeared to have influence over AB, assessment of AB's wellbeing was based on GPs' assumptions of AB's capacity, despite poor self-management of their physical health and on informal observations that they were not presenting as unhappy. Despite consideration of an assessment order, it was instead decided there was 'little evidence' AB met the three point criteria as an adult at risk of harm. This is concerning because the effect of AB and CD's non-engagement was that assessment and knowledge gained was limited and the ensuing lack of evidence remained a deciding factor in services taking no further action.

In interviews with us, it was acknowledged the approach by social work didn't follow the usual pattern or timescale due to AB and CD not wanting to engage and not being able to independently interview AB. This was balanced against potentially distressing AB and increasing the risk if more restrictive steps such as an assessment or removal order were used.

Given the difficulty in seeing AB alone and the fact that the basis of concern was the possibility that CD had undue influence over them, the Commission's view is every effort should have been made to speak with AB privately. The weight given to fear that they might leave the area impacted on proper investigation of the concerns (see section 2.3).

The protection plan from the second ASP investigation in 2015-16, also failed due to non-engagement with follow-up after AB's discharge from short-term detention in hospital. The little engagement that was possible was mainly with CD who denied access to AB; and they changed GP again and refused permission for the GP to speak with social work.

It was after the social worker spoke by phone with CD and briefly with AB and AB had attended some medical appointments that an ASP case conference decided engagement had improved. The guardianship application was suspended due in part to this. Although there was agreement that AB still met the ASP three point test as an adult at risk of harm, it was felt that the risk of harm was reduced. It was seen as being difficult at that stage to then go down a route that the professionals involved thought could reduce their engagement further. Fears they might otherwise leave the area played a part. The Care Programme Approach, which is a case management mechanism without the protective framework of ASP and intended to be multi-disciplinary, multi-agency and centred on patient and carer participation, was seen as sufficient for safe guarding and instigated instead but AB and CD did not take part.

Engagement remained difficult overall, the decision to suspend the application for guardianship wasn't revisited and the case was closed by social work in August 2017.

The Commission's view is at the point where application for guardianship was suspended, it is not clear engagement had improved to a degree where risk was significantly reduced or there was sufficient evidence AB would participate voluntarily with a casework mechanism such as CPA. The difficulty in engagement and the weight given to the fear AB and CD might

leave the area, together with the practical difficulty of capacity assessment, may have swayed decision-making away from the appropriate legal approach (see section 5.1).

3.2. Effect of letters from solicitor for AB and CD

CD and AB were both represented by the same solicitor. Social work received a number of letters from this solicitor challenging their actions.

The solicitor made a complaint to the health and social care partnership (HSCP) in relation to AB's detention in April 2016, which was not upheld, and about the wrong medication being accidentally given, which was upheld. While social work staff did not express being overtly influenced or intimidated by correspondence from the solicitor, it did have the effect of creating delay in dealing with AB as the letters had to be considered and responded to. Social work accepted the letters represented the views of AB and CD and were not swayed from their duty of care, but thought the solicitor did not have a good understanding of the whole situation.

The same solicitor drew up the power of attorney document based on their personal knowledge of AB and this was never challenged (see section 5.2). The solicitor represented AB at their appeal against the short term detention five months before the PoA was drawn up, at which they will have heard the views of the consultant psychiatrist about AB's impaired capacity for specific decision-making based on mild to moderate learning disability and concerns regarding CD's influence.

Section 15 of the AWI requires the solicitor to confirm in a certificate the granter has capacity and they are not acting under undue influence. Where there are any concerns about the capacity of the person seeking to grant a power of attorney, a solicitor should seek a medical report to establish whether or not there is capacity [see also the Law Society of Scotland's *Guidance on Capacity Generally* B1.5: Capacity Generally | Law Society of Scotland (lawscot.org.uk).

That this PoA was granted by AB in favour of CD in circumstances that raised questions as to AB's capacity and the involvement of CD in their medical treatment and where it was known that a guardianship order was considered five months earlier, is concerning. (See section 6.3)

The Commission's view is that, as was done in this case, it is important all challenges and complaints are carefully considered and responded to. It is the right of individuals to have legal representation. The complaints lodged by the solicitor were all responded to in writing, and social work offered to meet the solicitor repeatedly.

Staff need to be aware of the role that solicitors have in representing their clients and be clear about who the client is – in this case it proved difficult to be clear whether the letters were instigated by CD as the client rather than AB about whom social work staff had ongoing concerns.

However, social work could have questioned the solicitor about their assessment of AB's capacity and legislative steps to challenge the power of attorney and protect AB could still have been pursued (see section 6.2).

3.3. Non engagement and capacity assessment

The issue of AB's capacity to make decisions about their care and treatment was central to understanding their situation and the risks and to legal avenues for protection. The issue of professionals' understanding of capacity is dealt with separately in section 5.3 below.

During the second ASP process, AB's incapacity to make decisions about their care and treatment was confirmed by the consultant learning disability psychiatrist. However, the GP was unable to engage with AB to carry out a second medical report. The eventual suspension of the guardianship application was in part because a second medical report had not been obtained during or immediately after AB's admission under the 2003 Act.

The issue of AB's capacity or incapacity for decision-making in treatment and welfare decisions was key. The local Interagency Policy and Procedure for the Support and Protection of Adults at Risk of Harm discusses dilemmas faced in adult protection, and says,

> *"There is a tendency to believe that adults at risk of harm should be protected and that their right to choose is secondary to this. This is not the case; adults at risk are individuals and, if they are deemed to have capacity, and if there is no evidence of undue pressure, they must be allowed to exercise their rights, even if that means they choose to remain in a situation some people would consider inappropriate or harmful."*

The Commission's view is AB's unwillingness to engage in capacity assessment did not reduce its importance and the need to find alternative means to do so remained.

3.4. Non-engagement and physical health

AB and CD's reluctance to engage had serious consequences for AB's health. AB's engagement with health services was generally poor other than when there was a crisis. For example, AB didn't attended the primary care long-term conditions clinic between 2010 and 2014, they disengaged from these services when they felt well, didn't attend related screening in 2015, and blood testing in March and June 2016 suggested physical health self-management was poor. There was a lack of understanding by AB that even when you are physically well, there are times when you still need to go to the doctor or health clinic if you have a condition which requires monitoring. When very obviously ill, AB could usually be persuaded by CD to seek treatment.

When in the acute hospital in 2018, the potential role CD played in enabling AB to accept treatment was apparent and staff tried to balance the benefits of accepting this help against reducing the risk of harm to AB. However, during AB's stay in the rehabilitation hospital, they and CD resisted medical examination until a week after admission, by which time AB had developed pressure sores and other health issues.

CD removed AB from the ward repeatedly, disrupted therapies and encouraged AB to refuse care. This continued for 11 days before AB was detained and resumed again after a short period of cooperation. Partial visiting restrictions were not imposed until a month after AB's transfer and restrictions on phone use were not in effect for a further two weeks. Liaison psychiatry suggested they had perhaps not seen AB enough as a victim and whilst CD was also vulnerable, they needed to focus firmly on the harm caused to AB. It was in the latter

stages of this final hospital admission that input from the community learning disability team (CLDT) senior care manager and social work care manager was stepped up and definitive legislative steps taken to protect AB.

The Commission's view is action could have been taken much sooner to protect AB from CD's influence. There was evidence from AB's earlier detention in 2016 they were more engaging with medical treatment when CD's visits were restricted and AB had limited mobile phone contact. Medical professionals could have given consideration to legal options which would have prevented or restricted CD's visits and could have consulted the health board's solicitors on those. These options included seeking a court order to prevent CD's attendance with AB on an interim basis. The local authority, in discussion with the medical professionals in the hospital, could have considered a banning order with an interim order under section 18 of the ASP 2007 Act. The medical professionals could have refused to allow CD access to AB on safety grounds, recognising this is a significant step.

4. Learning from experience and communication

4.1. Learning from experience

Learning from previous hospital admissions was slow to be applied. During AB's first admission in 2016, to a high dependency ward in an acute hospital, ward staff were concerned about the impact of CD's behaviour on AB's care. Visits were limited and supervised.

Six days after they discharged themselves against medical advice, AB was admitted to a learning disability assessment and treatment ward in the psychiatric hospital. In the planning for admission for assessment, an ASP professionals meeting on 31 March 2016 decided if criteria were met, AB should be detained on a STDC to ensure they were a specified person in terms of the 2003 Act[23] so that they were unable to phone or FaceTime and CD should not be allowed to visit for at least the first week.

However, when AB was admitted, CD was allowed daily 30 minute visits and brought in food and non-hospital issue medications. By 20 April, AB had a phone and was freely communicating with CD. The step down from the initial level of restriction was deliberate as once AB was in hospital the concern for their safety at home was allayed by the realisation that although AB had a learning disability, their emotional attachment to CD was strong and inter-dependent. Some limited contact with CD was allowed to relieve AB's distress and facilitate some engagement from a clinical point of view.

AB was initially accepting of their care. Ward staff recorded hazards relating to CD's behaviour and interference with care in a risk assessment and noted AB was more resistant to care after CD's visits. While visits were being restricted and supervised, AB's physical condition was under control and they were more accepting of support.

It is not clear how much of the learning from these two admissions was available to ward staff in the acute hospital when AB was admitted in November 2018 after a fall. CD was allowed to stay with AB overnight in a side room. Over the first few days, CD was unhappy with staff giving AB personal care and was aggressive towards them.

When AB was transferred to the orthopaedic rehabilitation unit, they were again given a side room and CD allowed to stay overnight. It is not clear how much the treating ward staff knew of the previous issues with CD's behaviour, although social work staff were actively involved. The same pattern of CD obstructing and interfering with care developed and three ASP concerns were raised by hospital staff within a week. Efforts were made to manage CD's behaviour although not to the extent of using powers to ban visits. Despite the evidence from earlier admissions that AB fared better when CD's involvement was restricted or supervised, restrictions on visits were not put in place until 10 January, three months after admission. It is acknowledged that at this point both AB and CD were vulnerable and scared and ward staff were advised by social work that engaging them would be difficult.

The Commission's view is AB was put at unnecessary additional risk because the learning from previous admissions was not sufficiently taken into account. Professionals may have been too ready to believe the situation had changed for the better rather than see unhelpful

[23] This enables authorising of restrictions on individual's correspondence, use of telephones and also in relation to safety and security in hospitals.

patterns re-emerge and act to protect AB. As discussed above, seeking a court order preventing or banning CD from attending AB could have been considered. Medical professionals could have refused to allow CD into the room where AB was an in-patient on the basis of patient safety.

4.2. Communication

When AB was transferred to an acute hospital again on 10 February 2019, after a respiratory arrest, strenuous efforts were made by social work to try to ensure ward staff understood the situation and managed CD's involvement accordingly. Communication on 11 February included emailed guidance from council officer 3 to the medical registrar, explaining the legal position, that AB was an adult at risk of harm, the concerns about CD's behaviour and the need for vigilance during visits; and a visit during which the senior care manager discussed management of CD's behaviour with medical and nursing staff.

Yet on 13 February, the CLDT nurse visited AB and heard CD had stayed overnight, taken bags in and closed the door and curtain. Despite the information provided by social work, ward staff on duty were unaware of restrictions.

The Commission's view is although at this time CD was very concerned about AB's condition, and was cooperating, it is unacceptable there seemed to be no effective mechanism for ensuring duty ward staff were aware of the information received about the restrictions needed to mitigate the potential risk to AB of CD's behaviour.

5. Use and understanding of legislation

5.1. Welfare guardianship

During the second ASP process in 2016, it was decided to apply for a welfare guardianship order for AB and contact AB's family to explore their views on becoming welfare guardians. However, the ASP case conference on 21 June 2016 decided to suspend the application, instead pursuing the CPA approach.

The minutes record it was agreed AB met the ASP three point criteria as an adult at risk of harm. There was some evidence of improved engagement (mainly with primary care) and there were concerns that if guardianship was pursued, it might trigger AB and CD to leave the area. There was also vigorous opposition by AB and CD via their solicitor to any official involvement. The original intention had been to apply while AB was detained in hospital on the STDC but circumstances made it difficult to obtain the required second medical report; AB refused to see the GP who visited and the medical trainee on the ward had insufficient experience. The consultant learning disability psychiatrist could not find a second doctor to do the assessment either during the admission or in the weeks afterwards. The guardianship plan was dropped even though AB's circumstances had not changed significantly.

The lack of a welfare guardianship order was crucial. Without legal authority, it was not possible to follow through on proposals for supported accommodation. The possibility of more appropriate accommodation was raised in 2016 but AB and CD did not engage with housing on this and there were no legal powers to move AB.

In 2017, social work were informed AB had granted CD power of attorney which gave authority to make welfare (and financial) decisions on AB's behalf. Later, during AB's final hospital admission, CD's role with power of attorney meant they were able to take decisions on behalf of AB which may have made it more difficult for staff to intervene. This would not have arisen if AB had been subject to a guardianship order with a named guardian who was not CD.

It is also possible that if AB's family had been successfully contacted as intended, ways might have been found to rekindle AB's relationship with them.

The Commission's view is there was sufficient evidence for an application for a welfare guardianship order in 2016. This became more evident when there was no engagement by CD and AB in the CPA process. The inability to timeously identify a second doctor, who could assess capacity for decision-making in relation to AB's health and welfare needs, for the guardianship application was a system failure.

5.2. Local authority's duties and power of attorney

In February 2017, the local authority was informed AB had granted power of attorney to CD in October 2016. Although there was discussion about whether AB had capacity to grant this, no action was taken.

The Commission's good practice guide, *Common Concerns with Power of Attorney*[24], says:

> *"If there are concerns that the granter has drawn up a power of attorney document and has not understood its effects or has been subject to undue influence, it is important to contact the Office of the Public Guardian (Scotland) promptly so that they can examine this before it is registered."*

Of note, power of attorney can only be revoked if the granter still has the capacity to do so, and in AB's case the question arose as to whether they had the capacity to grant it in the first place. In situations where there are concerns about the capacity of the granter to grant the power of attorney or the unsuitability of an attorney acting under a continuing power of attorney, then contact should be made with the Office of the Public Guardian (OPG)[25]. The effect of doing so can start an investigation by OPG and result in a freeze on the actions of the attorney. Where the concerns about the actions of the attorney are solely about financial matters then the OPG is the relevant authority, whereas where there are welfare concerns the Commission can also offer advice.

Local authorities have a duty under s10 (1) (c) of the AWI 2000 Act to investigate concerns about an attorney's exercise of functions relating to the personal welfare of an adult. The local authority or any other interested parties have the option to apply to the sheriff for direction on how to proceed under section 3 to request that a PoA is revoked or use section 20 to challenge.

The Commission's view is the granting of the power of attorney and CD's appointment as attorney was open to challenge by any interested party given the longstanding concerns about CD's care of and influence over AB and was in keeping with the expressed intention by social work in April 2016 to challenge CD as named person. Where there are concerns about the capacity of a person granting a PoA under the AWI 2000 Act, advice should be sought from the Office of the Public Guardian.

5.3. Solicitor's duty and power of attorney

As stated in section 3.2 (effect of solicitor's letters), the Commission understood the surprise expressed by staff involved when this PoA was granted to CD by AB in circumstances that raised questions about AB's capacity to do so. Five months before the granting of the PoA, the solicitor lodged a section 50 appeal under the 2003 Act against the detention of AB on a short term detention certificate. At the Mental Health Tribunal hearing at which the solicitor was present, evidence was presented that AB's capacity to make decisions about treatment was impaired as a result of an established learning disability. Knowing that AB's capacity for decision-making about their treatment was disputed at the tribunal, this ought to have prompted the solicitor to seek a medical report on AB's capacity to grant the power of attorney.

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[24] *Common Concerns with Power of Attorney*, 2020, Metal Welfare Commission, https://www.mwcscot.org.uk/sites/default/files/2020-07/CommonConcerns_PowersOfAttorney_July2020.pdf
Similar advice in previous editions in 2015 and 2017.

[25] www.publicguardian-scotland.gov.uk

The Commission's view is CD's position as an attorney posed an added barrier for staff when considering how to respond to behaviours which posed a risk to AB.

Solicitors, when consulting with clients who seek to grant power of attorney, must fully consider their client's capacity to do so or vulnerability and they must also consider issues of any undue influence. The Commission has previously addressed this issue in a report published in 2012 *Powers of attorney and their safeguards - Mr and Mrs D*[26] . In response The Law Society of Scotland introduced guidance for solicitors which remains current.[27] [28]

The Commission wish to remind solicitors of their responsibilities when working with clients who seek to grant Power of Attorney and the usefulness of existing guidance. The Commission will draw this learning point to the Society's attention.

5.4. Understanding of capacity

During the first ASP investigation in 2014-15, the question of AB's capacity for decision-making about treatment was raised. AB and CD changed GP during the process; neither GP had formally assessed AB's capacity to consent to medical treatment but neither had concerns. Summary GP notes included repeated instances of CD insisting that AB had capacity to consent to medical procedures or of CD 'giving consent'.

The GPs' view of capacity seems to have been based on presumption of capacity rather than assessment. This appears to have been accepted without consideration of an assessment and despite the fact the court case, which first brought AB's circumstances to light, had been quashed during appeal in 2014, partly on the basis of a medical report that AB was not fit to give evidence because of mental incapacity. The ASP record of full investigation on 6 March 2015 said, "Deemed to have capacity to consent to medical treatment. This was confirmed by two general practitioners." Although capacity is of course decision-specific, the decision not to pursue further capacity assessment is cause for concern.

It was suggested to us that perhaps AB's verbal skills masked some of their comprehension difficulties.

The Commission's good practice guide *Right to Treat*[29] says:

> *"In law, there is a presumption in favour of capacity. The presence of a mental illness or learning disability does not automatically mean that a person lacks capacity to consent to treatment. Also, disagreeing with a suggested line of treatment does not necessarily mean that the person lacks capacity. It is important to assess capacity in relation to the treatment decision that the person is facing. "Presumption in favour of capacity" must be interpreted with care. It does not mean that a person is "assumed to have capacity*

[26] Publications | Mental Welfare Commission for Scotland (mwcscot.org.uk)
[27] Continuing and Welfare Powers of Attorney | Law Society of Scotland (lawscot.org.uk)
[28] B1.5: Vulnerable Clients Guidance | Law Society of Scotland (lawscot.org.uk)
[29] *Right to treat: Delivering physical healthcare to people who lack capacity and refuse or resist treatment*, 2011 and 2022, Mental Welfare Commission https://www.mwcscot.org.uk/sites/default/files/2022-02/RightToTreat-Guide_February2022_0.pdf

unless there is a certificate that states otherwise". A presumption of capacity can be challenged if there is evidence to the contrary."

Further limited understanding of capacity was demonstrated during the second ASP investigation. The advice given in an email from the local authority queried AB's incapacity on the grounds AB had shown refusal to meet with the GP by locking themselves in a toilet – that is they made a decision not to meet and appeared to act on it. This shows a lack of consideration of the complexity of the situation, including AB's general reluctance to engage, their limited understanding, and CD's influence.

The Commission's view is the first ASP investigation was a missed opportunity to assess AB's capacity to make decisions with regard to their care and treatment and, potentially, to have considered the appointment of a welfare guardian. It is concerning there was a lack of understanding of the legal authority required for proxy consent. It is also concerning there seemed to be limited understanding of the interpretation of presumption of capacity.

5.5. Use of specified persons measures[30]

During AB's final admission in the orthopaedic rehabilitation ward, they were detained on a STDC on 24 December 2018. For a few days, cooperation improved but by 9 January 2019 there were significant concerns. A multi-disciplinary meeting which included a liaison psychiatrist agreed specified persons measures under the 2003 Act should be put in place to control AB's use of the phone. However, this power was not put in place until 16 January and was not in use until 23 January. It was recorded on 14 January phone use was to be specified when the CTO was in place, which appears to indicate a lack of understanding, as this can be done when someone is detained on a STDC. It is not clear why a week elapsed between the decision and the formal specifying of AB for phones; nor why, once the power was available, did ward staff not use it for a further week.

The Commission's view is it was clear AB's use of the phone to contact CD was problematic and the decision to limit it under specified person's measures was appropriate but could have been put in place more quickly than it was.

[30] specified_persons_guidance_2015.pdf (mwcscot.org.uk)

5.6. Potential actions under ASP

A council can apply to the sheriff for three types of protection order under the Adult Support and Protection (Scotland) Act 2007[31] :

- An assessment order allows a council officer to take the adult somewhere to conduct a private interview and for a private medical examination to establish whether they are an adult at risk. The adult is not detained and is free to leave at any time. (An assessment order was considered, but not used.)
- A removal order allows a council officer to remove an adult at risk to a specified place if there is a likelihood of serious harm if they are not moved, and is valid for up to seven days. The adult is not detained and is free to leave at any time.

Given the strongly expressed unwillingness of AB to engage with social workers, it is unlikely either of these orders would have been of use in practice. Where an adult has capacity, they must have given consent to an ASP protection order, unless it can be shown they have been unduly pressurised to refuse consent and there is no means to protect them without their consent. If there is proof that the adult lacks capacity then AWI powers should be considered. The lack of clarity about AB's capacity made it impossible to apply this decision-making framework.

- The third protection order under ASP is a banning order which bans the subject of the order from being in a specified place for up to 6 months.

We asked whether a banning order had been considered at any point to ban CD from their home. Staff recalled they considered every piece of legislation at their disposal.

There were also a range of powers under the ASP 2007 Act which include the power to visit, interview, examine and obtain records which could have been applied in this case.

The Commission's view is the local authority applied an ASP framework in attempting to assess, support and protect AB. However, their poor engagement with staff and a lack of clarity in relation to capacity made this approach difficult for reasons we have already highlighted. Whilst accepting ASP legal interventions may not have fully addressed concerns in this situation, despite regular ASP meetings, we saw little recorded discussion of the concept of undue influence or pressure, a lack of use of chronologies, and inconsistent protection plans and decision-making.

We are pleased the local authority concerned have updated their inter-agency ASP procedures and practice since this time and this includes guidance on non-engagement.

[31] The Adult Support and Protection (Scotland) Act 2007. A short introduction to Part 1 of the Act. 2008, Scottish Government. https://lx.iriss.org.uk/sites/default/files/resources/0063124.pdf#:~:text=Removal%20orders%20are%20effective%20up%20to%20a%20maximum,a%20specified%20place%2C%20for%20up%20to%20six%20months.

5.7. Potential actions under the Mental Health (Care and Treatment) (Scotland) Act 2003

While detained in hospital on the STDC, a detailed case was made to be put before the Mental Health Tribunal to have CD removed as named person but not carried forward. Reasons given include it was thought likely the detention would not be extended to a CTO and concern was raised a second tribunal closely following the failed section 50 tribunal was not in either person's interest.

At no point was consideration given to the use of Section 315 of the 2003 Act to seek the court's view on the potential for conviction of CD under section 315 which states that:

> *"It is an offence for a relevant person who provides, or purports to provide, care and treatment to a patient to ill-treat or wilfully neglect that patient'. A relevant person is defined as 'a person who is (a) an individual employed in, contracted in to provide services in or to, a hospital (b) not being the Scottish Ministers is a manager of that hospital (c) provides care services or (d) is an individual who otherwise than, by virtues of a contract of employment or other contract with any person or as a volunteer for a voluntary organisation provides care or treatment."*

The provisions of section 315 apply to informal patients just as they apply to persons being treated under the 2003 Act. Similar powers exist under section 83 of the AWI Act 2000.

It is important to note concerns under Section 315 can be raised by any member of the public not just professionals involved in care and treatment.

Additionally, it appears at no point was consideration given to the use of Section 317 of the 2003 Act to explore the potential for the prosecution of CD for obstructing those trying to assess or provide care to AB when they were subject to detention under the 2003 Act. Under section 317, obstruction includes refusing to allow a person to access, interview or examine a mentally disordered person if they are authorised by the 2003 Act to do so, as well as persisting in being present when requested to leave by a person authorised by the 2003 Act to interview or examine a mentally disordered person in private. Section 317 only applies when the person being obstructed is exercising functions conferred on them by the 2003 Act,

There is a similar offence under section 49 of the ASP 2007 Act relating to obstructing a person from doing something they are authorised to do under the 2007 Act, such as an assessment, removal or banning order, or a warrant for entry. This did not appear to be reflected in ASP discussions. For example, where CD's actions caused concerns about compliance and engagement with ASP measures, staff could have discussed whether CD's actions meant there was evidence they were committing an offence under these provisions warranting a report to the police.

The Commission's view is the challenge to CD's role as the default named person in 2016 was legitimate. Had it gone ahead, added support could have been provided to AB by inpatient staff and appropriate follow-up given to CD.

Challenges under Section 315 are made only infrequently. There was potential for its use when CD's risk to AB as a relevant person under section 315 of the 2003 Act became more overtly evident in the acute inpatient unit and at the point when police charged CD with

culpable and reckless conduct. Section 317 on obstruction could have been used and consideration under section 49 of the ASP 2007 Act should have been given.

5.8. Interaction between the different Acts

There were difficulties with the interaction between the three pieces of legislation: the Adult Support and Protection (Scotland) Act 2007, under which the three investigations were carried out; the Mental Health (Care and Treatment) (Scotland) Act 2003, which was used to detain AB for assessment and treatment three times; and the Adults with Incapacity (Scotland) Act 2000, under which acutely needed physical treatments were provided, AB granted power of attorney and the local authority applied for welfare guardianship in the days before AB's death.

In 2016, the CLDT viewed the detention as having been helpful for assessing the extent of a learning disability (and stabilising physical health while an inpatient) but not effective in dealing with the adult support and protection concerns in the long term. Refusal to engage and resistance to social work input was seen as the most significant problem with the use of legislation and also created doubt about the effectiveness of guardianship even if powers were gained.

In discussing the various options available in February 2019, liaison psychiatry recorded their view that the combination of detention under the 2003 Act and AWI Section 47[32] did not extend to limiting undue influence, particularly given CD's powers as attorney under the PoA which had been granted, whereas a guardianship order would change that. Evidence had amassed that CD had repeatedly failed to co-operate with medical staff or follow their advice (about AB's treatment needs) and doubt existed that this would change. Staff endorsed this approach, although the advising local authority requested more evidence of 'necessity' of the guardianship order.

The Commission's view is there were a number of unknowns about AB which warranted formal assessment, including the diagnosis of learning disability, so admission for assessment under the 2003 Act was justified. AB appealed the detention to the Mental Health Tribunal Scotland, which found the STDC remained necessary and all the criteria were met.

We agree it is appropriate to consider less restrictive options for assessing capacity and needs when there are adult support and protection concerns than admission to hospital under the 2003 Act. In AB's case, assessment of capacity in the community had previously proven impossible and the grounds to apply for a CTO in order to complete the process of obtaining the assessments necessary before a guardianship application could be made could have been tested at tribunal.

Combining all three pieces of legislation in this case at earlier opportunities might have assisted in assessment, support and protection for AB. We have earlier highlighted opportunities to consider undue pressure under section 35 of the 2007 Act, a challenge to the PoA under the 2000 Act and an earlier application to secure welfare guardianship

[32] A Section 47 AWI certificate authorises treatment decisions to be made on behalf of people who lack capacity to make decisions about their treatment

powers. At times we observed a lack of working knowledge on aspects of these pieces of legislation and how they interacted.

The independent Scottish Mental Health Law Review[33] aims to "improve the rights and protections of persons with a mental disorder and remove barriers to those caring for their health and welfare", and is considering the need for the convergence of incapacity, mental health and adult support and protection legislation.

We will ensure the findings of this investigation are shared with Scottish Government as they consider the recommendations of the Review.

[33] https://mentalhealthlawreview.scot/

6. Local review processes

There was no local review of AB's death. Despite having a number of physical health conditions, AB could have anticipated more years of life. AB's death was not expected: until only two weeks beforehand options for their discharge were being discussed.

The circumstances of AB's last weeks in hospital were difficult and there was a criminal charge made and subsequently dropped against CD.

The Commission wrote to liaison psychiatry at the NHS board in July 2019 asking about a significant adverse event review but appears not to have received or not logged their response, which – according to a letter by liaison psychiatry in the NHS file - was they were not aware of a review other than there was police interest. In interviews, one member of social work staff told us they asked for a review to be carried out while another said there should have been a review but there seemed to be uncertainty as to where responsibility for doing so lay. We are unaware of discussions being had about a review being held by the local NHS which was jointly involved in AB's care and treatment.

At that time, the local Interagency Policy and Procedure for the Support and Protection of Adults at Risk of Harm stated that a significant case review should be considered by the local adult protection committee (APC) when an adult at risk of harm dies, and says,

> *"A Serious Case Review is not an inquiry into how an adult died or suffered injury or who is culpable. The case under review will be used to make recommendations to improve policies and procedures and further the learning of those involved in the adult and support and protection process."*

Staff from any agency with an interest in the adult's well-being or safety can raise concerns about a case to the local Adult Protection Committee should it meet the relevant criteria. The APC carries out these reviews in line with its functions of keeping procedures and practices under review, giving information and advice to public bodies and helping and encouraging the improvement of skills and knowledge of employees within these. Recent guidance from Scottish Government issued in May 2022 outlines the current ASP process for 'Learning Reviews'[34].

The Commission's view is the circumstances of AB's death warranted raising with the Adult Protection Committee with a view to conducting a significant case review - now known as a learning review. Notification to the APC would then have resulted in a rationale as to how to proceed, including consideration of joint work with the NHS significant adverse event review process.

[34] Adult support and protection: learning review guidance - gov.scot (www.gov.scot)

7. Other observations

There were some local processes which did not work effectively but which were not likely to have contributed to AB's death.

7.1. Mental Health Act paperwork

There were failures to send the Mental Health Act paperwork to the Commission, as required under the Mental Health Act 2003:

- No revocation notice was received from the psychiatric hospital for the 2016 STDC.
- Part of the paperwork for making AB a specified person in the rehabilitation ward in January 2019 was missing and the rest was incomplete.
- The CTO was revoked the day before AB's death in the general hospital but the revocation paperwork was not sent to the Commission.

The Commission's view is while these failings would not have affected the outcome for AB, they warrant local attention.

7.2. GP adult support and protection responsibilities

Section 5 of the Adult Support and Protection (Scotland) Act 2007 requires public bodies and office holders to co-operate with local authorities making inquiries. The inquiring council officer's request for information on prescribed medications for both AB and CD was turned down on advice from the GP's medical defence union, however other useful information was provided.

The Commission's view is this was not material to the outcome. However, section 10 of the ASP 2007 Act outlines the principle of sharing only what is requested and even partial information can be crucial. Caldicott Guidance on the sharing of confidential information to assist in the provision of safe and effective care is also relevant.[35] The 7th Caldicott Principle reminds that, "The duty to share information can be as important as the duty to protect patient confidentiality" and health and social care professionals should have the confidence to share confidential information "within the framework set out by these principles". They should also be supported in this by the policies of their employers, regulators and professional bodies.

The Commission is pleased to note the release of comprehensive guidance from Scottish Government for GPs and primary care teams which addresses the sharing of information in adult support and protection processes, with and without patient consent. [36]

[35] The Caldicott Principles - GOV.UK (www.gov.uk)
[36] Adult support and protection - guidance for GPs and primary care teams: consultation analysis - gov.scot (www.gov.scot)

8. Conclusion

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

We acknowledge professional judgement was repeatedly brought to bear with supervision of staff and the involvement of senior and experienced personnel. Multi-agency working was also in evidence across social work, health – primary care, acute services and learning disability and liaison psychiatry - police, and housing, although a collective and longer term understanding of the risks AB faced and the point at which further action and intervention was justified did not come through.

While social work was the 'lead agency' in undertaking the legal duty to inquire under ASP legislation, there were changes in personnel, changes in the roles undertaken by individual members of social work staff and changes in senior responsibility over time that may have contributed to a failure to take a long term comprehensive view of the risks faced by AB. Small pieces of evidence of improvement at single moments in time overly influenced the overall approach leading to a 'stop-start' situation and the repeated loss of momentum to step in and effect change.

We acknowledge staff recognised there was also duty of care towards CD.

We have looked back at the five years prior to AB's death. There were a number of learning points, which we address throughout the report and in our recommendations.

The proximate cause of AB's death was the infection which developed in a limb and then spread. It is likely the difficulty in engaging with AB and the active interference with their care and treatment by CD contributed to AB's decline.

However, in our view, the first pivotal moment was the decision in 2016 not to proceed with the welfare guardianship order application. This was a decision taken after lengthy discussion but in our view it was the consequence of circumstances – the difficulty in engaging with AB and of obtaining a second medical certificate – rather than confirmation their health needs were being safely and fully addressed and would remain so, that led to the decision to withdraw from seeking statutory powers.

The lack of a welfare guardianship order until the latter days of AB's life, which would have provided legal authority to manage their care and support and, if necessary, the level of involvement of CD, was a missed opportunity. Had it been put in place earlier, it might have helped professionals to focus their care and treatment, brought greater clarity as to who was overseeing AB's health and wellbeing needs and contributed to a different outcome for AB.

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

The complexity of the legal landscape, with three different Acts in play, was problematic. However, it is expected that staff working in NHS and social work are knowledgeable of the legislation available for use in treatment and safeguarding of people and have sufficient knowledge of the application of the Acts when in roles where decisions are taken on when to invoke legislation.

It is of concern there was no local review of AB's death. Our view is historical concerns about the role of and influence from CD as AB's accepted carer and CD's ability or otherwise to safely enable AB to have their health needs met was sufficient to warrant a local learning review.

In addition, AB was a relatively young person with mild to moderate learning disability whose death from a preventable cause – deterioration of physical health associated with a longstanding health condition in addition to a fracture – was also reason to trigger a multi-agency learning review. The early deaths of people with learning disabilities (at least 20 years sooner than the rest of the population) is a focus of study by the Learning Disabilities Observatory and a central ambition in the learning disabilities strategy published in March 2019 is to tackle health inequalities for people with learning disabilities – both in access to healthcare and in life expectancy.[37]

[37] Keys-To-Life-Implementation-Framework.pdf (keystolife.info)

9. Recommendations

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.

9.1. Recommendations for NHS A and local authority A

1. NHS A and local authority A will be asked to review their processes for deciding on when to initiate a local learning review ensuring that these meet the recommendations of the new Scottish Government Guidance for Adult Support and Protection Committees. [38]
2. NHS A and local authority A will be asked to ensure that staff are aware of the importance of reporting to the Office of the Public Guardian concerns about the appointment of an attorney by someone who may lack capacity to do so or be subject to undue influence, and of the local authority duty to investigate concerns about an attorney's exercise of functions. In addition, they will be asked to ensure that staff are aware of the ability of a person with an interest in the Adult's affairs under AWI to seek an order from the sheriff regarding the operation of a power of attorney or revocation of the PoA.
3. NHS A and local authority A will be asked to provide training and support for social work and health staff on adult support and protections under the ASP 2007 Act, including identifying an adult at risk when in hospital and the powers available when there is difficulty with engaging with the adult who may be subject to undue influence. This is also to ensure that where there is inter-agency complexity and multi-site treatment provision a single person is made the nominated lead for the case.
4. NHS A and local authority A will be asked to ensure that where guardianship applications are discontinued in preference for less restrictive case management arrangements that risk management planning includes trigger-points when guardianship should be reconsidered.
5. NHS A and local authority A will be asked to audit the effectiveness of their processes to monitor long term conditions management for people with learning disabilities.
6. NHS A will be asked to review medical records procedures in relation to the Mental Health (Care and Treatment) (Scotland) Act, including in general hospitals to ensure that the requirement to submit documents to the Commission is consistently met.

9.2. Recommendations nationally

7. Scottish Government will be asked to review the existing systems and processes for obtaining second medical reports ahead of applications for guardianship orders and instigate steps to improve access and monitor the impact of improvement processes on speed of access across boards and health and social care partnerships.

[38] Adult support and protection: learning review guidance - gov.scot (www.gov.scot)

10. Learning points

Learning points are not formal recommendations but points of best practice to be taken into consideration by all providers of mental health care, treatment and support.

- The concept of undue pressure introduced in the 2007 Act can present dilemmas for professionals during the course of adult support and protection investigations. Such a dilemma occurred in this case. The Scottish Government's Code of Practice details undue pressure but public bodies (NHS boards and local authorities) may want to focus on undue pressure as part of their ASP learning and development programmes, particularly on what evidence of undue pressure can be presented to a court when seeking a protection order.
- Similar considerations apply to **coercive control or undue pressure**. In such situations the control exercised over a vulnerable person may render them **unable** to take or action decisions that would protect them from harm. It is therefore important to understand the person's decision-making processes. This should include an understanding of any factors which may have impinged on, or detracted from, their ability to make and action free and informed decisions to safeguard themselves. In these circumstances an affected person should be regarded as unable to safeguard themselves.
- Solicitors when consulting with clients seeking to grant power of attorney must fully consider their client's capacity to do so, if there is any undue influence or vulnerability and the attorney's ability to fully comprehend their role. The Commission addressed this issue in a report published in 2012 *Mr and Mrs D*. In response the Law Society of Scotland introduced guidance for solicitors which remains current[39] [40]. The guidance for Rule B1:5 of the Law Society of Scotland Rules, notes that whilst the solicitor must satisfy themselves that a client has capacity, "if there is any doubt as to a client's capacity to instruct in a particular case (for example a client may have a profound learning disability), input should be sought from an appropriate professional".
- With the implementation of Mental Health Scotland Act 2015 named persons must be nominated and individuals need to have capacity to make a nomination[41]
- There is no absolute right to be allowed to visit an individual in hospital but this is balanced against the rights of the patient e.g. Article 8 ECHR – 'Right to respect for private and family life'. A statutory provision which could be used to prevent access by a visitor in a situation such as in this case is a Banning Order under section 19 of the ASP 2007 Act. This would be time-consuming but could be achieved. The health board could also go to court to seek an order at common law to prevent visits, and could seek an interim interdict pending a full case hearing.
- The Care Programme Approach (CPA) to meeting health and social care needs for people with complex mental health problems or learning disability needs the agreement and participation of the individual involved if it is to meet the person-centred objectives associated with CPA, in addition to effecting multidisciplinary and

[39] Continuing and Welfare Powers of Attorney | Law Society of Scotland (lawscot.org.uk),
[40] B1.5: Vulnerable Clients Guidance | Law Society of Scotland (lawscot.org.uk)
[41] Mental health law in Scotland: guide to named persons - gov.scot (www.gov.scot)

multi-agency collaboration. CPA has no legislative basis but can be a useful framework for multidisciplinary work when a legislative framework such as the 2003 Act is in place and care taken not to exclude individuals from other legislative processes which might be warranted and afford greater protection by more formalised risk management processes.

Appendix 1 – Glossary

Adult protection committee (APC) - APCs are in every council area. The committee monitors and reviews what is happening locally to safeguard adults. It is made up of senior staff from many of the agencies involved in protecting adults who may be at risk. These include staff from the council, the NHS and the police.

Care manager – employed by an HSCP to assess people's care and support needs and work with them and their families to arrange how these needs are met.

Council officer – appointed to investigate adult support and protection concerns. The role is defined under section 53 (1) of the Adult Support and Protection (Scotland) Act 2007 and is usually a registered social worker, but can be an occupational therapist or a nurse and must have at least 12 months post qualifying experience of identifying, assessing and managing adults at risk.

Health and social care partnership (HSCP) - organisation formed as part of the integration of health and social care services provided by NHS boards and local authorities; jointly run by the NHS and local authority.

Liaison psychiatrist – looks after the mental health aspects of the care of patients being treated in acute hospital for physical health problems.

Liaison psychiatry – consultant-led psychiatry input on general hospital inpatient settings.

Mental health officer (MHO) – a specialist social worker with additional training who has specific roles under mental health and adults with incapacity legislation.

Power of attorney (PoA) – a power of attorney is a way of giving another person – the attorney – the authority to deal with your financial and/or welfare affairs when you are no longer able to do so. It must be drawn up when you have the capacity to do so and registered with the Office of the Public Guardian.

Responsible medical officer (RMO) – responsible medical officer under the 2003 Act. Usually the person's treating consultant psychiatrist.

Service manager – senior member of HSCP staff who has responsibility for a particular part of HSCP service.

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