mental welfare commission for scotland

# Investigation into the care and treatment of GH

Investigations

**November 2023**

# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

## Investigation into the care and treatment of GH

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

This investigation addresses the period GH accessed mental health services prior to the homicide. The report is intended to highlight systemic learning for mental health services across Scotland, in addition to specific recommendations to the services and organisations highlighted within the report recommendations.

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

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

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

This report does not contain information about the victim of the homicide. The Commission fully acknowledges the distress and grief faced by the families involved and convey our sincere condolences to the victim's family and friends.

# Contents

## Investigation

This report is an investigation into the circumstances leading up to a homicide conducted by GH who was in contact with mental health services prior to this tragic incident.

## Executive summary

GH was an adult at the time of the homicide, which concerned an unrelated person previously known to GH. GH had longstanding difficulties in their relationship with their nearest relative and from early presentations to mental health services, GH's nearest relative raised concerns about GH's violent behaviour towards them. During the majority of GH's care by mental health services, GH declined to allow clinical staff to disclose information about their care and treatment to their family.

GH had documented issues with alcohol misuse from their early teenage years when they were referred to alcohol services by social work services whilst in high school. GH had a history of criminal convictions for violence associated with alcohol misuse as a teenager.

In their early 20s, GH was treated in hospital in Area B for cannabis induced psychosis and having moved to Area A, was then treated in the community there for a further episode of psychosis linked to cannabis misuse. GH moved again to another community mental health team (CMHT) catchment in Area A where they initially presented with possible attention deficit hyperactivity disorder (ADHD) and depressive symptoms. Two years before the homicide, GH was diagnosed as having a paranoid personality disorder following a community and subsequent second inpatient assessment. Prior to these assessments, GH's nearest relative, in addition to a close family member, had expressed concern about the increase in GH's level of violence directed largely at their nearest relative.

GH's next presentation to services was in their late 20s. GH had moved in with their nearest relative in Area B, but remained under the care of NHS services in Area A. The family again raised concern about the level of violence directed at GH's nearest relative prior to admission. GH was initially diagnosed as being acutely psychotic and was detained under a short-term detention certificate (STDC). They were treated with an anti-psychotic medication, and there was consideration of a possible compulsory treatment order (CTO), however GH's mental state appeared to settle, and they were discharged.

Although the consensus during the inpatient stay was that GH had an acute psychotic illness, the diagnosis made on discharge was again of a paranoid personality disorder. Follow up in the post-discharge period by the crisis team was difficult because of GH's return to their nearest relative's home in Area B against the advice of the inpatient team.

Immediately after discharge, concerns were raised by GH's nearest relative that they were too unwell to be out of hospital and that GH had assaulted them. The crisis team asked that GH be re-admitted to hospital because of lack of engagement with the community service, non-compliance with medication, and the reports of violence directed at their nearest relative,

however the senior medical view in Area A was that GH should continue to be supported in the community.

Following further violent behaviour at GH's ex-partner's house in Area B, GH was taken into police custody. A further senior medical review at the Sheriff Court in Area B confirmed the diagnosis of paranoid personality disorder. GH was thought not to be detainable under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) at that time and was released by the Court.

Despite the efforts of the crisis team in Area A, GH remained in Area B and did not attend follow up appointments with them. A close family member of GH, who was also a mental health professional, arrived from outside of Scotland to provide support to GH's nearest relative. This family member contacted the crisis team about GH's deteriorating mental health and further violence to their nearest relative over the previous weekend.

GH's nearest relative and close family member presented at CMHT-A to express concern regarding the lack of support given to GH. GH's nearest relative was advised by staff to return to their family member's residence outside of Scotland and not go home. The police were asked to trace GH in order that they could have a further senior medical review at CMHT-A that day, but they could not find GH.

The following day, GH was assessed by the crisis team having returned to their home in Area A. They presented well, denied all allegations of violence from their nearest relative, and agreed to comply with medication and further follow up with the crisis team in two days. GH did not answer the door to the crisis team at their follow up, two days later. It was noted that GH contacted the crisis team that evening to arrange a further appointment, however the crisis team were unable to make further contact with GH. The following day, the homicide occurred.

## Key findings

At the time of the homicide, GH had active symptoms of a psychotic illness and had consumed alcohol.

Information about GH's history of violent behaviour was lost over time. Reports of more recent violence largely directed towards their nearest relative were not taken into account, in particular by inpatient services in. As a result, GH's propensity to future violence was not fully recognised.

An important factor in the ineffective treatment of GH's psychotic illness were organisational changes made in NHS Area A during the Covid-19 pandemic. As a result of the loss of continuity of senior medical care, there was no recognition of either GH's psychotic illness at the point of discharge from hospital prior to the incident taking place, or of the increase in risk in the community associated with their active psychotic symptoms, alcohol, and cannabis misuse post-discharge.

During inpatient admissions in both NHS Area A and NHS Area B, there was insufficient account taken by clinical services of family concerns about the risk of violence posed by GH. In the post-discharge period prior to the incident, community staff did take account of the family's concerns and address these individually, but their efforts to respond were ineffective.

GH was able to present in a plausible manner and to mask their psychotic symptoms. This influenced decision making at critical points in their care.

By the time of the incident, despite the fact that the clinical team were not aware of GH's previous convictions for violence, it was apparent to staff that GH represented a threat to the safety of their nearest relative.

Although GH did pose an increased risk of violence following discharge from hospital because of their history of convictions for violence, active psychotic symptoms, and misuse of substances, the risk to the specific and unrelated victim could not have been predicted.

## Conclusions

There were many examples of good quality care in the health and social care partnerships (HSCPs) in both Area A and Area B during GH's care by mental health services. However, throughout GH's care, the risk of future violence was never assessed or managed in a systematic way.

Information about GH's history of violent behaviour, the best predictor of future serious violence, was lost over time. Reports of more recent violence, largely directed towards their nearest relative, were not taken into account, in particular by inpatient services. As a result, GH's propensity to future violence was not fully recognised.

An important factor in the ineffective treatment of GH's psychotic illness was the organisational changes made in NHS Area A in response to the Covid-19 pandemic. The lack of continuity of care as an inpatient resulted in a misdiagnosis at the point of GH's discharge from hospital, which impacted on how risk was assessed and managed in the community. Lack of clarity about the designated responsible medical officer (RMO) in the two weeks following discharge contributed to the lack of recognition that GH's mental health was deteriorating, and the level of risk was increasing.

A further effect of the pandemic was the impact on inpatient structured multidisciplinary team (MDT) meetings, including the involvement of the crisis team and lack of supported passes home prior to discharge. These issues are likely to have contributed to the lack of documented discussion about the risk of violence and how this could be mitigated, the lack of comprehensive discharge planning and of engagement by GH with the crisis team following discharge. There was pressure on clinical services to keep ward inpatient numbers low, increasing the requirement for the crisis team to monitor patients closely in the high-risk post-discharge period.

GH's previous violent behaviour was linked to alcohol intoxication. This association was identified and discussed with GH in the community in Areas A and B during two separate assessments, when GH was in their early and mid-twenties but thereafter not referred to again. There were questions asked about alcohol use on admission to inpatient services on two other occasions during this time but not in the final admission prior to the incident. There was no further discussion about alcohol misuse during any of the three inpatient stays, the focus there being the negative impact of cannabis misuse on GH's mental state.

During inpatient admissions in both NHS Area A and NHS Area B, there was insufficient account taken by clinical services of family concerns about the risk of violence posed by GH. There was a recurring pattern during all three of GH's admissions to hospital, in which the concerns of the family regarding the risk of violence by GH to their nearest relative were well documented by nursing staff, but there was no subsequent MDT discussion about the risk of violence prior to discharge.

There was no consideration of over-riding GH's refusal to allow information sharing with the family in view of the potential risk to their nearest relative. GH's nearest relative's reported

concerns were undermined by GH's persistent criticism of their nearest relative's motives and reliability, particularly during the admission in the year prior to the homicide. There was no documented discussion about GH's nearest relative's potential vulnerability as a carer who may have had their own support needs.

In the post discharge period of the admission prior to the incident, NHS Area A community staff did take account of the family's concerns and address these individually, but their efforts to respond were ineffective. The main reason for this was that GH spent the majority of the post-discharge period living at their nearest relative's house in Area B against the advice of staff on discharge from hospital. The crisis team were therefore unable to work effectively to monitor GH's mental state, compliance with medication, or their use of cannabis and alcohol. Despite efforts to engage GH, the crisis team only met with GH face-to-face on two occasions in the two weeks between discharge from hospital and the homicide.

Cross-boundary issues also impacted on the only senior medical review that took place between discharge and the homicide, as there was a lack of information available to the consultant psychiatrist who reviewed GH in Area B. The decision not to detain GH at that time, and the confirmation that GH did not have a psychotic illness but a personality disorder, was influenced by GH's diagnosis at discharge, the lack of information available, and GH's ability to present in a plausible manner.

GH was able to present in a plausible manner and to mask psychotic symptoms. This influenced decision making at critical points in their care prior to the incident, on discharge from hospital, on assessment at the sheriff court in Area B, and at the crisis team home visit three days prior to the incident. GH's nearest relative advised mental health services of GH's ability to present plausibly and to mask symptoms on each of GH's three admissions to hospital, including the final admission prior to the incident, but this was not taken sufficiently into account by staff.

By the time of the incident, despite the fact that the clinical team were not aware of GH's previous convictions for violence, it was apparent to staff that GH represented a threat to the safety of their nearest relative. However, there is no evidence that risk to others was considered by the clinical team.

If there had been recognition of the significant increase in risk of violence posed by GH as a consequence of the history of violent offending from an early stage, following their re-presentation to services in the last admission, this could have provided a focus for risk management planning. It is also more likely that the concerns raised by GH's nearest relative and close family member about the risk of violence would have been considered and responded to by inpatient services. It could have enabled a broader perspective to be taken of who may be at risk from GH. Insight orientated discussion with GH could have included the negative effects of both cannabis and alcohol.

Although GH did pose an increased risk of violence following discharge from hospital because of their history of convictions for violence, active psychotic symptoms, and misuse of substances, the risk to the specific and unrelated victim could not have been predicted.

The terms of reference for the Commission's investigation included care and treatment provided to GH, a review of how risks were assessed and managed, and whether family concerns had been sufficiently considered. These aspects of care are closely interwoven. Taking families' concerns into account and involving them in care should be part of how risks are assessed and managed. Risk assessment and management and involving families in care are both important aspects of care and treatment.

# 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.

## Recommendations for HSCP/NHS Area A

To be completed within six months of report publication:

1. HSCP/NHS Area A should ensure that the learning from this incident is shared with clinical staff.
2. HSCP/NHS Area A should review risk management training and risk documentation in light of this incident. The findings from the recent audit of documentation of historical risk information in relation to GH should be shared with the risk management training team. An MDT approach to review and seek corroborative information from families about historical risk information during inpatient admissions should be operationalised.
3. HSPC/NHS Area A should design a protocol for when patients refuse consent to share information with relatives/carers. This should include an indication of how frequently or in what circumstances this should be re-addressed and documented. It should also indicate the circumstances in which the patient's wishes may be overridden by services in the interests of safety either to the patient or to others. For reference, the Commission has produced the good practice guide *Carers and Confidentiality*.
4. HSPC/NHS Area A should ensure that there is clarity about the designated RMO for all patients, at all times.
5. HSPC/NHS Area A should ensure that CMHT protocols for working with primary care include the procedure to follow up with referrers where a decision is made not to progress a referral from primary care.
6. HSPC/NHS Area A should carry out an audit of timeliness of medical discharge letters for inpatient ward A and other acute admission wards against local standards and address any failings.
7. HSPC/NHS Area A should carry out an audit of immediate discharge letters from inpatient ward A and other acute admission wards and address any failings.

## Recommendations for HSPC/NHS Area B

To be completed within six months of report publication, unless otherwise specified:

1. HSPC/NHS Area B should ensure that the learning from this incident is shared with all clinical staff.
2. HSPC/NHS Area B should design a protocol for when patients refuse consent to share information with relatives/carers. This should include an indication of how frequently or in what circumstances this should be re-addressed and documented. It should also indicate the circumstances in which the patient's wishes may be overridden by services in the interests of safety either to the patient or to others. For reference, the Commission has produced the good practice guide *Carers and Confidentiality*.
3. HSPC/NHS Area B should ensure that clinical staff have access to violence risk management training within 12 months of the publication of this report.

4. HSPC/NHS Area B should provide appropriate training for approved medical practitioners (AMPs) required to cover for court duties in Area B, including use of the Criminal Procedure (Scotland) Act 1995.
5. HSPC/NHS Area B should audit and address the timeliness of letters to the Crown Office and Procurator Fiscal Service (COPFS), general practitioners and CMHTs following assessment by the Court Liaison service.

## Recommendations for Scottish Government

To be completed within six months of report publication:

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

## Learning points for all mental health providers

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

- Mental health care providers should recognise that a history of serious violence is the best predictor of future serious violence.
- Health boards should ensure that training in violence risk management for clinical teams highlights the importance of historical risk information as a predictor of future violence.
- Digital clinical documentation systems should support the retention of historical risk information and ensure availability to all staff 24/7.
- The RMO/consultant psychiatrist should provide leadership to clinical teams to ensure that historical risk information is as accurate as possible. New patient assessments, inpatient admissions and annual reviews are the best opportunity to review historical risk information and to seek corroborative third-party information where confidentiality issues allow this.
- Health boards should ensure that mental health service clinical staff are aware of the process for seeking details of offending history from the police where there are concerns about violence (see Appendix 2: Police Scotland information sharing request).

- All MDT staff should be aware of the important links between violence, substance misuse, and non-compliance and non-engagement with services.
- All patients should be asked for both a forensic history and a history of violence where there may not have been a criminal conviction.
- All patients should be asked for both a drug and alcohol history on presentation to either inpatient or community services.
- Where there is active substance misuse, patients should be referred or signposted and advised to self-refer to substance misuse services (SMS).
- All staff should be aware that discharge from hospital is a high-risk point in care and this should be reflected in comprehensive, inclusive discharge planning.
- All staff should be aware of the 10 key elements for safer care for patients highlighted by the National Confidential Inquiry into Suicides and Safety (NCISS).
- All staff should be aware of the importance of "consulting with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans" Safer services: A toolkit for specialist mental health services and primary care and the Commission's good practice guide *Carers and Confidentiality*.
- Nursing staff should ensure that all family contacts are documented, and any concerns raised by the family should be documented and discussed at MDT reviews both in the community and inpatient care.
- All staff should be aware of the potential vulnerability of carers and consider a carer's assessment. The Royal College of Psychiatrists Standards for Acute Inpatient Services Working-Age Adults states that "carers are supported to access a statutory carers' assessment, provided by an appropriate agency". This is a type 1 standard (criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment - to meet accreditation, the service must achieve 100% of these standards). Under the Carers (Scotland) Act 2016, local authorities have a statutory duty to provide support to carers with identified need.
- Clinical staff should be aware that of all the substance misuse psychoses, cannabis misuse psychosis has the highest rate of transition to psychosis (34-47%). There should be referral to substance misuse services. Consideration should be given to longer term follow up and identification of early warning signs, ideally involving the family, prior to discharge from services. There should be referral to early intervention services where available.
- Where a decision is made by a CMHT not to progress a referral from primary care, the reasons for deciding not to try to make further contact should be documented, discussed and agreed with the referrer.
- All staff should make contemporaneous notes following any clinical encounter.
- All staff should be aware that whilst thought disorder is a symptom of psychosis, it is not a pre-requisite for diagnosis.

# Introduction

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

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

The Commission was first notified about GH's case four months after the homicide occurred. NHS Areas A and B commissioned a significant adverse event review (SAER) of care within two months of the incident, and the finalised report was completed within ten months.

The Commission carried out an investigation into this case firstly because it was clear that the SAER had not included either the family of the victim, the perpetrator, or the perpetrator's family in the investigation. This was because the SAER was commissioned whilst criminal proceedings involving GH were still underway and therefore contact with the family or perpetrator could have prejudiced court proceedings.

This investigation by the Commission is a pilot investigation as part of the Commission's proposals to the Scottish Government for the review of mental health homicides across Scotland. Involving the families and the perpetrator in the investigation is an important aspect of these proposals.

## Focus and lines of enquiry

The terms of reference for this investigation were:

- Examine the care and treatment provided to GH from their first hospital admission until the incident occurred.
- Examine the impact of the Covid-19 pandemic in relation to care, treatment and discharge between their last admission to hospital and the homicide.
- Examine whether risk was assessed adequately, and appropriate management plans put in place.
- Examine whether the family were appropriately involved in care and sufficient account taken of family concerns.
- Consider and respond to questions raised by GH and their family.
- Identify any lessons to be learned both locally and nationally.
- Make recommendations as appropriate.

## Investigation process

The Commission's investigation team had access to mental health social work records and health records for HSPC/NHS Area A and HSPC/NHS Area B (medical, nursing, and allied health professionals). The investigating team also had access to the NHS Area B draft Standard Operating Procedure for Mental Health and Court Liaison Referrals, the draft Safety Assessment Framework and draft Clinical Risk Assessment Policy for Mental Health and Learning Disability services.

The investigating team had access to the NHS Areas A and B's joint SAER report and information from service manager A (NHS Area A) and service manager B (NHS Area B) for inpatient and community mental health services. The investigating team spoke to Dr K, lead investigator for the NHS Areas A and B SAER, and to Dr L from the NHS Area A's first episode in psychosis service.

The investigating team also spoke to Seena Fazel, Professor of Forensic Psychiatry at Oxford University who has a research interest in the relationship between mental illness and violent crime, the mental health of prisoners, and violence risk assessment.

The investigation team eventually traced the family of the victim but despite efforts to engage them in the investigation, were not able to do so during the investigation period.

The investigating team met with GH (the perpetrator), with their nearest relative and a close family member to understand what concerns, if any, they had about the care given to GH.

Having considered the records and the concerns about care raised, the investigating team then met with those key individuals who were part of the process during the period prior and up to the homicide.

The investigating team sought not to repeat interviews already held with involved staff for the health board SAER, unless it was necessary to gain further information on events prior to the incident. Interviews and meetings were conducted either remotely using video links, or in person.

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

**Findings area 1**: Care and treatment provided by NHS Area A and NHS Area B throughout GH's involvement with mental health services.

**Findings area 2**: Impact of the Covid-19 pandemic on care delivered prior to the homicide.

**Findings area 3**: Risk assessment and management by NHS Area A and NHS Area B.

**Findings area 4**: Involvement of the family in care and whether sufficient account was taken of their concerns.

**Findings area 5**: Response to concerns about care raised by GH and their family to the investigating team.

# Findings area 1: Examine the care and treatment provided to GH from the first hospital admission until the incident occurred.

## 1.1 Care and treatment by HSPC/NHS Area B services

GH's care by Area B community services was good. GH's history of violent behaviour associated with alcohol use was well documented, their low mood responded to antidepressant medication, and they were subsequently discharged from follow up. Following a review when they were in their early 20s, GH was appropriately encouraged to self-refer to addiction support services because of problems with alcohol.

There were many aspects of inpatient care that were good. Nursing staff appropriately spoke to social work and other agencies about GH's concerns.

GH refused consent for the release of information to the family. They were repeatedly highly critical of both their nearest relative's views and their reliability. Longstanding difficulties in the relationship with their nearest relative, the fact that their nearest relative was afraid of GH because of their violence towards them in the past, and concerns raised by the family were also well documented by nursing staff.

At GH's first admission and presentation with psychotic symptoms in the context of heavy cannabis misuse, GH's nearest relative asked about a possible referral to early intervention services (for schizophrenia), but this service was not available in NHS Area B services.

## 1.2 Care and treatment by HSPC/NHS Area A services

### 1.2.1 Community mental health team B (CMHT-B)

During their mid-twenties, GH moved to Area A and attended HSCP Area A social work services (SWS) with their nearest relative, looking for help with cannabis misuse and saying they were keen to engage in counselling and support. GH was appropriately referred to the Area A community addiction team by SWS and to CMHT-B in NHS Area A by their GP.

CMHT-B in Area A reviewed GH promptly and the community psychiatric nurse (CPN) carried out a detailed assessment including GH's history of violence and the link to alcohol misuse. There were several documented contacts between the CPN and SWS. The CPN appropriately requested a medical review and referred GH to community addiction team (CAT) services. Contacts with CAT were well documented. There was a further detailed assessment by a CPN and GH was reviewed in outpatients by a consultant psychiatrist.

The care provided over this time by CMHT-B was good, there were timeous, regular assessments, reviews including risk assessments by medical and nursing staff were of good quality and clearly documented. There was also referral to, and ongoing support from, addiction services, liaison and joint working between SWS, CMHT and addiction services.

There is a first episode psychosis service in NHS Area A, but as GH had a treated episode of psychosis in Area B, GH would not have met criteria for this service.

### 1.2.2 Community mental health team A (CMHT-A)

There are some aspects of community care during GH's early 20s that were good, in that GH was seen by two consultant psychiatrists from CMHT-A within a six-month period and on the first occasion, the assessment was carried out with GH's nearest relative.

### 1.2.3 Second inpatient admission

This was a relatively short inpatient admission (less than two weeks) given the history of GH's altered behaviour and of violence prior to admission and the concerns raised by the family. Nonetheless there was evidence of good practice. Risk assessment documentation was completed on admission including GH's prior history of "convictions for violence and assault". GH was asked about the use of both cannabis and alcohol and tested positive for cannabis use on admission.

GH's initial consent for information sharing with their nearest relative and subsequent withdrawal of consent were clearly documented. Family concerns were also well documented by nursing staff and this information appeared to have been passed on at MDT meetings with Dr A. Time was taken by Dr A to discuss the diagnosis of paranoid personality disorder and the impact of cannabis misuse on mental state with GH and they appeared to have insight into this. Dr A also contacted SWS to advise them of the outcome of the admission.

Nonetheless the investigation found there were issues with how risks were assessed and managed, and with regard to family involvement at this time, discussed in sections 3.4 (risk assessment) and 4.2 (family involvement) respectively.

## 1.3 Care and treatment – Commission findings

### 1.3.1 First inpatient admission HSPC/NHS Area B

The issue of how the risk of violence was assessed and managed during this admission is discussed in findings area 3, section 3.4.

Follow up after discharge was for four months by a CPN and at the outpatient clinic. Given the family concerns about GH's volatile and sometimes violent relationship with their nearest relative and the fact that GH had additional responsibilities, it would have been advisable to ensure GH had support to remain abstinent from cannabis and that SWS were aware of any concerns prior to discharge from follow up in the community.

GH should have been made aware of the level of responsibility they had for any violent behaviour and what advice and support they could access to help manage this, including the possibility of family interventions.

### 1.3.2 Community care HSCP/NHS Area A

There were issues with how urgent referrals from primary care were managed by CMHT-A over this time. An urgent referral from GH's GP advised that GH had ongoing relationship difficulties with their ex-partner and that GH had threatened to murder them. Staff were unable to make direct contact with GH. The reasons for deciding not to try to make further contact with GH at this time were not documented, nor was there evidence that this had been discussed and agreed with the referrer. GH was sent a letter, copied to the GP, advising GH of the contact details of the crisis team and out of hours service.

Later that year, following a further urgent referral by the GP and concerned contacts from GH's family, CMHT-A decided not to re-assess GH based on their previous assessments, GH's behaviour, their attitude to previous offers of support and the report that followed the forensic CPN assessment at court in Area B, in which no mental health issues were raised in court.

Given GH's recognised history of psychosis, the significant reported change in their presentation, urgent referral by the GP and requests for help from the family who were concerned that GH was ill and the increasing threat to their nearest relative, CMHT-A should have reassessed GH at this time. As GH's presentation was suggestive of psychosis, it was unlikely that GH would have had sufficient insight to engage with substance misuse services (SMS) or with the CMHT voluntarily as suggested by CMHT-A.

The investigation concluded that CMHT-A did not take full account of GH's family's concerns at this time, which is discussed further at section 4.2.

There were several adult concern reports documented in SWS notes from the police (GH was in their late 20s) and from SWS prior to the last admission, but on none of these occasions were criteria for Adult Support and Protection (Scotland) Act 2007 processes thought to be met. By the time of the adult concern report, GH had been admitted to hospital.

### 1.3.3 Cannabis induced psychosis and schizophrenia

Some people who experience substance-induced psychosis later develop an enduring psychotic disorder such as schizophrenia. Research in 2018 and 2020 (*Transition Substance misuse psychosis to Schizophrenia*, and *Predictors Substance misuse psychosis to Schizophrenia*) indicates that on average, anywhere from 25-32% of patients who have a substance induced psychosis will transition to schizophrenia or bipolar disorder. The type of substance used is the primary predictor of transition with the highest rates associated with cannabis ranging from 34-47% in these two studies. In the latter study, young age was associated with a higher risk of converting to schizophrenia.

Half of the cases of conversion to schizophrenia occurred within 3.1 years after a substance-induced psychosis, and half of the cases of conversion to bipolar disorder occurred within 4.4 years. The authors conclude that substance-induced psychosis is strongly associated with the development of severe mental illness, and a follow up period of at least two years and/or assertive intervention is required to identify the majority of cases.

Although the recent research above indicates that, ideally, services should consider follow up for at least two years where there is a cannabis induced psychosis, this is not established practice in the UK.

# Findings area 2: Examine the impact of Covid-19 pandemic in relation to care, treatment and discharge prior to the homicide

## 2.1 NHS Area A organisational changes

As a consequence of the Covid-19 pandemic, the government ordered a national lockdown.

Prior to pandemic, a patient referred to CMHT-A in NHS Area A would have a designated RMO providing continuity of care throughout inpatient and community care. Inpatient and community care would be delivered by multidisciplinary teams comprising medical, nursing, social work and occupational therapy staff with regular structured MDT reviews in both settings. During the pandemic, there was a major reorganisation of mental health services in NHS Area A to try to limit the spread of infection, protect staff and patients.

## 2.2 Changes to inpatient care

Consultant psychiatrists were asked to move into either community or inpatient posts requiring large scale shifts in caseload responsibility. In inpatient settings, consultants and nursing staff worked within a single ward without the usual regular input from other members of the MDT (social workers, community psychiatric nurses, occupational therapists) in order to reduce the likelihood of introducing or spreading infection on inpatient wards. Over the course of the pandemic, use of 'virtual' multidisciplinary team meetings using Microsoft Teams developed rapidly, but that was not in place at this time. Reviews of inpatients' care would not usually be by structured MDT review meetings but more frequent reviews with medical and nursing staff or medical staff with the patient on a one-to-one basis.

The crisis team, who since the pandemic were the principal clinical link between inpatient and community services, would not attend the ward in person. Junior doctors had been removed from mental health services to assist with the treatment of Covid-19 patients in acute hospital settings.

There was increased pressure on mental health inpatient beds and staffing as a result of Covid-19. Efforts were made to reduce the length of inpatient stays in order to reduce inpatient numbers, and thereby the risk of infection. Newly admitted patients or those returning from pass from the ward required a period of isolation.

As a result, where discharge planning in NHS Area A prior to the pandemic would usually include home visits accompanied by the crisis service followed by a return to the ward for review, this no longer usually happened. On the ward, there was a need for social distancing where possible by staff and patients at a time when staff numbers were also under pressure by sickness, by underlying health conditions putting some at a higher risk or by caring responsibilities brought about by the pandemic.

Across NHS Area A in mental health services, each CMHT has designated inpatient beds on a shared locality inpatient ward. Prior to the pandemic, when there was pressure on these locality beds, patients may have to be moved to another ward, but in these circumstances the RMO would continue to provide inpatient care, as would members of the extended MDT. When inpatients required more intensive observation on a locality ward, this would usually be managed by moving nursing staff between wards to provide any additional cover required,

thus maintaining continuity of care wherever possible. During the lockdown, there was no movement of staff allowed between wards to reduce the likelihood of spread of the virus. This meant that if a patient had to move wards either because of clinical, bed management or staff cover issues, their care was transferred to a completely new clinical team - a different RMO and inpatient nursing staff.

## 2.3 Changes to community care

Following discharge from hospital during the lockdown, care was transferred to the crisis team who communicated with the CMHT via daily community MDT meetings. Patients of clinical concern were discussed at these CMHT meetings with senior medical staff.

Nursing staff were 'thin on the ground' because of social distancing and so many of them were not in the building. One doctor described the working conditions as:

> "*…dreadful, supported the best we could be by management who were also in new, unchartered territory"; "What was getting lost was the more holistic approach to care for patients, it went back to a more medical model".*

A doctor described functioning at:

> "*…higher anxiety levels, with multiple emails every day from across the health board updating on the latest advice, guidance and then having to react to that, think about how this affects us, working out who's off sick and who's covering who…"*

Another doctor said that:

> *"…at first there was a fear of the pandemic. We were waiting for the ward to be ravaged with Covid. We were preparing for patients dying. Fortunately that didn't happen to us."*

## 2.4 GH's care during the pandemic in the few weeks prior to the homicide

Prior to their last admission, GH moved back to live with their nearest relative in Area B because of the pandemic. At the point of GH's discharge from hospital, the systems put in place to manage the Covid-19 crisis were coming to an end, with a plan in place to revert to pre-pandemic clinical service organisation within a month's time.

### 2.4.1 Admission HSPC/NHS Area A admission and discharge prior to homicide

The investigation found that the organisational changes made to NHS Area A mental health services as a consequence of the Covid-19 pandemic impacted on the inpatient care provided to GH.

The most striking effect was on senior medical continuity of care. Outwith the pandemic, it is likely that GH would have had care from a single RMO in both the community and as an inpatient. The nursing care team was likely to have remained consistent throughout their care. Because of the changes to services following the lockdown, GH was seen by four different consultants over the course of their admission and three-week inpatient stay – plus one additional change in consultant to provide cover for annual leave. GH also had two changes of nursing team, with a move early in the admission from their locality ward and then a transfer back to the locality ward on the day before discharge.

The most notable consequence of this was on the diagnosis at the point of discharge from hospital. The admitting consultant and the following three consultants who reviewed GH diagnosed a psychotic illness. After this, Dr A was the last to see GH prior to discharge. Although Dr A had been consulted about GH at various points during the admission having known GH from previously (aged late 20s), the only direct contact with GH on this admission had been at the point of discharge when Dr A assessed GH's mental state on a one-to-one basis. At this point, there was already the outline of a discharge plan and things appeared to have settled. Dr A was expecting to review GH in the community around one month later and saw GH prior to discharge to provide continuity. A diagnosis of paranoid personality disorder with psychotic features was made. There was *"huge pressure on beds at the time"* and *"a state of flux"* as services were about to revert to pre-Covid-19 arrangements. NHS Area A told us,

> *"Clinical activity was also probably at its' peak and we were starting to think about how we get back to normal and how we deal with the surging demand on services."*

After the homicide, during an assessment by forensic psychiatrist A for the court, GH said that they did not feel significantly better compared to the start of this admission, that they had played down their symptoms to doctors including not mentioning the voices they were hearing. The medication had made GH feel calmer, however.

Without the changes in RMO cover during this admission, it is more likely that the contrast in presentation between this and the previous admission would have been recognised, and a diagnosis made on discharge of a psychotic illness. GH was able to present plausibly and mask symptoms at meetings with doctors. The diagnosis on discharge of paranoid personality disorder is likely to have impacted on how the risk of violence was perceived and managed post discharge (see section 3.4 Clinical assessment and management of risk of violence) and to have influenced Dr B's decision not to detain GH in the Sheriff Court in Area B eleven days before the homicide took place.

Aside from the loss of continuity of care, the reorganisation of services during the lockdown also impacted on the provision of structured inpatient multidisciplinary review meetings which would usually have included a mental health officer (as GH was a detained patient) and a member of the crisis team as well as other disciplines. This multidisciplinary input may have made fuller discussion of the risk issues and how this was to be managed in the community more likely, as well as aided more comprehensive discharge planning.

Prior to the pandemic it is likely that there would have been a series of passes home prior to discharge to allow engagement with crisis services and/or a CPN, to ensure GH's flat was habitable (GH stated that their return to their nearest relative's house following discharge was because there was a fault in the electric meter at their own house), to monitor their mental state out with the inpatient environment and to ensure compliance with medication prior to discharge. Because of the restrictions brought about by the pandemic the crisis team were not attending the wards. Although they received a detailed referral from the inpatient team, there was no opportunity for them to meet with GH initially on the ward or for any supervised passes prior to discharge.

A further effect of the pandemic was the additional pressure on clinical services to reduce length of stay because of the pressure on inpatient beds.

### 2.4.2 Community care after final admission

#### 2.4.2.1 Care by HSCP/NHS Area A

Prior to the pandemic, GH's care would have remained with the same RMO on transferring from inpatient to outpatient care. However, during the lockdown, consultant responsibilities were divided into inpatient, or outpatient care as described in section 2.1. Usual practice during the lockdown was that on discharging a patient from the ward, there would be a transfer of care discussion (using Microsoft Teams) between inpatient and outpatient consultants. Care following discharge would usually be with the crisis team who would then update the CMHT MDT meetings regarding any concerns in the post discharge period. However, there does not appear to have been any transfer of care discussion at the time of GH's discharge from the ward, possibly because the lockdown was due to come to an end in three weeks at that stage and Dr A, then currently working as an inpatient consultant, assumed that the next medical review required by GH would be by them having returned to working in the CMHT.

There was no immediate discharge letter generated at the point of discharge and the discharge summary was not dictated until two weeks after the homicide. This latter delay was ascribed to the lack of junior doctor cover available to the wards, as this is a task usually delegated to junior medical staff. The result was that there was neither verbal nor written transfer of GH's care to the community consultants.

The lack of clarity about who had RMO responsibility following discharge was identified in the NHS Area A and Area B SAER. The impact of this on risk assessment and management is discussed further in section 3.4. Staff interviewed for the SAER said they were confused about who had overall responsibility:

> *"Although during the lockdown, care for community patients would usually reside with the community consultants, the community team initially directed their concerns about GH to Dr A".*

The crisis team met GH for the first time twelve days before the homicide took place and were concerned about their presentation. Instead of discussing this with a community consultant, the crisis team spoke to Dr A.

> *"Despite having no outpatient responsibility at that time, Dr A provided advice and did not redirect the community team to the community consultants, instead assuming that the issues raised were also being raised by the crisis team at the daily CMHT MDT meetings."*

Dr A was first approached by the crisis team twelve days before the incident when the crisis team had met GH for the first time together with their nearest relative at CMHT-A. GH's nearest relative said that GH had assaulted them over the weekend and had been non-compliant with medication. The crisis team thought that GH was psychotic. However, Dr A advised the crisis team to continue with community support and was reluctant to readmit GH to hospital.

Given the concerns raised by both the crisis team about their ability to safely manage the risk at that time and by GH's nearest relative, there should have been a medical review carried out.

However, shortly after Dr A's phone call to the crisis team advising they should continue with community support of GH, the crisis team received a phone call from GH's nearest relative to say that GH had been taken into custody by the police in Area B, having smashed the window of their ex-partner's house.

**2.4.2.2 Senior medical review NHS Area B eleven days before the homicide**

Following an arrest in Area B where there are concerns about mental health, there is a referral to the court liaison service. The Procurator Fiscal (PF) asks for a mental health assessment to see whether the person is well enough to attend Court or whether they should be diverted to hospital. In the first instance, a forensic community psychiatric nurse makes an initial assessment and, if concerned about the individual's mental state, then refers on to senior medical staff for advice on further management. The forensic service gathers as much background information as possible about the person, however, if the patient is not domiciled in the NHS Area B, then there is no direct access to the digital case records of other areas.

Prior to assessment of GH, forensic CPN A had access to the police report from the current arrest but no information about previous offending. Unfortunately, CPN A's written notes from the day are lost, although the letter to the GP (typed two days after the incident) following the assessment is available. GH had taken their nearest relative's car and driven to their ex-partner's house which was in Area B. GH was referred because during the subsequent arrest, they were making claims such as that bodies were being buried in their nearest relative's back garden. Forensic CPN A spoke to CMHT-A, and heard that GH was well known. They had just been discharged from hospital and the CMHT were concerned about GH's mental health. The forensic CPN does not recall any information about a risk of violence. Forensic CPN A's view was that GH was mentally unwell as they were voicing beliefs that the forensic CPN believed to be psychotic in nature. The CPN does not recall thinking that GH posed a risk to others other than from driving in their current condition and shouting at their ex-partner. The CPN asked Dr B who was the approved medical practitioner (AMP) on duty for the court that day to see GH. The CPN gave Dr B a verbal handover including the information from CMHT-A.

Dr B works in Area B where general adult psychiatrists each cover the duty AMP rota about four weeks of the year. The duty AMP is the point of contact in NHS Area B for CPNs, GPs, wards and other health boards for mental health assessments and includes cover for the court rota. In Dr B's experience, they had been asked for a mental health assessment in court about once in every two years. Dr B had training for court liaison as a junior doctor in Area A but had not had training since becoming a consultant in Area B. Dr B was unfamiliar with working in court and with court processes, with use of the Criminal Procedures (Scotland) Act 1995 and the process involved in organising for someone to be admitted to hospital under a court directed assessment order where required.

Dr B did not make any written notes following their assessment of GH so their comments below are from memory and from their letter dated six days after the incident. Dr B spoke to the crisis team from Area A who informed them of GH's recent hospital admission, the diagnosis of paranoid personality disorder and that they were concerned that GH may be psychotic. Dr B recalled that GH had stolen their nearest relative's car and gone to their ex-partner's home where they broke the door. Dr B could not remember whether the history of

GH assaulting their nearest relative was true or not. Dr B was not aware of any other historical violence. Dr B recalls being advised that GH was not taking their medication.

From Dr B's letter, the information available to them on the NHS portal from the emergency care summary (ECS) was that GH had been prescribed an antibiotic but no other medication. On the NHS Area A regional portal there was a warning regarding challenging behaviour, being verbally abusive to staff requiring police intervention on refusing to leave premises and recent assault of their nearest relative. Dr B then tried to contact Dr A prior to seeing GH but was unable to get through to Dr A. Dr B reviewed GH and concluded that they were not psychotic, and that they were well enough to go to court.

After seeing GH, Dr B did speak to Dr A who confirmed that they knew GH well and that GH probably suffered from a paranoid personality disorder rather than a psychotic illness. Dr B then emailed both the forensic CPN and Dr A, thanking Dr A for letting the Area A crisis team know the outcome of the assessment. Dr B assumed that the ongoing responsibility for managing GH's care then returned to NHS Area A CMHT and crisis team who knew them well.

The investigation found that the assessment at Area B Sheriff Court was not affected by the Covid-19 pandemic and the consequent lockdown. The psychiatrist involved in this assessment was unfamiliar with court processes and procedures and was given only a verbal handover by the forensic CPN who was familiar with these systems.

There was no history of previous offending made available either to the forensic CPN or to Dr B prior to assessment and little clarity about the nature and extent of any previous violence to GH's nearest relative. Neither Dr B nor the forensic CPN had access to clinical information on the NHS Area A digital clinical system. They could not therefore give a fully informed view of GH's potential for violence. GH had recently been discharged from inpatient care with a diagnosis of paranoid personality disorder. Dr B commented that GH's non-compliance with antipsychotics was not immediately concerning in this situation. According to Dr B (there are no contemporaneous notes of the interview), GH presented well at interview with no evidence of formal thought disorder (breaks in the train of thought resulting in incoherent or irrelevant speech) and no fixed delusional beliefs.

It was reasonable for Dr B to be influenced by Dr A's views on diagnosis and risk as Dr B regarded Dr A as GH's RMO who knew them well. The diagnosis on recent discharge from inpatient assessment accorded with Dr B's own views on GH's presentation.

Dr B's decision not to detain GH at this time was therefore influenced by the lack of information available, the recent discharge diagnosis of paranoid personality disorder, and GH's ability to present in a plausible manner at interview. This decision also served to confirm GH's discharge diagnosis of paranoid personality disorder and the fact that, in the view of a consultant psychiatrist, GH did not meet criteria for detention under the Mental Health Act at that time.

There were omissions and delays in documentation, communication and safe retention of case notes during and following this episode of care picked up in the NHS Areas A and B SAER, but these did not impact on the outcome.

The NHS Areas A and B SAER made additional findings regarding the court liaison service in Area B. The SAER comments on the pro-forma for staff to complete during their assessment which includes a section on risk. The pro-forma completed for GH could not be located. The blank document contains a section for "known history of previous offending", a section on deliberate self-harm and a series of "prompt" questions for core symptoms of mental illness. However, other than the question on previous offending, it does not include any prompts to guide staff to assess the risk to others. The SAER also commented that whilst NHS Area B does have a more comprehensive risk assessment tool which includes prompts around risk of harm to others, there is no policy which indicates when this risk assessment tool should be used.

Since the incident, the Commission is informed that there have been changes to the procedure for the court liaison service. The court liaison assessments undertaken by forensic CPNs are initially shared verbally with the referring Procurator Fiscal (PF) and followed up by a copy of the assessment on the same day of the assessment. We were advised that this process was in place prior to this investigation and continues to date. In addition, where there is a need for a further assessment by duty AMP/ forensic psychiatrist they are given a verbal handover report and a copy of the forensic CPN's written assessment together with details of any alleged offences, summary of evidence available and any other available correspondence. A letter is written to the GP and local CMHT within a ten-day timescale.

Previously, the Commission was advised that the questions asked in the forensic CPN pro-forma focussed mostly on mental health and addictions history but in the light of this incident, questions are now asked on this pro-forma about previous offending history, particularly violent offending from both the patient and the PF. The Commission was informed that a new section on risk has been added to the form and that the PF is usually willing to share this information.

Since the incident, a forensic psychiatrist now provides advice to the court liaison rota, however general adult psychiatry services continue to cover for leave. When this happens, the Commission was advised that the forensic CPNs are now aware that the general adult psychiatrists may need reminding of Court processes. The on-call forensic psychiatrist can also provide advice if required.

Following assessment by the duty AMP, the draft NHS Area B Standard Operating Procedure states that it is the responsibility of the psychiatrist to liaise directly with the PF by telephone to advise on current mental state, fitness to plead and potential diversion from court. When the opinion is that diversion from court is not necessary, the PF may request a basic report to that effect. New formal paperwork for this includes advice to the Court about the arrangements made for any further care and treatment if required.

## Findings area 3: Examine whether risk was assessed adequately, and appropriate management plans put in place.

### 3.1 Research evidence

Research (Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies - PubMed) indicates that a number of dynamic risk factors are significantly associated with violence risk including hostile behaviour, poor impulse control, lack of insight, recent drug or alcohol misuse and non-adherence with psychological therapies and medication. However, criminal history factors (previous violent behaviour and prior arrests) are stronger predictors of risk compared with substance misuse and certain demographic factors.

### 3.2 Documentation of GH's historical risk

Over the course of GH's involvement with mental health services, the history of violence documented varies from being comprehensive, with the severity of previous violence, use of weapons and association with alcohol misuse clearly documented to either no documentation of forensic history at all, or the statement that there is no history of violence. By the time of the last admission to hospital, most of the documentation about previous violence is restricted to the more recent assaults on their nearest relative.

There are several possible reasons for this variation in documentation. In many instances, mental health service staff rely on the account given to them by the patient of any past history of violence or offending. In acute situations, staff may have limited opportunity to speak to family members who could provide a corroborative history. There is also a lack of clarity about how mental health service staff seek information about offending history from the Police where there are concerns about possible violence.

A further issue is that information about previous violence may not appear relevant to the management of the presenting complaint at that time. The challenge for mental health services is to ensure that information about previous violent behaviour is nonetheless retained by services, sometimes over many years and multiple presentations, in anticipation that it may become clinically relevant in the future.

The OxMIV OxRisk | Oxford Forensic Psychiatry Risk Tools is a free to use web-based risk calculator for assessing risk of violent offending over the next 12 months in individuals with a diagnosis of severe mental disorder, however it could be used across general adult psychiatry populations as the risk factors for violence are shared across psychiatric disorders

### 3.3 Clinical risk management policy in NHS Area A

The understanding of clinical risk assessment and management and how it should be documented is inconsistent across mental health services in Scotland. Many health boards have developed their own systems to document risk issues.

In 2013, NHS Area A began a comprehensive review of the clinical risk assessment and management policy in mental health services. Learning from significant clinical incidents

(SCIs) in NHS Area A identified recurring issues with risk assessment, management and documentation and the need for risk management training. There was evidence that historical risk information was being lost and that families were not always as involved in care as they should be.

The risk management policy was revised, training was piloted and a research project to monitor the implementation of the new policy was initiated. The principal clinical value of risk documentation was recognised to be as a communication tool, now to be available in a digital format to enable access to it by all staff, "24/7". One section of the form is a broad risk screen, the next is a repository for historical risk information, to be updated as events arise. A third area prompts the involvement of families/carers and their view of risks.

There was a delay in the implementation of the new policy largely because the functionality required by the new documentation enabling previous risk history to be "pulled through" from previous assessments required an upgraded version of the electronic clinical records system in process of being rolled out across the service.

Whilst all NHS Area A staff should have completed a LearnPro module (e-learning training giving an introduction to clinical risk management), in-person risk management training roll out has been delayed by the effects of the pandemic.

A recent audit reviewed the accuracy of historical risk information on an inpatient ward and found there was a lot of historical risk information missing. The management plan to improve this is a multi-disciplinary approach over the first 72 hours of admission. Part of the nursing role is to ensure there is relative contact during this period and this should include a corroborative history from the family about historical risk information.

Despite the recognition by NHS Area A that the loss of historical risk information was a recurring finding in SCIs, the subsequent review of risk assessment paperwork and improved functionality of the clinical digital system to enable this information to be retained, recent audit demonstrates that historical risk information is still being lost in NHS Area A.

## 3.4 Clinical assessment and management of risk of violence

GH had two previous convictions for violence. The violence was associated with alcohol misuse but there was no link to mental illness at that time.

### 3.4.1 Community care NHS Area A

During their mid-20s, GH was treated in the community for an episode of cannabis induced psychosis but there was no documented increase in hostility or violence associated with illness at that time.

The following year, GH moved to the CMHT-A catchment area. Initially, referrals were made by their GP because of possible ADHD. On two occasions, GH's presentation was extremely challenging to the involved staff and as such was very different to earlier presentations to services – GH had some personal issues to deal with and their focus was on securing a medical report to assist them. When this expectation was not met immediately by services,

GH's behaviour deteriorated and this is likely to have been counterproductive, alienating involved staff. GH's behaviour is also likely to have impacted on the ability of staff to complete comprehensive assessments at this time (there is no documentation of forensic history or about alcohol use at these assessments). Nonetheless GH did not appear to have a mental illness and was discharged from CMHT follow up.

### 3.4.2 Inpatient admissions

At the time of GH's first inpatient admission in Area B with a cannabis induced psychosis, their nearest relative stated that over the years, GH had been violent towards them.

At this presentation, it seems that violence to GH's nearest relative was longstanding with no indication that there had been an increase in violence associated with GH's psychotic symptoms. Nonetheless there should have been discussion about how the risk of violence towards GH's nearest relative could be mitigated. GH should have been made aware of their level of responsibility for any future violence towards their nearest relative and been given advice and support on how to modify their behaviour.

On admission to hospital for the second time it appeared to the Commission's investigating team that the increase in violence was associated with the deterioration in GH's mental health. Prior to discharge there was documented discussion about how GH's "interactions" (presumably with their nearest relative), cannabis use and stress exacerbated their paranoid personality traits.

During the third admission to hospital, there also appeared to be an increase in violence associated with GH's mental illness. The nursing risk assessment stated,

> *"GH has outstanding charges due to assaults to their nearest relative, can become irritable with aggressive and threatening manner. GH declines any information to be shared with their nearest relative. Noted that GH's nearest relative is currently afraid of them, fears for their safety and has required another family member present out of concern for their own safety".*

Prior to discharge, GH talked with insight of the stressors prior to admission including living with their nearest relative in confined circumstances during the lockdown and difficulties in their relationship. GH also admitted regular cannabis use prior to admission and acknowledged that this exacerbated their paranoid thinking. The link between GH's relationship with their nearest relative and a negative effect on their mental state was explored at MDT review.

However, in all three inpatient admissions, although there was awareness of recent violence towards GH's nearest relative in risk documentation, there was no documented discussion about the risk of future violence, how it may be linked with mental illness and how it could be mitigated.

The association between violence and alcohol misuse was identified and discussed with GH in the community in Areas A and B when GH was in their early 20s, but thereafter not referred

to again. There were questions asked about alcohol use on admission to inpatient services in the first two admissions but not in the admission prior to the homicide. However, there was no further discussion about alcohol misuse during any of the three inpatient stays, the focus being on the negative impact of cannabis misuse on GH's mental state.

GH does not appear to have been advised to seek advice or support from substance misuse services (SMS) and was not referred to them at the point of discharge from any of the three inpatient admissions. In the last admission, this was complicated by the organisational changes in the NHS which impacted on discharge planning (see findings area 2). The availability of third sector organisations who would usually provide advice and support for cannabis misuse was also likely to have been affected by the pandemic.

### 3.4.3 Community care prior to homicide

Evidence of recent violence to GH's nearest relative was clearly documented in risk assessment documentation prior to discharge. Although the risk of violence was not explicitly referred to in MDT notes, nonetheless, the principal components of a plan likely to mitigate the risk to GH's nearest relative were in place at the point of discharge. The treatment plan was ongoing antipsychotic medication, advice on the negative impact of use of cannabis and of returning to live with their nearest relative in their mental state. It was agreed that GH would be discharged to their own home in Area A with follow up by the crisis team to monitor mental state and compliance with medication.

However, even though GH's nearest relative appeared to be the principal focus of GH's delusional beliefs, had recently been assaulted by GH and was afraid of them, GH's nearest relative was not made aware of the discharge.

The crisis team were not able to contact GH on the day of their discharge or the following morning to arrange follow up as planned. A police welfare check was requested, and GH was located at their nearest relative's house in Area B. GH's nearest relative is reported to have stated to the police that they did not wish to make any complaint regarding GH and had no present concerns. It was reported by the police that GH's nearest relative "passed the phone to GH". Whilst this feedback to the police appeared reassuring, by that time, GH's nearest relative had alleged GH had assaulted them again and GH was close enough at their house to pass the phone to them, it may be likely that GH's nearest relative's positive account to the police was influenced by their fear of GH. Having been given an assurance that they had no concerns by GH's nearest relative, the police were likely to be satisfied that they had no further role.

The decision to agree to see GH after the weekend was a difficult one. The crisis team had not met GH before and their task was to engage GH with their service and encourage compliance with medication. As GH was staying outside their area, the crisis team could not visit GH themselves. The investigation considered whether the use of ASP processes may have been helpful at this time, but given that the police had already been involved, the investigation concluded that this was unlikely to have affected the outcome.

The crisis team were concerned about GH's mental state and their lack of compliance with medication, but the senior medical view (on days five and six post discharge) was that GH should remain in the community.

The crisis team visited GH at their home in Area A on day 14, three days prior to the incident. It was clear to the crisis team that GH remained delusional, they were pleasant and amenable. Since their discharge from hospital, the principal target of GH's violent behaviour had been their nearest relative, who was now removed to safety. It would also be less likely that GH would be moving between Areas A and B and therefore would be easier to support in the community. GH again agreed to comply with medication and to a further review in two days. According to the NHS SAER, the crisis team therefore did not think there were grounds for a medical review at this time.

The view of the NHS SAER was that in the post discharge period, the risk of violence posed by GH was increasing:

> *"The lack of clarity around GH's consultant care [see findings area 2] contributed to their care being managed as a series of individual presentations, rather than anyone taking an overarching view of GH's presentation. For example, when Dr B assessed GH on day six post discharge, Dr B did not believe GH was detainable during their interview. This was also the case when crisis carried out a home visit (on day 14 post discharge) and reported GH did not seem to be an acute risk."*

The NHS SAER further concluded,

> *"With the benefit of hindsight, it is possible that if GH had one individual taking overall responsibility for their care it may have been recognised that GH's mental health was fluctuating and at worst, they were experiencing acute psychotic symptoms that GH was responding to and acting in an increasingly risky manner. It may have been recognised that whilst at some interviews GH was agreeing to accept follow up, they did not go through with this in practice, would be non-compliant with medication and not attend or cancel offered appointments".*

The Commission agrees with the SAER finding that the lack of a single RMO providing overarching leadership contributed to the failure to recognise the increasing risk of violence posed by GH following discharge from hospital. Whilst the CMHT and crisis team did respond to concerns raised by the family about violence in the post discharge period, their response was ineffective (see section 4.2.2).

### 3.4.4 Diagnosis and risk management

The diagnosis of paranoid personality disorder (ICD 10 F60 – see appendix 2) is likely to have impacted on how the risk of violence was perceived and managed post discharge. Features such as a tendency to suspiciousness or to misconstrue the actions of others may increase the likelihood of violence but in this situation, the patient is likely to be regarded as having responsibility for their actions.

Whilst antipsychotic medication may be used in some circumstances to treat severe symptoms of paranoid personality disorder, psychological approaches are more likely to be first line treatment. By contrast, where there is a psychotic illness, there is a strong evidence base for treatment with antipsychotic medication and as this disorder is characterised by a loss of insight, the care providers are likely to have more responsibility for ensuring compliance with medication.

Subsequent to GH's discharge from hospital on that last admission, GH was seen by Dr B, a consultant psychiatrist from Area B (see section 3.4.2.2). Asked about the history of non-compliance prior to being seen, the doctor responded that they were probably not that concerned because of the paranoid personality disorder and from assessing the patient.

### 3.4.5 Clinical risk assessment and management: the Commission's view

Throughout GH's care, the risk of future violence was not assessed or managed in a systematic way. Violence risk management involves both the awareness of an individual's propensity to violence (largely determined by historical risk factors - see section 3.1) together with active clinical management of modifiable or 'dynamic' risk factors (including active symptoms of mental illness usually subsequent to non-compliance and engagement, substance misuse) in order to mitigate risk.

Information about GH's history of violent behaviour prior to contact with mental health services was lost over time and reports of more recent violence largely directed towards their nearest relative were not taken into account by inpatient services in particular. As a result, GH's propensity to future violence was not fully recognised.

The impact of the pandemic on the continuity of senior medical care had two consequences. The first was that GH's psychotic illness was not diagnosed at discharge and effectively treated, the second was that the increase in risk in the community associated with their active psychotic symptoms, alcohol and cannabis misuse was not recognised. As a result, the impact of these modifiable risk factors was not mitigated.

By the time of the incident, even though the clinical team were not aware of GH's previous convictions for violence, it was apparent to staff that GH represented a threat to the safety of their nearest relative. However, there is no evidence that risk to others was considered by the clinical team.

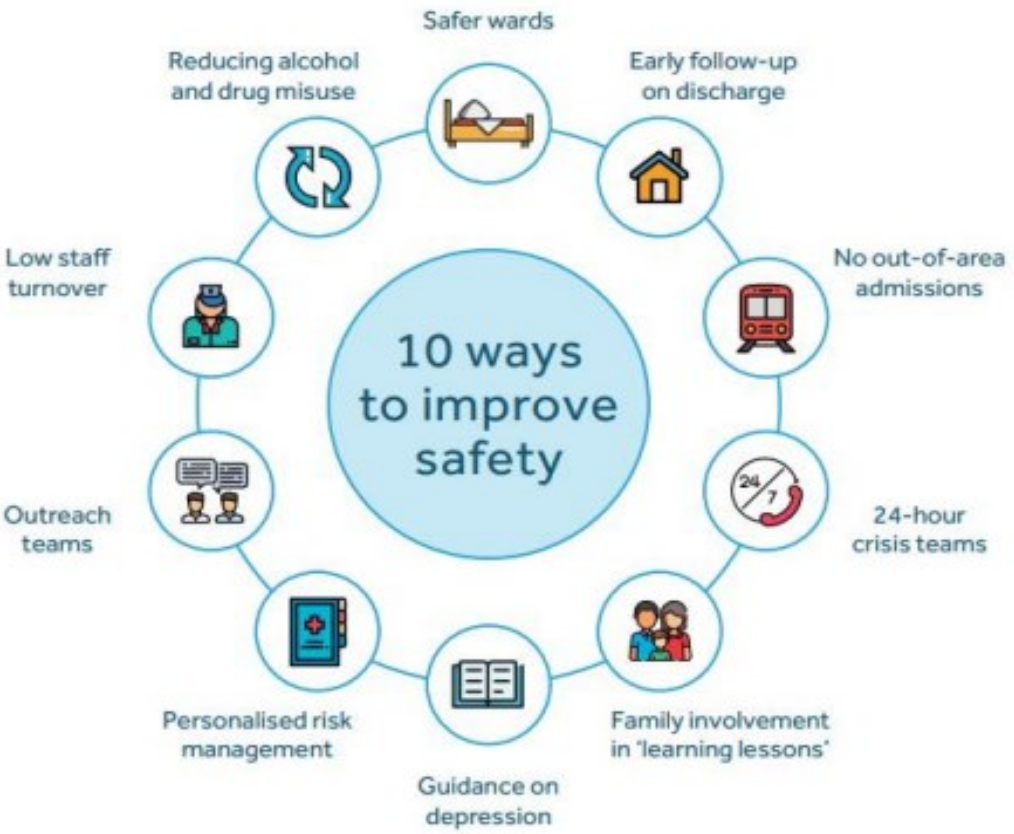
If there had been recognition of the significant increase in violence risk posed by GH as a consequence of the history of violent offending from an early stage in their re-presentation to services in their last admission, this could have provided a focus for risk management planning. It is more likely that the concerns raised by GH's nearest relative and close family member about the risk of violence would have been considered and responded to by inpatient services. It could possibly have enabled a broader perspective to be taken of who may be at risk from GH. Insight orientated discussion with GH could have included the negative effects of both cannabis and alcohol.

The view of the forensic psychiatrist who interviewed GH after the incident was that delusional beliefs which involved the victim were central to GH's delusional belief system. However, from the documented information prior to the incident, (interviews with crisis team days five and 14 days post discharge, letters by forensic CPN A and Dr B dictated day 16 post discharge and six days after the incident respectively following interviews with GH on day six post discharge) there is no reference to this belief or to the victim. GH was seen by the crisis team three days before the incident, and denied thoughts of harming others at that time.

Therefore, although GH posed an increased risk of violence following discharge from hospital because of the history of convictions for violence, active symptoms of psychosis and misuse of substances, from the information available in the notes, the risk to the specific victim could not have been predicted.

## 3.5. Key elements for safer care for patients

Based on data collection over 20 years, the National Confidential Inquiry into Suicides and Safety (NCISS) have developed a list of 10 key elements for safer care for patients: NCISH | The University of Manchester This includes the guidance* referred to below.



Four of these refer to "high risk points of care". These are, inpatient care, out of area admissions, the post discharge period, and care under the crisis team.

Another two indicate important risk factors which may affect safety. These are outreach teams to reduce non-compliance and non-engagement with care and drug and alcohol misuse. A further safety area is around personalised risk management, another is family involvement in learning lessons and care. The final two relate to guidance on depression and the importance of low non-medical staff turnover to enhance safety.

Of these ten areas, in the two weeks following discharge, there were "red flags" in six of these areas:

**Post discharge period**

*Guidance – "Patients discharged from psychiatric inpatient care should be followed up by the service within 72 hours of discharge. A comprehensive care plan should be in place at the time of discharge and during pre-discharge leave."

The restrictions brought about by the pandemic impacted on pre- discharge planning. Because of GH's move to another NHS area, the crisis service was unable to review them face to face as planned within the 72-hour period.

**Crisis team care**

*Guidance – "Crisis teams provide intensive support in the community to patients who are experiencing crisis, as an alternative to inpatient care. Contact time within Crisis Resolution Home Treatment Service (CRHTS) should reflect the specialist and intensive nature of that role. Both the King's Fund Under Pressure report and the Independent Commission on Acute Adult Psychiatric Care referenced these recommendations in 2015, and emphasised the importance of CRHTS operating efficiently as intensive specialist community-based alternatives to in-patient care, and not simply as generic crisis teams."

There was pressure on clinical services to keep ward inpatient numbers low to reduce the risk of infection, increasing the requirement for crisis services to monitor patients closely in the high-risk post-discharge period. The lack of pre-discharge leave affected the ability of the crisis team to engage with GH prior to discharge. Following discharge, the crisis team were unable to provide intensive supervision and support as an alternative to inpatient care because of GH's decision to live out with the NHS Area A boundary. In the two weeks following GH's discharge, the crisis team met GH face to face on only two occasions.

**Reducing substance misuse**

*Guidance: "local drug and alcohol services should be available to work jointly with mental health services for patients with mental illness and alcohol and drug misuse."

One of the key findings in the National Confidential Inquiry into Suicides and Homicides (NCISH) Annual report 2017, is that, "in all four UK countries, most patients convicted of homicide also have a history of alcohol or drug misuse, between 88% in England and 100% in N Ireland. In other words, it is unusual for mental health patients to commit homicide unless there is a co-existing problem of substance misuse". The NCISH 2018 report states that one

of the "clinical measures most likely to prevent patient homicides and by implication reduce the risk of interpersonal violence is reducing alcohol and drug misuse."

GH's paranoid ideation was thought to be exacerbated by cannabis misuse and violence in the past was associated with alcohol misuse. GH was an inconsistent historian with regard to cannabis misuse. However, the crisis team had insufficient access to GH or contact with their nearest relative to monitor GH's use of substances effectively. Following the incident, GH stated that they had been using cannabis and drinking alcohol in the post discharge period and prior to the incident.

**Outreach services - non-compliance and non-engagement**

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

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

GH was non-compliant with medication and repeatedly failed to attend appointments with Crisis.

**Personalised risk management**

*Guidance – "A study of suicide risk assessment in UK mental health services, found that risk is often individual, suggesting the management of risk should be personal and individualised. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk."

Components of the care plan in place at the time of GH's discharge likely to mitigate risk to GH's nearest relative were ongoing treatment with antipsychotic medication, avoidance of cannabis use, living separately to their nearest relative in their own home and follow up by the crisis service.

GH did not comply with medication, moved back to live with their nearest relative and did not engage with the crisis service. Although denying this to clinical staff, GH later admitted to the use of cannabis and alcohol.

**Family involvement**

*Guidance – "Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans."

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

GH's family expressed concerns about GH's mental health and the risk of violence to their nearest relative repeatedly during the post discharge period. The response of services to these concerns is discussed in findings area 4.

# Findings area 4: Examine whether the family were appropriately involved in care and sufficient account taken of family concerns.

As noted above, NCISH have developed a list of 10 key elements for safer care for patients: NCISH | The University of Manchester. One of these is with regards to involving the family,

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

## 4.1 GH's nearest relative

From early in GH's presentations to services, it was evident that the relationship between GH and their nearest relative was volatile, and GH's nearest relative said they were afraid. GH persistently stated that their nearest relative had problems themselves and that they were an unreliable source of information. By the time of the last admission, GH also described delusional beliefs about their nearest relative.

At outpatient assessment two years prior to the last admission, GH accused their nearest relative of adding a substance to their tea and their nearest relative confirmed they had done so. Later that year, it was reported that GH's nearest relative was presenting as challenging and irritable towards reception staff when accompanying GH to CMHT-A.

During the inpatient stay that year, it appeared that GH's relationship with their nearest relative was volatile and contact with their nearest relative could leave GH unsettled. Nursing staff reported that GH's nearest relative was asking GH strange questions and appeared to instigate delusional content.

During this admission in particular, GH's views of their nearest relative and some aspects of their nearest relative's behaviour may have influenced the decision by services to involve the family in care by undermining the credibility of GH's nearest relative as a reliable witness

## 4.2 Was the family appropriately involved in care and was sufficient account taken of family concerns?

### 4.2.1 Inpatient admissions

GH was able to present in a plausible manner and to mask their psychotic symptoms. This influenced decision making at critical points in care, on discharge from their last admission to hospital, on assessment at the Sheriff Court in Area B six days post discharge and at the crisis team home visit three days prior to the homicide.

GH's nearest relative advised mental health services of GH's ability to present plausibly and to mask symptoms on each of GH's three admissions to hospital but this did not appear to be taken into account by staff at this time.

The other main concerns of GH's nearest relative and close family member from the first admission, and all contact until the incident occurred, were that GH was mentally ill and they were concerned about the risk of violence to GH's nearest relative. These concerns were well documented by nursing staff at these times.

During their first admission, GH had refused consent for the release of information to family.

During the second admission, feedback to the family about their concerns was complicated not only by GH's withdrawal of consent for staff to share information with family, but also the clinical team's uncertainty about the credibility of GH's nearest relative as a witness (see section 4.1 above).

Prior to discharge following the third admission to hospital, the link between GH's close relationship with their nearest relative and a negative effect on their mental state was explored at MDT review. Feedback to GH's nearest relative on this occasion was likely to have been complicated by GH's refusal of consent to allow staff to share information with family and by the impact of the Covid pandemic on inpatient services (see findings area 2).

During these three inpatient admissions there was a recurring pattern in which the family's concern about the risk of violence to GH's nearest relative to nursing staff was well documented by nursing staff but was not discussed at inpatient MDT review. There was no documented direct contact between GH's nearest relative and medical staff on any of the three admissions. There was no documented discussion with GH about violent behaviour to their nearest relative and how this could be mitigated. There was no consideration of whether to over-ride GH's refusal to allow information sharing with family.

The investigation concluded that from GH's first admission during their early 20s (Area B), until the last inpatient admission (Area A), sufficient account was not taken of family concerns.

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

The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice (Vol. 1, Chapter 11) states that, where the patient states that he/she does not wish a carer or relative to be interviewed, the MHO should weigh up the advantages and disadvantages of over-riding these wishes (of the patient, for their carer/relative not to be contacted). "This is a judgement call which should be discussed with the patient's RMO and other members of the multi-disciplinary team. Decisions will be informed by the nature of the relationship between the patient and the carer or relative; the nature of the illness and the impact on the behaviour of the patient; and the perceived potential value of the views of the relative or carer."

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

### 4.2.2 Post discharge period following last admission

The NHS Area A SAER stated that "the family had repeatedly raised concerns about GH's mental health in the post discharge period (on six specific incidences)". The SAER concluded that,

> *"following discharge from hospital, individually the family concerns were each responded to and generated a review either in person or over the telephone. The police were contacted when there were particular concerns (on day six and day twelve post discharge) but did not think they could take further action."*

The Commission agrees with the SAER finding that after discharge from hospital prior to the incident, the service did respond to each individual concern raised by the family. The service attempted to trace and eventually assessed GH by telephone (on days two, eight, nine and sixteen post discharge) and at face-to-face assessments on days five and six (Area B) and day fourteen.

As a consequence of the organisational change in response to the Covid-19 pandemic, there was no single identified RMO who could provide an overarching view of the situation (see findings area 2). The ability of the crisis team to effectively monitor GH was compromised by the fact that for most of the post discharge period prior to the incident, GH was staying out of the area and repeatedly failed to attend appointments.

The investigation concluded that in the post discharge period, whilst the service did sufficiently take the family concerns into account, the response of the service was ineffective. The family's concerns were that GH was mentally ill and that their nearest relative was at risk of harm from GH. Ultimately, GH's psychotic illness was not effectively treated, and GH's nearest relative was advised to leave their home to stay with a close family member to ensure their own safety.

## Findings area 5: Concerns raised by GH and their family.

**Should GH have been diagnosed with a psychosis earlier in their care and continued on regular treatment with an antipsychotic? Was the link with the use of cannabis fully explored?**

Antipsychotic treatment for a psychotic illness would not usually be continued indefinitely once symptoms settle. In the presentations when GH was in their early to mid-20s, antipsychotic treatment was reduced and stopped prior to discharge from follow up. Some research now recommends longer follow up (up to two years) following an episode of cannabis induced psychosis but this is not established practice in the UK. It is unlikely that GH would have agreed to follow up over the long periods between the episodes of illness (about two years apart).

The link with cannabis was fully explored, GH was regularly asked about and advised to abstain from the use of cannabis. GH appeared to have a good insight into the links between the use of cannabis and a deterioration in mental health. However, in findings area 1 and section 3.4, the investigation found that in each inpatient admission, there should have been referrals to substance misuse services (SMS) or advice given to GH to attend SMS following their discharge from hospital.

There is a 'first episode psychosis' service in Area A however, as GH had been treated for psychosis in Area B, they would not have met criteria for referral to this service.

**Was GH discharged too early from their last hospital admission prior to the incident?**

No, not necessarily. Prior to discharge, GH was reviewed by two consultant psychiatrists who considered that GH's mental state was settled sufficiently for discharge. We now know (see section 2.4.1) that at the time of discharge, GH had ongoing psychotic symptoms and GH's psychosis was therefore not effectively treated at that time. The investigation found (see findings area 4) that the clinical team did not take sufficient account of GH's family's warning that GH could appear plausible. If GH had stayed longer in hospital on regular antipsychotic treatment, GH's mental state would have continued to improve and the likelihood of GH gaining sufficient insight to comply with the discharge treatment plan would have increased.

However, the fact that GH had ongoing psychotic symptoms at the time of discharge does not necessarily mean that they continued to require hospital treatment at that time. There are many patients in the community with some active symptoms of psychosis who can be supported safely at home. If GH had complied with the discharge treatment plan i.e., continued to take medication, engage with the crisis team, abstain from cannabis misuse and stay in their own home rather than moving back to Area B, it is likely that GH's symptoms would have improved, and they could have been safely supported in the community. The fact that there was no opportunity to 'test out' GH's adherence to the care plan and to closely monitor GH's mental state on a series of passes home prior to discharge because of the Covid-19 restrictions meant there was an increased risk in the transition from inpatient to community care.

The investigation found there was a failure to recognise the risk of violence GH presented and the importance of GH's adherence to the agreed care plan following discharge to mitigate that risk (see section 3.4).

**Why was GH not detained and admitted to hospital when seen in police custody by a psychiatrist eleven days prior to the homicide?**

This is discussed in detail in section 2.4.2.2. The investigation found that Dr B's decision not to detain GH at this time was influenced by the lack of information available, the recent discharge diagnosis of paranoid personality disorder, and GH's ability to present in a plausible manner at interview.

**Did services take sufficient account of the concerns raised by the family about the risk of violence?**

See findings area 4 which discusses this in detail. The investigation concluded that during the first inpatient admission (Area B), prior to and during the subsequent two admissions (Area A), sufficient account was not taken of family concerns.

In the post discharge period of the last admission, whilst the service **did** take sufficient account of family concerns, the response of the service was ineffective.

**Did services take sufficient account of GH's history of violence in their decision making?**

No. GH's history of criminal convictions for violence was not documented consistently in the notes and its significance was not recognised by clinical staff. There was insufficient account taken of GH's violence directed towards both their nearest relative and ex-partner.

**Was there appropriate discharge planning including involving the family?**

Involving the family in care and discharge planning was complicated by GH's refusal to allow staff to communicate with family about care. Discharge planning in the last admission was adversely affected by the reorganisation of services, in response to the Covid-19 pandemic. However, the investigation found that, given the repeated concerns expressed by the family about the potential risk of violence to GH's nearest relative, there should have been consideration for over-riding GH's refusal to communicate with them prior to discharge (see findings area 4).

**Did the two health boards work effectively together?**

There was evidence of effective inter-health board communication and working, most noticeable prior to GH's last admission to hospital when GH was initially seen by NHS Area B services and referred to CMHT-A.

Six days post discharge, the court liaison service in Area B reviewed GH however the lack of detailed clinical information available influenced the decision not to detain GH at that time. There is not a uniform clinical case record across Scotland through which clinical information can be shared.

In the post discharge period this was the only contact made between NHS Area A and NHS Area B despite the difficulty NHS Area A had in reviewing GH.

After discharge from hospital, the crisis team could not contact GH. There was no contact made with HSPC/NHS Area B services at that time as there was uncertainty about GH's location and no obvious point of contact in NHS Area B as GH was not open to their services.

**Was there evidence of co-operative interagency working between clinical and police services?**

Yes. NHS Area A asked for help from the police and received it on several occasions following GH absconding from the ward in their last admission, seeking a welfare check from GH's nearest relative post discharge and help with trying to trace GH and speak to their nearest relative four days before the incident.

There was also well documented evidence of cooperative working between the police and SWS.

GH was not subject to either CPA (Care Programme Approach) or MAPPA (multiagency public protection arrangements) which might have triggered statutory involvement of the police. The fact that GH moved between two areas is likely to have made communication between police forces in the two areas more complex.

Currently the Commission does not have access to data from police records and so were not able to explore communication and joint working between the police and mental health services. Ensuring that data can be shared between Police Scotland and the Commission is an area we have identified from this investigation.

## Appendix 1: Glossary of terms

**Assessment order:** an order granted by the court under Part 6 of the 1995 Act remanding an individual to be detained in hospital after they are charged with an offence.

**AWI Act:** The Adults with Incapacity (Scotland) Act 2000. It concerns the welfare of adults who are unable to make decisions for themselves because they have a mental disorder or are not able to communicate.

**CAT:** Community addiction services are joint social work services and health addiction teams. The teams include addiction workers, addiction nurses, doctors, psychologists and occupational therapists.

**CPA:** the Care Programme Approach is a framework that mental health professionals work within to assess individuals' needs, plan ways to meet those needs and check that they are being met. Care will be planned in partnership with the individual, based on their needs.

**Criminal Procedure Act:** The Criminal Procedure (Scotland) Act 1995. It includes provisions for people who are accused of a criminal act and who may have a mental disorder.

**CTO:** Compulsory treatment order granted for up to six months in the first instance under the Mental Health Act.

**ECS**: Emergency care summary is a summary of basic information about individuals' health which might be important if they need urgent medical care out of regular hours, or when attending accident and emergency departments.

**HSCP:** Health and social care partnership. An 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.

**ICD-10:** is the 10$^{th}$ revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organisation. It is a system used by physicians to classify and code all diagnoses and symptoms.

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

**MAPPA:** Multi-agency public protection arrangements. These are a set of statutory partnership working arrangements introduced in 2007. The purpose of MAPPA is public protection and reduction of serious harm. In Scotland MAPPA brings together the Police, Scottish Prison Service, health boards and the local authorities in partnership as the responsible authorities, to assess and manage the risk posed for certain categories of offenders.

**Mental Health Act:** Mental Health (Care and Treatment) (Scotland) Act 2003. The provisions of this act are intended to ensure that care and compulsory measures of detention can be used only when there is significant risk to the safety or welfare of the patient or other people.

**MDT:** A multidisciplinary team meeting is a meeting at which professionals from various disciplines contribute to decisions about the assessment and treatment of individuals.

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

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

**NHS Portal:** provides emergency care summaries which gives healthcare staff access to data to support patients during emergency situations or when a patient's GP is closed.

**PF:** Procurator Fiscal. The Crown Office and Procurator Fiscal Service (COPFS) is Scotland's public prosecution service and death investigation authority.

**SAER**: Significant adverse event review. A SAER is carried out by NHS boards following events that have resulted in unexpected death or harm. SAERs analyse factors that have contributed to the circumstances of the adverse event and make recommendations for change and learning.

**SCI:** Serious critical incident – a serious critical incident involves a set of instances where there is a risk of significant harm to patients.

**SCR:** Social circumstances report – a statutory report by a mental health officer that examines the interaction of an individual's social and family circumstances with their mental health condition, when planning care and treatment under the Mental Health Act.

**STDC:** Short term detention certificate – the preferred 'gateway order' of the Mental Health Act when a person needs compulsory care and treatment in hospital against their will and can last for up to 28 days.

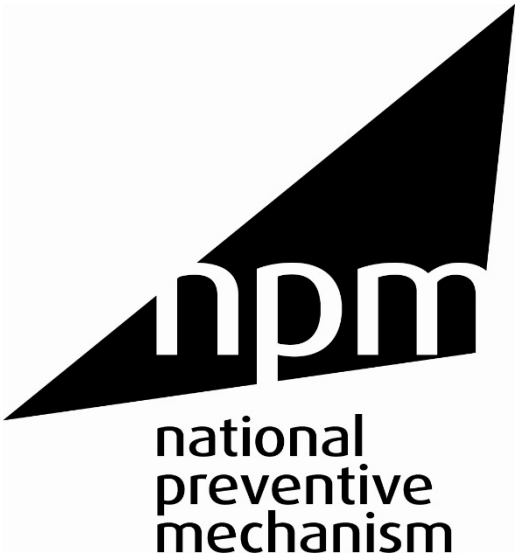
**Third sector:** the third sector is an umbrella term which covers a range of different 'not for profit' organisations, with different structures and purposes. The third sector is not classed as belonging to either the public or private sector. Scotland's third sector includes but is not limited to, charities, social enterprises, voluntary organisations, and public social partnerships.

## Appendix 2: Police Scotland – Information Sharing Request

# Concern Hub Information Sharing Request

| Request for the Attention of | |
|---|---|
| **Concern Hub** | |
| **Division** | |
| **Police Station** | |
| **Town** | |
| **Postcode** | |
| **Telephone Number** | |
| **Email Address** | @scotland.police.uk |

| Government Security Classification (GSC) |
|---|
| The Data Protection Act 2018 places an obligation on the police to ensure sufficient security to prevent accidental or unauthorised disclosure of sensitive information. It should be noted that the information contained within this report has been marked at a predetermined level of **OFFICIAL SENSITIVE: POLICE AND PARTNERS**. It is expected that agencies in receipt of this report will adhere to the following principles:<br>• **Physical Security –** Information that is restricted in this manner, in any format, should be protected by a single security barrier: for example, a locked container, cupboard or filing cabinet.<br>• **Disposal –** Dispose of using commercial secure disposal products to make reconstitution unlikely.<br>**Note –** Under no circumstances should this report be shared or distributed to any agency / individual other than those agreed under existing child or adult protection procedures. Any request to share this information outside the set criteria should be made to Police Scotland. |

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