mental welfare
commission for scotland

“They didn’t ask me”: Investigation into the care and treatment of Mr E (2024)

Investigations

January 2024

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

Contents

Executive summary

Mr E was in his mid-50s when he was detained in hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003 in August 2020. Mr E had been unwell for a long time prior to this detention.

His case was referred to the Mental Welfare Commission for Scotland by the Mental Health Tribunal for Scotland (MHTS) following the tribunal's decision to detain Mr E for compulsory treatment in September 2020. Mr E's circumstances had been brought to the attention of the President of the MHTS who alerted the Commission to the apparent lack of involvement by health and social work services in Mr E's care, despite his diagnoses of schizophrenia and diabetes, and the detrimental impact on Mr E's physical and mental health as a result.

The purpose of this investigation was to investigate the care, treatment and support given to Mr E by the NHS board, local authority, and health and social care partnership (HSCP)[1]. Our focus was on the period from 1 January 2015 to 31 July 2022. We specifically considered:

- knowledge, practice and application of the Mental Health Act, the Adults with Incapacity (Scotland) Act 2000, and the Adult Support and Protection (Scotland) Act 2007;
- integrated multidisciplinary working across health and social work services to assess and deliver individual outcomes for Mr E;
- financial management; and
- meaningful engagement with Mr E's family.

In addition to the terms of reference, we considered the failure to carry out a comprehensive local learning review of Mr E's care and treatment by any agency.

As is the case with all Commission investigations, the aim was to identify any lessons to be learned both locally and nationally and to make recommendations as appropriate.

Following receipt of care and treatment in hospital, Mr E is now subject to a local authority welfare guardianship order, and he is living in a care setting registered to support older people with dementia. The Commission and Mr E are keen to find out if this is a permanent arrangement.

Mr E has maintained contact with the Commission via our social work officer throughout the investigation process and our report reflects his views and gives some insight into who he is as a person, whilst ensuring anonymity. This is particularly important given that prior to hospital admission in 2020, evidence would suggest a failure by every agency involved to engage and form a working partnership directly with Mr E.

Mr E was first diagnosed with a mental illness in 1996; the specific diagnosis of schizophrenia was given during a compulsory admission to hospital in 2003. There was a strong history of non-compliance with mental health medication which, in turn, impacted on Mr E's willingness to take medication for his diabetes. However, our investigation found no

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[1] Health and Social Care Partnership (HSCP) – delivery arm organisation formed as part of the integration of health and social care services provided by NHS boards and local authorities.

consideration of chronological events or patterns to inform how best to provide care, support and treatment to Mr E, instead, his presentations to services were dealt with as single events. When Mr E did come to the attention of services, there was no co-ordinated multidisciplinary approach, with individual agencies often assuming the responsibility to support Mr E lay elsewhere.

It is evident throughout Mr E's health records that, with the exception of a few months in 2015 when district nurses were visiting and administering medication, there was little objective evidence to determine whether or not Mr E was actually taking antipsychotic mental health medication. There was heavy reliance on Mr E's brother taking responsibility for administering and accurately reporting on medication compliance, for Mr E's physical and mental health conditions, despite repeated questions about the reliability of this situation and the complexity of this relationship, which included Mr E's brother blocking access to health care for Mr E.

It is concerning that a more holistic approach was not taken by health and social work services in regard to the importance of treating both Mr E's mental and physical health, and that when faced with evidence that both were deteriorating, more proactive action, including the implementation of legal safeguards, was not taken to protect and ensure Mr E's right to care and treatment.

The result is that Mr E was failed by the systems and structures put in place to protect and support him to claim his rights.

Mr E's mental illness is now reported to be partially treatment resistant, his mobility is poor such that he needs to use a walking frame, and he is blind.

Recommendations

The following five recommendations are far reaching for the senior leaders of HSCP A, its local authority and health board.

Recommendation 1

The Care Inspectorate should take account of the content of this report in full as it monitors the progress of the HSCP's improvement plan in response to inspection activity. This report will also inform improvement plans of all other HSCPs in Scotland. It will be of interest for phase 2 of the joint inspections of adult support and protection undertaken by the Care Inspectorate, Healthcare Improvement Scotland, and His Majesty's Inspectorate.

Mr E's experience and life changing negative outcomes have arisen from structural weaknesses in the assessment, planning and delivery of integrated services in HSCP A. Mr E received no social work or health care assessment, there was no assertive outreach or evidence of relationship-based practice, and no account was taken of the needs of his brother or mother as carers. We learned that there has been a failure to implement legislation, a failure to manage significant organisational change, and a failure to embed standard operating practices leading to inconsistencies of practice across geographical patches and variations of practice within professional groups. This raises significant questions regarding senior leadership and connection with front line service delivery and outcomes for individuals in this HSCP area.

Recommendation 2

HSCP A should work with NHS Education Scotland to commission a training needs analysis and a delivery plan of multidisciplinary training, to support health and social work staff to feel confident and competent in the implementation and crossover of the three key acts to support and protect people (Mental Health Act, AWI Act and ASP Act).

We were told of practice that had evolved in HSCP A where general practitioners (GPs) required to undertake emergency detention assessments rather than consultant psychiatrists assessing for short term detentions. We learned of the poor commitment to completion of social circumstances reports in HSCP A despite the law requiring this. There were further views expressed that the three pieces of legislation were the responsibility of different agencies rather than taking a collective approach to ownership and exploration of the interrelationship of various aspects of the laws. We learned that staff are working in very difficult and changing circumstances and require investment in their training to support them to work in an environment of consistency and support.

Recommendation 3

HSCP A must ensure an agreed framework for multidisciplinary working is communicated, embedded and audited across health and social work.

The lack of formalised multi-professional meetings, or use of a framework such as the Care Programme Approach, to provide a robust structure for review and multi-agency planning was concerning in Mr E's case. This lack of a cohesive multidisciplinary approach meant collective expertise was not harnessed and indeed missed (lack of psychology, occupational therapy, physiotherapy consideration) and this contributed to the risks in Mr E's care and enabled him to repeatedly slip through the gaps of services.

Had such structures been in place, silo working and failure to assertively engage would have been less likely and Mr E may not have suffered the degree of physical harm and poor long term mental health outcome that he did.

Recommendation 4

HSCP A must review its duties and responsibilities in relation to models of learning and duty of candour. The clinical and care governance committee, together with professional leads for social work, medicine and nursing, must take action to address the failure to do so in Mr E's case and avoid repetition.

There were a number of missed opportunities to prevent Mr E from living a life which was not of his choosing; a life contained in a single room as a result of the combination of his deteriorating mental and physical health conditions. The staff we spoke with reflected on what could have been done better. They spoke of the lack of confidence in the reporting systems (Datix and adult support and protection) which must be addressed. They reflected on some learning in relation to corporate appointeeship, which was good but single agency driven.

An integrated approach to learning from case reviews must inform the way in which HSCP A's services work together to deliver joined up safeguarding, support and care to those who need it. Mr E's experience and poor outcomes should have initiated such learning. This did not happen, neither did anyone consider legal responsibilities according to duty of candour.

Recommendation 5

HSCP A should review Mr E's current care, accommodation and finances to ensure his fundamental rights are promoted and protected, and the failures identified in the provision of his care and treatment throughout 2015-2022 are not continuing.

Mr E tells us he is not happy living in his current care setting. He is now in his late 50s and living in a setting for older people with dementia who do not necessarily share his interests. He tells us his mood is low and there is little stimulation. Whilst the care home staff are aware of what is important to Mr E, it is not clear if anyone else has asked him. The appointment of the chief social work officer as guardian, in law, should afford Mr E protection. HSCP A required to give assurance of this protection and commitment to respect Mr E's rights.

Introduction

The investigation into the care and treatment of Mr E was conducted under section 11 of the Mental Health Act by the Mental Welfare Commission.

Section 11 gives the Commission the authority to carry out investigations and make recommendations as it considers appropriate, including where an individual with mental illness, learning disability or related condition may be, or may have been, subject to ill treatment, neglect or some other deficiency in care and treatment.

Mr E's case was referred to the Commission by the MHTS following the tribunal's decision to detain Mr E according to a compulsory treatment order in September 2020. Mr E's circumstances had been brought to the attention of the president of the MHTS who alerted the Commission to the apparent lack of involvement by health and social work services in Mr E's care and the detrimental impact on Mr E's physical and mental health as a result.

This investigation into the care, treatment and support provided seeks to identify what lessons can be learned from the experience of Mr E and his family for local authorities, health boards and health and social care partnerships across Scotland, as well as those organisations directly involved in Mr E's care.

Background

Mr E was in his mid-50s when he was detained in hospital under the Mental Health Act in August 2020.

Prior to being admitted to hospital, Mr E had lived with his mother and his older brother, who was also thought to have health difficulties, in the family home. The family had a lack of trust in health and social work services following the death of Mr E's father some years earlier.

Mr E had a known physical health condition (diabetes) and mental illness (schizophrenia) and had been detained according to the Mental Health Act three times (2003, 2004 and 2008) before his detention in August 2020.

Mr E had a history of non-engagement with services. Throughout 2015 (and previously), Mr E's older brother, with whom he lived, made various attempts to secure health and social work services for Mr E (with limited success). During the years to follow, a more regular pattern developed of Mr E's brother denying health and social work staff access to the family home thereby hindering Mr E's access to support, care and treatment. In 2017, there is communication stating Mr E's brother's wish for all services to work together 'seamlessly' however records describe Mr E's brother as both controlling and not acting in the best interests of Mr E.

Mr E's finances were managed by social work services under corporate appointeeship[2] since at least 2007. The reason for this was concern regarding his older brother causing financial harm. Records noted that Mr E's brother did not want benefit monies to be accepted; there was a view that this was 'charity'. The social work service, as appointee, was therefore responsible for making and maintaining any benefit claims and for ensuring spend of the benefit monies was in Mr E's best interests and met his day-to-day needs.

Mr E was not seen by any mental health professional between 2009 and 2015.

Mr E also went without care and treatment for his physical and mental health conditions between the summer of 2017 and 2020. He did not see his GP, social work staff, or medical staff from the community mental health team and had reportedly neglected his personal care throughout this time. By the time services became aware of Mr E again in 2020 he had lost his sight, was largely bedbound, and had sores on his legs from dragging himself on the floor. It then took a further five months to use mental health legislation to secure his right to care and treatment. At this time, Mr E's older brother wrote asking that a "deep dive" into Mr E's psychiatric notes be undertaken to learn how Mr E had "ended up a prisoner in his bedroom for five years".

Mr E is now subject to a local authority welfare guardianship order and is living in a dementia unit receiving 24-hour care. There has been no improvement in his eyesight or his mobility issues, and his mental illness is now regarded as partially treatment resistant.

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[2] A corporate appointee is responsible for making and maintaining any benefit claims on behalf of a person and for ensuring spend of the benefit monies is in their best interests was in Mr E's best interests and meets their day to day needs.

No significant adverse event review (SAER) or significant case review (SCR)[3] was carried out locally following Mr E's admission to hospital to determine what might have gone wrong or whether his experience identified any learning for services involved in the provision of care, treatment and protection.

The Commission therefore decided to investigate Mr E's care and treatment and focussed attention on the seven-year period from January 2015 to July 2022. We believed that the concerns raised by the MHTS were significant and the apparent gaps in Mr E's care and treatment required examination to determine whether there were any systems issues which could have contributed directly or indirectly to the poor reported outcomes. Mr E's contribution to this process has been particularly powerful and we are grateful for his engagement and trust in this investigation process.

"I was told that my care and treatment was being investigated by the Mental Welfare Commission. I was asked if I would like to be involved. At first I said no, as I don't like contact with services due to bad experiences I have had with them in my past. I then changed my mind as I want what happened to me to be shared in this investigation. I want people to know what I went through, what I have lost and the negative impact it has had on my life. Most importantly for me, I hope that by sharing my story it will stop this from happening to anyone else."
Mr E, 2023

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[3] Adult support and protection: learning review guidance - gov.scot (www.gov.scot): From May 2022, SCRs were replaced by learning reviews.

Terms of reference

The purpose of this investigation was: to investigate the care, treatment and support given to Mr E by the NHS board, local authority and health and social care partnership from 1 January 2015 until 31 July 2022, with particular focus on:

- Knowledge, practice and application of the Mental Health Act, the AWI Act and the ASP Act
    i) Referral processes
    ii) Assessment processes
    iii) Timescales
    iv) Roles and responsibilities
    v) Legislative principles
    vi) Training and support

- Integrated multidisciplinary working across health and social work services to assess and deliver individual outcomes
    i) Communication and sharing of information
    ii) Processes for multidisciplinary review
    iii) Processes to include family/carers as appropriate
    iv) Policies and procedures in relation to decisions to close cases

- Financial management
    i) Corporate appointeeship and how this is managed in practice

- Meaningful engagement with family
    i) Processes which inform practice in relation to both engagement and response to concerns

As is the case with all Commission investigations, the aim was to identify any lessons to be learned both locally and nationally and to make recommendations, as appropriate.

Investigation process

The investigation team had access to social work records, mental health team records (hospital and community), and general practitioner records from 1 January 2015 up to 31 July 2022. We sought specialist advice from a diabetologist[4] and a member of the Coalition of Carers' black, Asian and minority ethnic group.

We also read the local adult support and protection procedures and Care Programme Approach procedures.

We engaged with Mr E at the outset of the investigation process and we include his invaluable perspective throughout this report. We also attempted to engage with Mr E's family members by telephone and in writing (in English and in Punjabi). In the absence of direct engagement with Mr E's family, it should be noted that all references to them in this report are based on interviews with third parties or access to written records.

Having considered the records and Mr E's views, we interviewed the following professionals involved in his care over the seven-year period 2015-2022:

- Psychiatrist x4
- General practitioner
- Social work manager x3
- Senior social worker
- Mental health officer x2
- Community psychiatric nurse
- CMHT lead
- Lead officer adult support and protection
- Advocacy manager

We are grateful to the staff who we met virtually and helped to bring to life the records and notes we had read. We are also grateful to the services for agreeing to provide maximum support to their staff throughout this process in recognition of how difficult this process of learning can sometimes be.

The Commission's investigation team comprised:

- Social work officer
- Medical officer x2
- Engagement and participation officer (carer)
- Nursing officer
- Casework manager (investigations)
- Chief executive officer

Once the interviews had been conducted, the information was analysed using a content analysis model, using the terms of reference shared with the relevant services at the beginning of the investigation process. In addition to the terms of reference, we considered

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[4] Diabetologist: a doctor who has expert knowledge in relation to the physical health condition of diabetes.

the failure to carry out a comprehensive local review of Mr E’s care and treatment by any agency.

Eight themes are considered in the ‘Findings’ section of this report under the headings of:

1. Medical treatment
2. Safeguarding legislation
3. Corporate appointeeship
4. Roles and responsibilities
5. Multidisciplinary working
6. Mechanisms for learning and improvement
7. Family
8. Participation

Mr E

“I was born in Scotland. My family originate from Pakistan and are Muslim. We believe in Islam and prayer is important to us.

“I had hoped that one day I would get married. I remember being shown a photograph of a beautiful Pakistani woman that I would like to have married. I feel it is no longer possible for me to have friendships and/or relationships as I am blind and live in a care home. I have very little contact with people now and feel very lonely and isolated. I often think about ‘lost love’. I have written song lyrics about this loss as it helps me comes to terms with it.

“My main passion in life is music. I really like jazz music. When I moved [to the mainland], I frequently visited local record shops and the music section of libraries. I liked looking through the vinyl LPs and would buy some to add to my own collection. I used to play music every day in my house for hours. I still have my vinyl collection but it is kept in my family home. I don’t think I would be able to play my vinyl LPs anymore as I am blind. I miss having my record collection and personal belongings as they used to bring me happiness.

“I especially like lyrics and I started to write my own lyrics in a notepad. I have written some songs that I am proud of. I miss being able to write down lyrics that come into my head and feel a sadness I am not longer able to write. I try to remember my lyrics but this is difficult as my memory is not as good as it used to be.

“I have been told I have a mental illness. I do not believe in mental illness although I have experienced paranoia before. I have to take medication that I don’t like taking.

“My physical health is bad, I don’t really understand why it got so bad. I am now blind. I am unable to walk without my zimmer frame and spend most of the day lying in bed. I have no quality of life.”

Mr E’s words written by a Commission officer, anonymised as appropriate and agreed by Mr E in 2023.

Brief chronology of events recorded across social work and health records 2015-2022

January 2015

GP referral of Mr E to the community mental health team (CMHT); **last seen by CMHT in 2009.** Mr E not taking any medications at all; lost substantial amount of weight.

Mr E attended the social work office, concerns over his physical appearance – unsteady on feet, loss of weight noted. Mr E would not agree to attend GP.

February 2015

Referral to social work from Mr E’s older brother (with whom he lived) for social work assessment and raising concerns over lack of psychiatrist and social work contact and concerns over neglect of his brother’s care and treatment by services.

Discussion regarding joint social work and health visit, however psychiatrist and community psychiatric nurse (CPN) visited. They then referred to social work, raising adult support and protection concerns.

Record of home visit with CMHT nurse and doctor. Longstanding fixed views regarding medications noted.

Social work record concern regarding covert medication in relation to Mr E’s brother and issues in relation to Mr E’s capacity to manage medication and understand diabetes.

March 2015

Mr E’s brother asking for visit by social work. Social work advised no visit planned and concerns raised were passed to the psychiatric service.

Joint visit undertaken by social work and CPN. Visit recorded as difficult due to Mr E’s brother’s presentation – speaking over Mr E.

April 2015

Concerns noted that Mr E’s diabetes had been untreated for many years. Concerns over brother’s health – discussion regarding arranging a case conference to discuss concerns.

Lack of clarity which agency would arrange case conference and what auspices the meeting was under. CPN reported on meeting Mr E on his own, he presented and engaged better. Notes record case conference arranged on 29 July 15 – no record of meeting. The meeting did not take place.

June 2015

Mr E was briefly admitted to hospital in England due to issues with diabetes. Concerns from hospital staff regarding ‘safeguarding’ issues and poor communication with family. Social work from Scotland stated to hospital staff in England that they had no concerns advising that the CMHT were involved.

October 2015

Mr E seen by CMHT nurse. Mr E accepting medication for mental illness. Slightly improved. Concerns about relationship between Mr E and his brother and associated vulnerabilities.

December 2015

Psychiatrist email to GP stating Mr E was refusing medication for mental illness. Asked GP to prescribe mental health medication in dosette box to be administered by district nurses (DNs). No authority in place to do so however.

No social work involvement recorded from November 2015 – June 2016 (social work remained corporate appointee during this time).

January 2016

CMHT appointments January and April 2016 were unsuccessful. **Case closed by CPN in December 2016 due to non-engagement.**

June 2016

DN and GP reported to social work that Mr E was not engaging in treatment. Mr E's brother told DNs not to go back to the house. Decision to continue with corporate appointeeship to ensure social work team maintained weekly contact to monitor his health.

July 2016

Mr E had not picked up his Department for Work and Pensions (DWP) benefit monies from the social work service for four weeks. GP was contacted and advised that he had seen Mr E on 6 July 16 and took bloods. GP noted that he had not seen Mr E walking around the local area for a few weeks which was a change. Social work decision: no further action.

August 2016

Social work service met with Mr E's brother and agreed he could pick up Mr E's benefit monies for a period of four weeks as Mr E was reportedly not feeling well.

December 2016

Annual review of DWP appointee completed by social work. Record of financial harm concerns in relation to Mr E's brother noted however he continued to collect Mr E's money fortnightly.

Mr E noted to have savings of £14,000 in corporate account. Four months on, Mr E's brother still picking up Mr E's DWP benefits although it had been agreed this arrangement would be for four weeks only. Mr E's brother asking for benefits to be sent to bank. Not agreed.

January 2017

Mr E's brother continues to collect DWP benefits. Social work attempted to discuss Mr E's £14,000 savings with brother. Letter subsequently sent to Mr E's brother regarding savings. No letter to Mr E.

May 2017

Enquiry received from a Councillor. Questions raised that the previous case conference to discuss concerns on 29 July 15 did not take place and case was then closed due to non-engagement.

Social work checked that GP had not seen Mr E since October 2016 and undertook ‘cold call’ to the house, no access, card left.

Mr E’s brother attended the social work office to collect DWP money. Records note that brother did not want to engage with social work and refused a home visit for the purpose of assessment for Mr E.

June 2017

Unannounced visit by social work. Mr E’s brother did not allow access to the house. Social work report that Mr E is heard shouting for assistance. Second home visit a week later; no entry permitted by brother. Social work and CPN report concerns over brother’s presentation.

29 June 2017: Adult support and protection **assessment order granted.**

30 June 2017: Assessment order home visit. Police in attendance. GP took bloods. Mr E reported to be ‘dishevelled, dirty, smelt of urine, flat in mood, unclean’. Brother making threats to GP – Police intervention required. Mr E stayed at home throughout and remained at home.

July 2017

Adult support and protection case conference held and noted that assessment order granted and was ‘successful as bloods taken’, records state no further action required under the ASP Act. Recorded that social work to continue to monitor case as ‘corporate appointee’ (although Mr E no longer attending the office). Social work closed the case nine days later.

August 2017

Letter from CPN to GP stating they had received minutes of the ASP case conference held in July, that there were no particular concerns, and Mr E presented in reasonable form. CMHT had subsequently offered home visit to assess Mr E’s mental health and gauge whether there was a current role for CMHT. Visit cancelled so after multidisciplinary team (MDT) discussion CMHT decided to discharge Mr E back to GP care. **There was then a four-year gap in involvement by the CMHT in Mr E’s care.**

Gaps in social work recording from Dec 2017 – 22 March 2018.

March 2018

Police raising concerns re Mr E’s brother’s presentation. Police report Mr E as nervous. Police reported Mr E’s mobility issues, injury to knee, poor eyesight, dirty home environment. Mr E’s mother explains he is refusing to wash or allow bed sheets to be cleaned. Police suggest initial referral discussion as per adult support and protection legislation.

April 2018

Case note from duty team social work records stating joint visit with social work and police is required. Social work notes record unable to arrange visit due to ‘other duty commitments’.

June 2018

Mr E’s brother attended the social work office. Two social workers met with him and attempted to discuss the concerns raised by the police three months earlier.

November 2018

Benefit monies application declined due to social work not providing information on time.

Gap in social work recording for 15 months, only one case note in 2019.

March 2020

No DWP benefit monies had been collected by Mr E or his brother since December 2018.

DWP questionnaire due, social work called Mr E’s brother; records state some concern over Mr E’s brother’s presentation on the call.

Social work called the GP requesting information on when Mr E last had contact with GP. GP advised that Mr E did not attend annual diabetic review adding that the CMHT/psychiatry had not reviewed Mr E “in some time”.

Social work requested police to undertake welfare visit, police refused as social work had not made attempts to visit Mr E at the house.

Social work subsequently met with Mr E in his home. Concerns raised in relation to his mental and physical health and capacity. Concerns recorded regarding Mr E’s eyes, visible sores on his knees from crawling on the floor. Mr E’s mother and brother both stating she was unable to care for Mr E. Agreement given to a GP visit.

GP practice would not agree to visit due to COVID stating that they felt the situation was ‘chronic’ and did not require urgent visit. GP felt hospital admission required.

April 2020

Noted that benefit monies had stopped in January 2019 due to unmanaged claim which social work, as appointee, should have dealt with.

Minutes of adult support and protection case conference. Outcome for GP and mental health officer (MHO) to visit on 6 May 2020. Record that CMHT not willing to assess Mr E until GP assessment undertaken. Four-year gap since any involvement by CMHT.

May 2020

6 May 2020: MHO and GP assessment of Mr E. Outcome that Mr E’s physical health “ok”, difficult to assess mental health and therefore referred back to CMHT.

June 2020

CMHT visit, reported back to social work that “**situation dire”**. Detention under Mental Health Act required.

August 2020

Short term detention certificate granted.

September 2020

Social work decision to pay £2000 into Mr E’s mother’s bank account due to main source of income in recent years being from her pension. No discussion with Mr E.

Compulsory treatment order (CTO) granted.

Gaps in social work recording from 28 October 2020 – 1 December 2020 and 3 December 2020 – 3 February 2021.

March 2021

Extension to CTO granted.

June 2021

Mr E’s balance in his corporate account is £23,964.61.

July 2021

Interim local authority welfare guardianship order granted.

Findings

“I used to walk around my local community most days. I also travelled to other places, mainly to explore the libraries, local landmarks and monuments. My favourite part of the day would be going for coffee and food. I love coffee and I love food. I liked going into local coffee shops and chatting to people. I enjoyed finding out about their background, music interests and culture. I miss being able to do things I enjoy.”
Mr E, 2023

1. Medical treatment

1.1 Mental health care

Mr E was first diagnosed and treated for mental illness in his early 30s and was diagnosed with schizophrenia during his first hospital admission in 2003, prior to the age of 40.

Schizophrenia is a severe and enduring mental illness that affects approximately one in a hundred people during their lifetime. There are expected standards of care in the form of National Institute for Health and Care Excellence (NICE) guidelines in England[5] and the Scottish Intercollegiate Guidelines Network (SIGN) guideline 131[6] in Scotland.

Follow-up by community mental health teams and additional therapies and support such as psychological therapy, family therapy, educational and employment supports are also recommended to aid a person’s recovery and enable them to live as fully as possible.

What we found

Mr E first received treatment for mental illness in 1996, before moving with his mother and brother to a different area of Scotland, where he continues to live today.

Historical medical records showed that when Mr E was taking antipsychotic medication regularly, his mental and physical health were much improved. He had a consistently good response to one oral medication which was the main antipsychotic prescribed from 2003. When his acceptance of medication reduced, a pattern repeatedly followed in which his physical and mental health gradually deteriorated, he lost insight into his mental ill health, became more suspicious of treatment, and gradually disengaged from the community mental health team.

At the time of his re-referral to the community mental health team (CMHT) in January 2015, Mr E had not been seen by a mental health professional for six years. The GP record showed that he had last been given a prescription for antipsychotic medication in March 2010, indicating that his schizophrenia had been untreated for at least four and a half years.

Mr E had made two requests to the GP for an antipsychotic prescription in February 2013 himself. The GP, noting that he had not had the medication since 2010, asked Mr E to make

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[5] Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

[6] Management of schizophrenia (sign.ac.uk)

an appointment. When no appointment was made, no medication was prescribed and no further action was taken.

When re-referred to the CMHT in January 2015, the GP indicated that Mr E was not taking any medication at all and wrote in the referral of concerns that Mr E’s mental health was getting in the way of treating his diabetes**.**

Following subsequent assessment by a psychiatrist who knew Mr E previously, Mr E was not re-started on medication immediately, as he was not thought to be mentally unwell. A GP review for his physical health was encouraged and CPN follow-up was arranged.

In September 2015, on further review, the same psychiatrist did note concerns about a deterioration in Mr E’s mental state. Mr E agreed to a trial of a new oral mental health medication at this time, which the DN was to administer when visiting daily to give him his insulin. The clinical records suggest that initially the district nurses were able to administer this but Mr E then began refusing, complaining of side effects. A trial of a third oral antipsychotic medication was then started in October 2015.

When the psychiatrist next saw Mr E in April 2016, it was reported that Mr E and his brother were refusing entry to both the CPN and the DNs. Although Mr E’s brother reported administering insulin and monitoring Mr E’s blood sugar levels, the psychiatrist wrote to the GP and noted that there was no way of knowing this and it was "hard to know what, if anything, can be done". It was said that Mr E’s brother controlled access and that Mr E did not appear to have any specific complaint himself. The psychiatrist noted:

> *"There remains the suspicion that [the brother] may have his own health issues which affect his decision making and may directly or indirectly affect Mr E, but it is not clear there would be any way to intervene."*

A plan was made for the CPN to confirm if prescriptions were being collected and to discuss with social work whether an adult support and protection case conference was needed.

Mr E was not seen again by this psychiatrist. He was then discharged from CPN follow-up in December 2016, having had no contact with the CPN over the previous six months.

When an adult support and protection case conference meeting was called by social work in July 2017, there was no representation from the CPN service or the psychiatrist who had been previously involved in Mr E’s care. As detailed later in this report, one of the outcomes of the case conference was a recommendation for follow-up by the CMHT. Appointments were offered in August 2017 by both the psychiatrist and the CPN, but these were declined. The response was to discharge Mr E back to GP care again.

Mr E’s next contact with the mental health service was following re-referral by a different GP three and a half years later, in May 2020. The subsequent home visits by the psychiatrist, in May and June 2020, in response to this re-referral by the GP, are detailed in section 2.1. Compulsory treatment – use of the Mental Health Act.

The GP records show that during the period when Mr E was not seen by the CMHT, between 2016 and 2020, regular prescriptions for antipsychotic medication continued to be issued. However, it is not clear whether this medication was consistently collected and taken or administered by Mr E's brother. There is at least one instance during this period when the pharmacy contacted the GP with concerns about medication which had not been collected.

Mr E's past history suggests that his mental illness responded well to oral medication, when he was reliably taking this. However, by the time of his admission in August 2020, it was suggested that his illness had become at least partially treatment resistant as a result of long gaps in treatment. We would have expected there to be significantly more action, both from the psychiatrist and GP, about the consistent concerns surrounding the treatment received by Mr E, given his diagnosis of a severe and enduring mental illness.

As discussed later in this report, the lack of consideration of legal safeguards to intervene, to more fully assess Mr E's needs and deliver his mental health care and treatment, was also a significant failing.

Depot medication (medication given by injection)
The SIGN guideline recommends that maintenance treatment with depot medication is considered for people with schizophrenia who have difficulties complying with medication.

According to the clinical record, prior to 2015 Mr E's first and only treatment with depot antipsychotic medication was briefly in 2003 during his first hospital admission. His psychotic symptoms responded well, but the depot was discontinued due to side effects of akathisia (a movement disorder characterised by an inner feeling of restlessness and difficulty sitting still).

We found no evidence in the CMHT records to suggest that depot medication had been considered or discussed with Mr E between 2015 and his admission to hospital in August 2020, despite the availability by 2015 of several newer depot antipsychotic preparations that were less likely to cause similar side effects. Depot treatment would have had the added benefit of ensuring regular CPN contact to administer medication and the ability to swiftly identify any difficulties or gaps in treatment.

1.2 Physical health care

Diabetes is a medical condition characterised by abnormalities in the control of blood sugar (glucose) levels. In people with diabetes, problems with insulin production or function mean that insulin does not regulate blood glucose in the way it should, and blood glucose levels are too high.

Prevention of long-term complications is an important part of good diabetic care. People with diabetes are invited for routine eye screening, foot checks, and blood tests, so that any signs of diabetic complications can be picked up early and appropriate monitoring, treatment and support can be provided. This is the standard of care we expected Mr E to receive.

What we found
By 2015 Mr E had been living with diabetes and prescribed treatment with insulin for over fifteen years. At times he had been prescribed additional oral anti-diabetic medication.

Throughout his clinical records (both GP, inpatient and CMHT records), it was stated that Mr E had type 1 diabetes. It is only in 2015, in correspondence relating to his inpatient stay for diabetic care in England, and later in an email exchange between Mr E's GP and a professor of endocrinology in 2020, that it is confirmed that Mr E does in fact have type 2 diabetes.

Although this does not seem to have made a significant material difference to his care and treatment, it is an important distinction and represents a consistent diagnostic error made throughout his clinical records.

Physical deterioration over time

It is clear from past clinical records and from the testimony of Mr E himself, that he was previously a fairly independent and physically active man. The deterioration in his physical health over the course of just a few years is striking and was borne out in the clinical records and in our interviews with the health professionals involved in his care.

The GP who took over Mr E's care from 2016, recognised this change. Recalling the descriptions of their GP colleague, who had previously been Mr E's GP for many years, they said:

> *"I know that my colleague used to see the patient walking outside, walking along [main street], going to record shops and things. So I think yes, I think his mobility was certainly worsening with time."*

From the chronology within GP and CMHT records, the trajectory of Mr E's decline in mobility is clear to see (see appendix 1). This appears to have been associated with diabetic neuropathy. With continued poor diabetic control, his symptoms and pain gradually worsened. It is likely that the reduced movement that ensued led to the development of contractures[7], to the extent that by 2020 he was barely mobilising at home, was largely bed-bound, and crawled on his knees to use the bathroom. Later assessment by occupational therapists and physiotherapists identified that by this stage there was limited potential for further rehabilitation.

Mr E's sight loss occurred primarily as a result of cataracts, which were first alerted to the GP by an optician in June 2016. There was also reference to underlying diabetic retinopathy (eye disease). An ophthalmology appointment was offered in October 2016. Mr E contacted the GP surgery asking for this appointment to be cancelled as he could not walk down the stairs. Ambulance support was offered by the GP but was declined. No other action was taken to arrange follow up. By the time Mr E was seen by ophthalmology, four years later in 2020 during his hospital admission, his sight loss was no longer reversible by cataract surgery (see chronology in appendix 1).

The SIGN[8] guideline for diabetes management talks about the prevention of visual impairment, including the increased risks of cataracts in people with diabetes, with this risk further increased when there is poor glycaemic control.

The guideline recommends "cataract extraction should not be delayed in patients with diabetes".

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[7] Contractures: shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints. Oxford dictionary

[8] Management of diabetes (sign.ac.uk)

Blindness caused by these conditions can be preventable if signs are picked up early and treatment is provided. Mr E did not attend eye screening appointments and did not attend the diabetic clinic or ophthalmology appointments. When these appointments failed, nothing further appears to have been done.

Diabetic management

The clinical records highlight frequent and persistent concerns about Mr E's diabetic care. The consistent narrative from 2015 was that Mr E's brother was giving his insulin injections and was responsible for monitoring his blood sugar levels. There were concerns raised at times about the reliability of this reporting and also whether Mr E was accepting of this.

The only time that Mr E's diabetic care could be objectively monitored in the community was following his admission to a hospital in England in June 2015, when it was recommended that on discharge, district nurses visit him daily to dress his foot ulcers, to administer insulin, and monitor his blood glucose levels. This was the first time that district nurse support had been provided. However, over time, district nurses stopped being permitted entry to the home back in Scotland and Mr E's diabetic care returned to the responsibility of his brother.

Mr E was not attending appointments with the GP, nor was he receiving annual blood or physical health monitoring that would have been expected, both for his diabetes and for his mental health.

The only record in the GP notes of blood glucose levels being checked was in 2015 and 2016.

We asked the GP about what happened when people did not attend for screening appointments or general diabetic care:

> *"So generally they get three letters in sequence inviting them for an annual review and then it does get noted in their notes. We call it informed dissent, particularly if they've let reception know they don't want to attend. Often receptionists will flag up to us if a patient hasn't been attending or we've had several did not attends (DNAs) and again, it's a case-by-case basis, but we'll try and phone them or make some contact."*

Pathways of diabetic care in the health board

We spoke with a senior diabetic specialist in the local health board to find out about care pathways for people with diabetes.

We were advised that the expectation was that all people with type 1 diabetes would have an annual review appointment at a specialist diabetic clinic. This was also the case for people with type 2 diabetes who were on treatment with insulin (Mr E).

We heard about complex cases where individuals with significant mental health difficulties, including those who lacked capacity to consent to treatment, were supported with their diabetic care: the diabetic team, which included a liaison psychiatrist, would work with other professionals from primary care, secondary care, and sometimes with social work and care providers, to devise individual care plans to support each person in the most effective way. A pragmatic approach, based on the principles of Realistic Medicine[9], was described. The aim

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[9] Realistic Medicine – Shared decision making, reducing harm, waste and tackling unwarranted variation

was to enable delivery of the best available diabetic care and preventive screening, in the least intrusive and most acceptable way to the individual concerned.

We heard about particular focus on the group of patients in middle age with “decades of life ahead” (Mr E), where the aim of intervention was to “avoid potentially life-changing complications”.

We asked about how this type of tailored, multidisciplinary approach might be accessed, particularly if a person was not responding to screening letters or diabetic clinic appointments and was not engaging with attempts to monitor their diabetes in primary care. In this type of situation, we were told that the GP (or other health professional) could contact the diabetic clinic for advice or make referrals via an online gateway.

We found no evidence of a referral or request to local diabetic specialists for joint working after attempts to support Mr E to attend the diabetic clinic in 2017 had failed.

Given the longstanding concerns about Mr E’s diabetes over many years and the worsening of his physical health from 2015, it seemed significant to us that neither the GP practice, nor the CMHT, appeared to have reached out to specialist services more proactively to request a multi-agency meeting to discuss how best to manage Mr E’s diabetic care. Had this been done, it seems likely that Mr E’s diabetic management could have been considerably improved and the complications that he suffered could have been lessened considerably, if not avoided entirely.

1.3 Impact of mental illness on management of diabetes

A further complicating factor appeared to be differing views at times between the GP and psychiatrist about the impact of Mr E’s mental health on his ability to manage his diabetic care, particularly in relation to his non-compliance with antipsychotic medication.

When the GP, who had known Mr E for many years, re-referred him to the CMHT in January 2015, a number of concerns about Mr E’s physical health were highlighted: he had “lost a substantial amount of weight”, had a poor diet, lacked insight into his condition, had declined referral to the diabetic clinic, and was not taking any medication at all. The GP raised concerns that Mr E’s mental health was getting in the way of treating his diabetes and continued:

> *“This means that he is continuing to slowly damage his health on account of his psychiatric issue. I am not sure if we are obligated to step in again to try and get him on a medication to improve his mental health."*

When the psychiatrist then assessed Mr E on 9 February 2015, he wrote of Mr E’s beliefs that diabetes does not exist, noting:

> *"They are not delusions and did not change when he had treatment for mental illness."*

We asked the psychiatrist involved at that time if he thought there was a link between Mr E’s mental ill health and his diabetic care:

> *"I think they were associated…I think that if he was acutely unwell and was disorganised then he wouldn't take treatment for diabetes either. That was pretty clear."*

This appeared to support the evidence in the clinical records that when Mr E was taking antipsychotic medication, his acceptance of diabetic treatment improved, even though he was said to continue to hold underlying beliefs questioning the existence of diabetes.

The psychiatrist who looked after Mr E following his admission to hospital was clear that Mr E's mental health impacted on his diabetic care:

> *"There was a direct link between his mental health and his ability to look after himself. Whether it was his diabetes or eyesight or his immobility, there was a direct link and the fact that was not addressed in a timely fashion led to the deterioration."*

This view was borne out by the historical clinical record, in which there appeared a clear correlation between Mr E's compliance with mental health medication and his willingness to accept diabetic care and treatment. Indeed, as far back as the very first referral letter to the CMHT in 2002, the GP noted Mr E's brother's comment that antipsychotic medication "allows him to be sufficiently rational to take his insulin medication".

2. Safeguarding legislation

2.1 Compulsory treatment – use of the Mental Health Act

"I went through a very difficult time at home before being admitted to hospital. This is when I lost my sight and stopped being able to walk. My care needs became too much for my mother and brother to cope with. This caused family relationships to be strained which was very difficult for me. At this time, I felt sad, hopeless and depressed. I blamed myself thinking the situation was my own fault. I quite often felt scared and unsafe. I remember people coming into my home, I was hoping they would help me. I needed help and support; I didn't get it. Many of the staff who visited only saw the physical deterioration."
Mr E, 2023

Following his re-referral to mental health services in 2015, Mr E continued to have poor compliance with antipsychotic medication. He also expressed concerns about side effects and not wishing to take medication. There was almost a four-year gap in his contact with mental health services from 2016-2020 when it is not clear that he was taking antipsychotic medication.

We found little reference in the CMHT record to suggest consideration had been given to assessment for treatment under the Mental Health Act. Indeed, social work staff told us that psychiatry colleagues believed that adult support and protection legislation was more appropriate than the Mental Health Act in Mr E's case.

Following the home visit to Mr E with the CMHT lead in February 2015, the psychiatrist wrote to the GP that there was "no need at present time for antipsychotic medication and he certainly doesn't fall within the realms of the Mental Health Act". This was one of the few references to compulsory treatment in the CMHT notes prior to 2020.

It was surprising to us that there had not been more consideration of use of the Mental Health Act over time, particularly in the context of Mr E's repeated disengagement from services, ongoing concerns from the GP about non-compliance with medication and suggested ongoing deterioration in his mental health.

Mr E's previous history suggested that when he was taking antipsychotic medication for a consistent period, his mental state significantly improved. At these times he was also more willing to accept treatment for diabetes and his physical health became less of a concern. It appeared from the clinical records that improved compliance with medication had also had psychosocial benefits: during these brief periods he had begun to tentatively explore opportunities in education, spoke about his wishes for employment, and appeared to be more engaged in his local community.

These episodes of remission had been relatively short-lived and appeared to have correlated with periods following discharge from hospital, when he remained subject to compulsory measures in the community prior to 2015. When these compulsory measures were removed, a pattern followed of poor compliance with medication, reduced insight into both his mental and physical health needs, and gradual disengagement from health and social care services.

The lack of consideration of the potential use of mental health legislation to support Mr E's care and treatment, particularly when he had a history of lengthy periods of being untreated and unsupported in the community for schizophrenia, a severe and enduring mental illness, is a concern.

Mental Health Act assessment and admission

When Mr E was re-referred to the CMHT on 9 May 2020 by his GP, it was evident that in the intervening four years, both his mental and physical ill health had deteriorated significantly.

The GP visit had been prompted by social work raising concerns that neither Mr E nor his brother were attending the social work office to collect Mr E's benefit monies. A virtual case conference followed involving the social worker, MHO, police, and GP in March 2020 (around the time of the onset of the Covid-19 pandemic). The GP then undertook a home visit.

The GP's referral letter to the psychiatrist, who had been the responsible consultant for the geographical area since 2018, noted that Mr E's situation was complex and that in addition to schizophrenia he had become housebound, was spending all his days in bed, he had poor mobility, could not feel his feet, and had very poor eyesight. He had deteriorated over the last few years and his only communication with family now was shouting for meals and cups of tea. He was described as agitated and aggressive prior to each mealtime. He was said to be taking mental health medication with his brother administering this. The GP noted "as far as I can tell he gets it regularly". His brother also reportedly administered insulin for his diabetes and checked his blood sugars. The GP said multiple attempts to refer Mr E to the diabetic clinic over the years had failed due to his brother cancelling appointments. The GP noted that Mr E had last been referred to psychiatry in 2017, following a similar GP visit. At the time, a home visit had been offered by the psychiatrist but had been cancelled by Mr E's brother and he was discharged by the psychiatrist with no further intervention offered.

An initial home visit was attempted on 27 May 2020 by a new psychiatrist to the geographical area together with a CPN from the CMHT. Mr E's brother denied entry to the flat, saying that the appointment letter had not mentioned a home visit. A letter was sent to confirm a planned home visit two weeks later. This visit went ahead on 10 June 2020, carried out by the psychiatrist and CPN.

When we asked about this visit on 10 June 2020, the psychiatrist gave a clear description of Mr E's circumstances, which were described as "shocking".

> *"Mr E was in his bed, he had contractures. The room itself was not recently cleaned and there was no stimulation. Mr E was really quite dishevelled, his hair was very long, his beard was very long, and he didn't look clean and tidy at all. He wasn't really willing to engage in much conversation. I did manage to at least establish that all he could see was a light coming from the window, he wasn't able to actually see any more than that."*

Both the psychiatrist and CPN were clear that a Mental Health Act assessment was indicated, with a view to admitting Mr E to hospital under a short term detention certificate. However, it was unclear from the clinical records why there was then a gap of 11 weeks between this visit and the assessment taking place on 27 August 2020.

We asked the professionals involved about this delay. The psychiatrist confirmed that a Mental Health Act assessment had been deemed urgent and, at interview, wondered if the delay related to availability of MHO resource. The MHO reflected separately at interview on whether the delay related to responsible medical officer (RMO) resource; neither were sure of why it took so long.

Although a hospital bed had to be identified, the psychiatrist confirmed that this would not have been a significantly delaying factor neither did she believe Covid-19 impacted on the delay.

The social worker reported feeling powerless:

> *"We were just really frustrated at the length of time that it was taking and we felt we had absolutely no control over it, because we didn't."*

There was no contingency support provided to Mr E by the CPN or other mental health professionals during this 11 week period following the "shocking" circumstances observed on 10 June 2020.

A recurring theme we found in Mr E's case was the "chronic" lens through which his difficulties were viewed. Because his mental health and physical health problems had been longstanding, there seemed to be a lack of proactive intervention. We saw evidence of this tendency across professional groups during the period of contact that we reviewed.

> "*Yes there can be times where you can have situations where…somebody's in the community and their situation is chronic and it is bad and it has been bad for a long time, and it often leads to people saying well one more week's not going to make any difference…"*

There appeared to be a degree of complacency that suggested some staff involved had perhaps become accustomed to the chronicity of Mr E's complex mental health difficulties and social situation and possibly immune to the underlying risks involved.

> *"…it [his home] wasn't in the best condition but I've seen worse and I know that, I'm saying that in the context of having been desensitized because I'm sure we've all seen some pretty horrendous houses."*

This lens also seemed to be a significant factor in the deterioration of Mr E's physical health.

2.2 Adult Support and Protection

The ASP Act was implemented in 2008 in Scotland. This legislation was introduced to complement existing mental health and incapacity laws and was designed to protect those adults who are unable to safeguard their own interests and are at risk of harm because they are affected by disability, mental disorder, illness, physical or mental infirmity.

Section 53 of the ASP Act sets out definitions of harm; it is not an exhaustive list. What is considered harmful to an individual must be in a context and person specific. The ASP Act is clear that harm can be intentional or accidental.

"Harm" as defined in the ASP Act, was evident in Mr E's circumstances throughout the timeframe of our investigation. The harm identified in Mr E's case records mainly related to neglect, financial harm, and undue pressure/influence.

What we found

Health and social work records referred to financial harm from Mr E's brother which resulted in corporate appointeeship being put in place to manage the risk of financial harm continuing. This arrangement did not ultimately protect Mr E (see section 3. Corporate appointeeship).

Records noted multiple incidences of self-neglect whereby Mr E was not taking care of his physical health and mental health. Mr E was not compliant with medication relating to his health conditions, did not attend appointments for review of his diabetes, and there were questions about his capacity which seemed to go unanswered. As the concerns escalated, there was evidence of increasing neglect of Mr E's personal care and changes in his physical presentation. We were told:

> *"Mr E was dishevelled, dirty, smelling of urine, and living in an unclean environment."*
>
> *"Mr E was lying in bed, appeared bedbound, nervous, poor mobility, poor eyesight, grazes on his knees from crawling on the floor, bedclothes dirty."*
>
> *"I wasn't sure he had been out of his bedroom very much…he appeared to be in almost traction in terms of his position in bed."*

Records detailed significant challenges to accessing Mr E because of his brother's regular refusal to allow access to the home.

> "We *definitely agreed he was vulnerable, partly because of his brother blocking access to him…it was his brother that would control access to him [Mr E] and decide whether or not he would be allowed to see medical professionals or go to appointments."*

We read that Mr E's brother also presented as confrontational and controlling at times towards Mr E and was covertly medicating Mr E.

There were differing views amongst professionals as to whether this harm was intentional or not. This however is irrelevant in relation to harm, as the ASP Act is clear that neglect can be unintentional as well as intentional. The focus should have been the impact on Mr E, not whether the neglect by his brother was intentional or not.

Recognition of harm itself was a feature in Mr E's case. The fact that Mr E was "being fed" seemed to be seen as a key protective factor. The staff we interviewed told us:

> *"I was happy the house was warm, he was getting fed."*
>
> *"One thing that was apparent was that he was not in immediate danger because he was clearly being fed…yes he appeared disturbed, his mobility had gone down."*

The lens of chronicity referred to earlier resulted in staff not seeing urgency in the situation and some staff told us they had "seen worse".

We consider that there was clear evidence that Mr E was an adult at risk of harm in relation to the criteria set out in the ASP Act and that his rights extended beyond being warm and fed.

Duty to Inquire (DTI)
When it is suspected or believed that an adult is at risk of harm and intervention may be necessary to support and protect the adult, section 4 of the ASP Act places a duty on local authorities to make inquiries into the person's circumstances. HSCP A's local ASP Act guidance records that anyone reporting concerns, only need to "suspect or believe" that the adult is at risk of harm.

What we found
We found that, on a number of occasions, harm was reported or suspected in relation to Mr E but the duty to inquire was not undertaken according to local procedures and guidance. Whilst the focus of our investigation is from 2015-2022, it is clear from records that similar practice existed prior to 2015.

Adult support and protection concerns were increasing in January 2015. Mr E's younger brother had again called social work services raising concerns about a deterioration in Mr E's physical health and not managing his diabetes. Social work made enquires with the GP who reported that Mr E had not been seen "for many years". Social work records state that the GP "would make a plan". The GP made a referral to the CMHT. Mr E was collecting his regular DWP benefit monies from the social work office at this time and staff had noted that he was "unsteady" on his feet and had lost weight.

In February 2015, the CPN raised concerns with the social work service. A review undertaken by the psychiatrist and CPN had highlighted concerns over Mr E's capacity to manage and understand his diabetes. The CPN also raised concerns over Mr E's brother "covertly medicating" him. A joint social work and CPN home visit was undertaken on 24 March 2015. The outcome of this visit from a social work perspective was that health services were the lead agency in offering Mr E support in relation to the physical health issues he was experiencing, and the visit/intervention was not recorded or regarded as an ASP intervention by social work. Health staff, on the other hand, were clear that they had concerns in relation to adult support and protection at this time and were of the view that they had raised ASP concerns.

In June 2015, social work received a referral from a staff nurse based in a hospital in England reporting that Mr E was an inpatient receiving urgent diabetic care. The staff nurse reported that Mr E was ready for discharge however this could not be facilitated as Mr E's brother who was his "main carer" had not engaged with hospital staff, adding that they had concerns regarding Mr E's brother's health. The staff nurse raised "safeguarding" issues in relation to Mr E's physical and mental health, his home situation and family relationships. In response to this referral, social work contacted the GP and recorded that the GP was of the view that Mr E "would require a place of safety". Social work also contacted the psychiatrist from the CMHT and recorded that the CMHT were aware of Mr E being in hospital but advised that the psychiatrist would be "unable to assess the situation", no reason was recorded as to why not. Social work reported to the staff nurse in England that they "did not know of any concerns within the family home and that mental health services were involved". No consideration was given to Mr E's support needs by social work at this stage with, again, a view that health was the responsible agency at this time. There was no evidence of appropriate co-ordination.

On 12 May 2017, Mr E's brother contacted a local councillor to raise concerns over the lack of care and treatment Mr E had received from health and social work services. The senior manager who received the complaint from the local councillor noted that a CPN had requested a case conference to consider ASP concerns back in 2015 but the meeting had not taken place as requested. The 2017 referral was passed to a senior social worker based in the duty intake team to progress (this team dealt with "one off" issues or short-term interventions only). The social work manager recorded the referral details under a Getting it Right for Everyone (GIRFE) (see section 5. multidisciplinary working) casework management plan rather than ASP.

In March 2018, the police submitted a report to social work following a welfare check they had undertaken on Mr E after neighbours raised concerns. The police reported serious neglect concerns. This information was initially assessed by the social work duty intake team and recorded as an ASP duty to inquire. The outcome was to proceed to ASP investigation. The next case record in relation to ASP however is recorded on 20 April 2018 and reports "a visit has not been progressed due to other duty commitments".

This chronology is not exhaustive but evidences a pattern of the social work responses to adult support and protection concerns resting with the duty "intake team" with individual concerns being seen in isolation, not appropriately recorded or addressed as adult support and protection, with no chronology or oversight of the cumulative concerns. In the absence of an allocated social worker, the opportunity to develop relationship-based practice and a holistic assessment of risks, needs and outcomes was missed.

From 2020, we noted an improvement in recording and management of ASP concerns in accordance with local ASP guidance. However, we were told that failure to do so previously had made the task more complicated.

It is important to repeat that the ASP Act was implemented in 2008 and over a decade on, staff from HSCP A told us they neither felt skilled nor confident in carrying out their ASP duties. We were told that this was further complicated by the use of a casework management system known as Getting It Right For Everyone (GIRFE).

> *"Staff were confused by when to use GIRFE and ASP."*
>
> *"Staff used GIRFE when ASP should have been used."*

Adult support and protection law is the legal framework to investigate harm, share information and activate the duty to cooperate on relevant organisations to promote support and protection underpinned by the key legislative principles.

We were told that GIRFE is a generic framework to support people with complex needs "to live well".

This model was not appropriate to Mr E's needs in 2017 and potentially could have placed him at greater risk by not invoking safeguarding legislation at the outset.

Mr E's case confirms that staff were unable to separate the two frameworks due to a lack of understanding and, in some cases, GIRFE was used as it was "less cumbersome", potentially to the detriment of adults at risk of harm.

Interagency Referral Discussion (IRD)
IRDs provide a forum for interagency discussion and decision making about the next steps in protecting an individual. An IRD is not written in law, however the code of practice[10] and some local area procedures, including HSCP A's, define expectations of IRDs.

The local procedures in HSCP A state that participants of the IRD should include police, social work, and health services as a minimum and any of these core agencies can initiate an IRD. Although IRDs should have been in place in HSCP A, based on local procedures, the practice in relation to Mr E did not match the procedures.

From January 2015 until February 2017, no IRD is recorded in social work or health case records even though increasing ASP concerns were being presented in relation to Mr E.

The first IRD was not initiated until 21 June 2017, this was in response to concerns being raised on 12 May 2017. Initially the concerns were not considered under ASP leading to an unnecessary delay in the IRD being initiated.

We noted from records that health staff did not participate in IRDs in relation to Mr E and asked staff about this:

> *"Health don't do it, they won't do it. There has been a move for that to be a thing, we've tried, there's a section for them to do it or at least a template but they never do, it's quite frustrating."*
>
> *"It is social work and police really and they decide whether there's an IRD. I think we [health] should be involved because I think we bring a different approach to what the progression could be…more recently I put in a referral. I said I'm hoping we'll have an*

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[10] Adult Support and Protection (Scotland) Act 2007: Code of Practice (www.gov.scot)

> *IRD, social work said to me – we will tell you whether we're having an IRD – I was like really?"*

There were clear tensions among health and social work staff regarding IRD participation. Nevertheless, all staff agreed that health input would have been beneficial in IRDs for Mr E given his complex physical and mental health needs. It was not clear why the multi-agency procedures in HSCP A were not implemented in practice, leading to the tensions noted and a failure to embed a multi-agency approach to ensure best outcomes for adults at risk of harm.

There were limited records available detailing IRDs. Where we did find information relating to an IRD, for example in March 2020, it was concerning that health colleagues were not involved but also that, in the absence of health colleagues, a decision was made to arrange admission to hospital. This admission to hospital did not take place until five months later.

There were missed opportunities for all partner agencies to initiate IRDs in HSCP A but it was clear that, in practice, social work was seen as the gatekeeper to these.

We identified a number of concerns in relation to the application of the ASP Act at every stage of the process and staff we interviewed confirmed this to be the case, albeit some staff did view it positively at times, as the only way of "getting round the table" to discuss concerns.

Concerns in relation to ASP Act implementation is particularly borne out in relation to the application for an assessment order in respect of Mr E.

ASP investigation and assessment order

When the referral was received on 12 May 2017 from a local councillor the social work service had information that Mr E had not had contact with the CMHT for 18 months, had not had a diabetic review since 2015, staff had witnessed Mr E in the social work office "dishevelled and in old clothes" and Mr E was still subject to corporate appointeeship based on historical concerns related to financial exploitation.

The decision was made to undertake a home visit, however this was not conducted as an ASP investigation. Instead, it was agreed that Mr E would be advised that the purpose of the visit was to "review the corporate appointeeship". It is not clear from the case records why social work were not transparent with Mr E and his family, particularly given the context of Mr E's brother's concerns too.

Transparent use of the ASP Act would have ensured consideration of the safeguards available, not least the legal authority (section 7) to enter a property and gain access to an adult where there are concerns they may be at risk of harm, and where the person declines to participate or entry is refused, in order to consider the capacity of the adult to understand the assessed risks and to explore undue pressure.

On 1 June 2017 and 9 June 2017, a social worker and CPN attempted to visit Mr E but access was denied by his brother. Case records from 1 June 2017 state that Mr E was heard shouting for assistance. Following the visit on 9 June 2017, a decision was made by the senior social worker that Mr E's case required urgent allocation to a social worker to apply for an assessment order under ASP legislation.

We found that no consideration was given to inquiry and/or assessment according to the Mental Health Act and would question why not.

An assessment order according to the ASP Act requires consent from the adult; Mr E had a history of non-engagement with services and his case being closed by health and social work services as a result. The ASP code of practice is clear that if it is considered that the adult will refuse consent, the merit of applying for an assessment order should be re-considered as to what benefit it will offer.

It is important to highlight at this stage that, if social work had undertaken an ASP investigation and been transparent with the family regarding their concerns and the shared view that Mr E required support, the family may have engaged. The notes reflect that there was an assumption that Mr E's brother would not allow services access and while this may have been the case, services did not consider the principles of the ASP Act when making these decisions.

The assessment order was granted on 29 June 2017, over six weeks after the initial concerns were raised with social work. A joint GP and social work visit took place on 30 June 2017, there was no evidence of multi-agency discussion and planning prior to the visit. The order stated that Mr E should be assessed out with the family home. There was no consideration or planning as to how this would be actioned as Mr E's brother had stated that Mr E was unable to leave the house due to his poor mobility. On 30 June 2017, Mr E remained in the house during the assessment order visit.

Case notes record that the GP spent time with Mr E and took blood tests and the results showed "stable" blood levels. Social work record that they spent "a couple of minutes" with Mr E as Mr E said he wanted to be left alone.

We were concerned to read a subsequent case conference case note dated 19 July 2017 that the "assessment order had achieved what we required to make sure Mr E was ok and in reasonable health". No account was taken of the marked deterioration in Mr E's function, mobility and ability to carry out activities of daily living during the past year. During the previous 12 months he had failed to attend an ophthalmology appointment to discuss cataract surgery, his feet had become too painful to walk on, and he was no longer able to manage the stairs to leave his home. ASP measures were however subsequently ceased with a statement that "social work will continue to monitor the situation". The case was closed to social work nine days later. There was no evidence of "monitoring" Mr E and no contact was made with Mr E to review his circumstances prior to case closure.

2.3 Adults with Incapacity legislation

The AWI Act introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves.

We would expect every possible assistance to be given to the person to understand their own circumstances and/or medical condition and the decisions required in relation to these.

Where the person is assessed as not being able to make a decision we would expect the legal framework to be taken into account and implemented to ensure appropriate safeguards and respect for the person's rights, in particular:

- Part 5 of the AWI Act gives a general authority to treat a person who is incapable of consenting to the medical treatment in question, on the issuing of a certificate of incapacity for that treatment (a section 47 certificate). For the purposes of Part 5, medical treatment includes any procedure or treatment designed to safeguard or promote physical or mental health. The s47 certificate usually needs to be completed by the medical practitioner (doctor) who is primarily responsible for the person's medical treatment.
- Guardianship orders under the AWI Act allow relatives/carers or other parties, such as local authorities, to make certain decisions or take certain actions regarding the welfare or financial affairs of adults who are assessed as lacking capacity to make these decisions themselves. One of the primary uses of welfare guardianship under the AWI Act is to authorise not just where a person should live, but also the care they should receive, and how this is delivered.

What we found

We found that the limited direct contact with Mr E and therefore lack of evidence of supported decision making, made it difficult for any agency to make assessment of Mr E's level of understanding and his ability to make decisions and act on them.

No one took time to get to know Mr E.

"Staff did not spend time talking to me to ask how I was feeling, I did not get any emotional support. Staff mainly spoke to my brother, they didn't speak to my mother. They didn't ask me."
Mr E, 2023

Whilst there were queries about whether Mr E was taking or not taking his medication for his diagnosed mental illness and diabetes, and questions about whether his brother was administering medication covertly or with force, legal authority to administer this medication was not explored by those charged with safeguarding according to legislation. One of the doctors told us:

> *"There was absolutely no doubt that he was better when he was taking medication and that, even though he didn't always want to take it, he was willing to accept it most of the time if [his brother] told him he had to have it. I guess we ended up going along with that and I think with the benefit of hindsight we shouldn't have done, we should have gone for a guardianship application at that time."*

Scottish Government's *Adults with incapacity: guide to assessing capacity* (2008) is clear that "doctors have principal responsibility for the formal assessment of capacity – in relation to money management under Part 3 (Access to Funds) and financial and/or personal welfare decision-making under Part 6 (intervention orders and guardianship)". However, the importance of multi-disciplinary assessment is stressed here and in the codes of practice.

In Mr E's case, multidisciplinary working did not feature strongly across a number of key intervention points and this included consideration of capacity issues.

On 27 February 2015, records state that health staff raised concerns regarding Mr E's capacity to manage and understand his diabetes resulting in possible harm. Whilst social work undertook an initial assessment on 13 April 2015, there is no record that capacity issues were considered.

Case records and interviews suggested that social work staff understood capacity assessments to be the realm of medical staff and not the responsibility of social work.

We also found there was a difference in view as to which doctor (GP or psychiatrist) would be responsible for completing a capacity assessment if this was indicated.

The GP thought that for a patient under the care of the CMHT, it should be the psychiatrist who determined capacity and completed a s47 certificate. The CPN largely supported this view. However the views of the psychiatrists we interviewed differed again, with some suggesting that responsibility lay with primary care.

We were told there was no clear local policy, with agreements made on a case-by-case basis. We found this situation, with disagreements about where and with whom responsibility lies for an essential aspect of patient care, to be unacceptable.

It was not until an adult protection review case conference held on 23 June 2020 that the notes record an agreement that an assessment of capacity for Mr E "was required regarding welfare decisions". However progress of the capacity assessment was not recorded as part of the ASP safety plan despite the need for this being unanimously agreed at the meeting.

In addition to delivering the medical treatment itself with the appropriate legal authority, wider issues could have been considered as part of a process of assessment for a welfare guardianship order. Powers could have been considered to support Mr E's engagement with health care professionals in order to assist in the management of his physical health care. This could have included access to the family home to deliver treatment, healthcare workers to support his attendance at clinic, and routine health screening appointments.

Mr E was known to be living in a single room and crawling on his knees with deteriorating eyesight. A change from the person who used to be seen out and about visiting charity shops and enjoying music; yet his welfare and access to services did not cause significant enough concern to warrant assessment according to AWI legislation. However, on the day of admission to hospital (27 August 2020) the admitting doctor assessed requirement for both a CTO under the Mental Health Act and a welfare guardianship order according to the AWI Act that same day.

In trying to understand some of the subsequent delays relating to the AWI process for Mr E, we learned that HSCP A has a system in place whereby the decision of an AWI case conference is subject to additional scrutiny from senior management within the social work service. We were told that this additional oversight was about finance and related to local authority applications only:

> *"Local authority welfare guardianship orders have a financial implication for the council so every application goes through [manager] and they look over it and will ask any follow up questions."*

We question the value of an additional process to determine whether the decision of a case conference is acceptable or not, by a manager who was not in attendance and by a system which has a focus on financial implications for the local authority rather than the individual needs and rights of the person.

A local authority welfare guardianship order was granted in respect of Mr E on 12 August 2021, informed by a safeguarder's report[11] which described Mr E's condition prior to admission to hospital in August 2020 as "alarming".

Guidance in relation to all three pieces of Scotland's safeguarding legislation highlights the importance of the consideration of each when making decisions in relation to harm, welfare, care and treatment. We found that when legislation was considered in relation to Mr E, the approach was linear, that is, there was not full multidisciplinary exploration of the interrelationship of various aspects of the law underpinned by principles to include Mr E, to promote Mr E's rights and to protect him. The failure to consider the full range of interventions available in Scottish legislation led to incomplete assessments and seriously poor outcomes for Mr E; opportunities to support and protect Mr E, informed by a legal framework, were missed.

3. Corporate appointeeship

An appointee is someone who can look after another person's finances if that person becomes unable to manage their finances themselves either through issues of capacity or where there may be coercion or intimidation, and the person is keen for support from someone else. The appointee can be a family member or a friend and it relates to benefit monies only. In Mr E's case it was the local authority (HSCP A) who took over this role and was authorised by the DWP to do so. When the local authority takes on this role, they are referred to as corporate appointees. The corporate appointee is responsible for making and maintaining any benefit claims and for ensuring spend of the benefit monies is in the person's best interests and meets their day-to-day needs.

What we found

We learned that there were concerns about Mr E's ability to manage his finances back when he was a hospital patient prior to 2015. At this time Mr E was not claiming benefits because his brother was reportedly not allowing him to do so. There were concerns about debts and so the hospital declared that Mr E was not able to manage his finances and started applying for benefit monies on his behalf. Once home from hospital, the same concerns regarding acceptance of monies continued.

Although our period of investigation in Mr E's case begins in 2015, we accessed social work records referring to the corporate appointeeship in 2007. These records spoke of Mr E attending the social work office weekly for his benefit monies. There were no bill payment arrangements in place, only money collection. A review of the corporate appointeeship in 2010 highlighted that Mr E wished for this to continue as he was worried about losing his ATM card, he did not want his brother to manage his money as he "forced him to take medication" and said the corporate appointeeship "gave him a bit independence". Handover records to a new social worker recorded that Mr E lived in a house owned by his younger

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[11] Safeguarder: A person appointed by the Sheriff to safeguard the interests of an adult with incapacity if the adult does not have the capacity to instruct a legal representative, and to advise the court of the adult's views. Safeguarders are often lawyers or social workers and are paid to carry out the role.

brother and there was possible financial exploitation and/or controlling behaviour on behalf of his older brother with whom he lived.

In February 2015, Mr E attended the social work office with his mother and asked that his monies be paid into a bank account, as he was finding it difficult to walk to the office due to a chest infection. The next record states that in June 2015, Mr E was too ill to attend the office so his monies were given to his older brother instead, with senior social work agreement. Mr E's older brother was the person Mr E had said he did not wish to manage his finances and had reportedly prevented Mr E from claiming benefit monies previously.

The pattern in 2016 then changed to Mr E no longer attending the office independently but always being accompanied by his older brother. Social work records note at this time that the corporate appointeeship was only a "banking service" but at least provided an opportunity for the team to maintain weekly contact with Mr E and to check on his brother's behaviour with him. However, no social worker was allocated and this responsibility appeared to be passed to business support staff.

Records state that Mr E stopped coming into the social work office in October 2016. His brother started attending on his own instead.

By December 2016, Mr E had accrued £14000 held by the corporate appointee. This information was not shared with Mr E. His brother asked that a bank account be set up to save him from always having to attend the office but this was deemed an "inappropriate request to rescind the corporate appointeeship". However, Mr E was no longer attending the office, so the previous note stating that the weekly appointment meant Mr E was able to be seen by business support staff and allowed a check on his brother's behaviour with him, no longer applied.

Throughout 2017 and 2018, the corporate appointee increased the weekly amounts paid directly to Mr E's brother in order to reduce the amount of money held given the potential impact on benefit entitlement. In the absence of an allocated social worker, benefit information and follow-up got missed, and this included the Personal Independence Payment (PIP) claim ending in 2020 due to failure by social work to provide information as requested in 2018.

No one seemed to notice that Mr E's brother had stopped collecting Mr E's money in January 2019. For 14 months it seems that Mr E, his brother, and his mother were surviving on £134 per week (their mother's pension). When the PIP was finally reinstated in 2021, Mr E had a balance of £24k held by the corporate appointee whose duty had been to ensure Mr E had access to his own money. This duty had not been fulfilled.

We discussed these events with people we interviewed. It was clear that there was not a joined up holistic approach or shared background understanding by those charged with supporting Mr E. Some of the people we spoke to said they were aware of the corporate appointeeship but it was not something they focussed on,

> *"I remember there being some concern because people weren't sure if Mr E was getting his money and the brother seemed to have charge of it. So I think that's where it [corporate appointeeship] came from. But that's all I know about it."*

> *"It wasn't something that I looked at at all."*

We ascertained that no mandate or permission was given by Mr E to have his brother collect the monies to which Mr E was entitled.

> *"I think informally there was a great degree of trust because the financial abuse became more historic and there wasn't issues with that corporate appointeeship, there wasn't strange demands for more money for example, which is a clear sign when things aren't working right, when people come at odd times and ask for more cash."*

This view suggests a false understanding. It was highly unlikely that Mr E's brother would be demanding more monies as he did not believe Mr E should receive benefit monies and did not collect his own. Mr E's independence and his day-to-day needs were neglected as a result.

HSCP A undertook a review of corporate appointeeship in response to what was described as "dropping the ball" in Mr E's case. The focus was on reviewing all existing corporate appointeeship cases we were told and on protocols, ensuring the allocation of a social worker for people for whom the HSCP/local authority had a duty in relation to appointeeship. When we asked staff if this had improved things, people were not sure.

4. Roles and responsibilities

"Most of the staff I have worked with have not taken the time to get to know me however expected me to share personal and difficult information with them. I think staff should be aware of the importance of communication. Communication to me is more than verbal. I felt more able to communicate with staff who smiled at me, were honest, and presented as friendly. Many of the staff who visited my home ignored me and instead spoke to my brother who did not always give the response I would have given. I did not make decisions about my life and did not feel listened to."

Mr E, 2023

4.1 General practitioner

General practitioners (GPs) are 'expert generalists' and treat all common medical conditions and refer individuals to hospitals and other medical services for urgent and specialist treatment.

GPs routinely offer annual health checks to people with diabetes and mental illness to monitor progression of disease and development of any complications or side effects of medication. District nurses attached to a practice are critical resources in the community to help people manage medication and any such complications or side effects.

The interface between the GP and mental health services is critically important. We would expect clarity of roles, responsibilities and expectations, underpinned by high quality communication and partnership working which wraps around the individual.

What we found
We found that GPs did not respond when multiple physical health screening appointments were missed by Mr E, nor when district nurses withdrew from his care because of access issues. They did not consider the local specialist diabetologist service which had expertise in engaging with people with diagnoses of mental illness and diabetes; a missed opportunity for assertive support for Mr E.

They placed inappropriate expectations on Mr E, for example to take his own blood pressure and deliver results to the GP practice, even though they knew his mobility was poor and he could not manage the stairs at his home to exit the property.

The GP had great difficulty accessing specialist secondary care mental health services and indeed we found local practices had evolved whereby psychiatrists expected GPs to undertake initial emergency assessments under the Mental Health Act, contrary to the code of practice. One psychiatrist explained that they were too busy to undertake these assessments and another relatively new psychiatrist explained that they had been told that was how the practice was in this particular geographical area:

> *"I trained in a different way of working where you would go out and immediately do an assessment. It was made clear to me by colleagues that in this situation we as a CMHT or we as the consultant would not immediately go out and do a short term assessment, we would ask the GP to go out and do the assessment."*

The interface is further explored in section 4.2 community mental health teams, but we would question this practice. Assessment by a psychiatrist and detention according to a short term detention certificate remains the preferred route to compulsory admission, given the rights afforded to the individual.

4.2 Community mental health teams

The role of the community mental health team (CMHT) is to deliver care and treatment to people living in the community who are experiencing a mental illness/disorder that impacts their ability to manage their daily living. CMHTs are at the heart of secondary care mental health services.

CMHTs should operate as part of a whole system of care. They should be responsive and work flexibly and inclusively to engage patients, family members, and carers in the planning and delivery of care and reviews of care, offering choice and flexibility wherever possible.

Discharge from the service should be based on the needs of the individual. Where needs have been met as per the care plan, we would expect discussions to take place to agree where that person will be discharged to and any transitions to be supported and informed. These multidisciplinary discussions should focus on care plans, crisis plans, and relapse signatures as appropriate.

We would expect CMHTs to have a standard operating procedure (SOP) in place for disengagement, non-engagement, and discharge.

This is the service we expected for Mr E and his family.

What we found
The CMHT in Mr E’s geographical area consisted of psychiatrists, community mental health nurses, occupational therapists, psychologists, and support workers. We heard that referrals to the CMHT can come from a range of sources; GPs, mental health inpatient wards, and home treatments teams. Referrals are triaged by the CMHT team leader who decides the most appropriate place for the referral to go to. Options include outpatient clinics, CMHT or primary care. The GP we spoke to told us they felt it can be difficult to get a patient seen by secondary care mental health services.

There appeared to be different understanding of the timeframes of urgent and routine referrals between different members of the CMHT and the GP. This ranged from three to five working days for urgent referrals, and two to six weeks for routine referrals.

Despite the ongoing concerns for Mr E’s wellbeing and vulnerability, referrals to the CMHT were never marked or triaged as urgent for Mr E. The referral received from the GP in May 2020 was identified as a routine referral, despite the situation being described as an “extremely complex situation”.

We were told that individuals with a diagnosis of schizophrenia and severe and long-term disorders would be allocated a keyworker.

> *“…the CMHT would be responsible for preparation of the care plan in terms of outlining the various interventions that were being offered, who was going to offer them and who would be responsible for arranging periodic multidisciplinary reviews...”*

We found no evidence of single agency or multidisciplinary care planning in Mr E’s clinical records despite the complexity and level of concern in his case.

We heard that the CMHT met every week to discuss referrals. We were told there were opportunities for complex case discussions following this meeting where staff could discuss anyone on their caseload they were worried about. We also heard that the psychiatrist had regular slots in his diary where keyworkers had the opportunity to book formal reviews to discuss patients.

We were unable to find any documentation to suggest these reviews took place between professionals working with Mr E. We were told by one of the psychiatrists that they believed it was the responsibility of nursing staff to record these discussions.

We did find emails from the CPN to the psychiatrist following visits in 2015 and 2016 highlighting concerns regarding medication and Mr E being a vulnerable adult.

We were told that many of HSCP A’s operational policies were out of date and required review. We were consistently told that there was no operational policy or procedure for non-engagement and discharge from the CMHT. Professionals we spoke to had a good understanding of non-compliance in relation to compulsory measures but there did not appear to be much consideration given to people with complex needs who were not subject to detention.

We were concerned to see the amount of visits that were cancelled by Mr E’s brother and the acceptance of this by the CMHT. At interview with one of the psychiatrists, we heard that sometimes they received letters that were clearly written by Mr E but more often they appeared to be in Mr E's name but written by his brother. We did not find evidence of this being addressed or escalated.

We were unable to find evidence of any kind of assertive outreach approach by the CMHT in Mr E's case.

The SIGN[12] guideline makes the following recommendation about community outreach:

> "Assertive outreach should be provided for people with serious mental disorders (including for people with schizophrenia) who make high use of inpatient services, who show residual psychotic symptoms and who have a history of poor engagement with services leading to frequent relapse and/or social breakdown (for example homelessness)."

We asked if HSCP A had an assertive outreach team. We were told that this had not been available in Mr E's locality.

We asked the clinicians we interviewed about the usual CMHT approach when a person with a severe and enduring mental illness repeatedly disengages from contact. We were told non-engagement and disengagement would be discussed between nursing and medical staff and outcomes would be dependent on risk. We were also told that past history and presentation would be taken into account.

We asked the clinicians interviewed about local policy and practice in the care of people with schizophrenia. Were individuals with schizophrenia often discharged to primary care? Was there a local standard operating procedure in relation to discharging individuals from the CMHT to GP care?

Three of the four psychiatrists we spoke with said this was another practice area where there was variation:

> "*I can only comment on my own practice. I expected to keep patients with schizophrenia open and to see them even if they were stable…"*

Another psychiatrist said:

> *"…there's two schools of thought here, one is that people with a diagnosis of schizophrenia should stay in the clinic forever on annual review. The other school of thought is that you are almost catching the wrong group of people. What I mean by that is if you think about people who are essentially well...When those people come to the clinic, you're doing an annual review, but you're not changing anything.*
>
> *…Some people say you should never discharge people with a diagnosis of schizophrenia, but I'd say what do you do if they're DNA, what do you do if they're DNA twice? Oh, we discharge then. So you do discharge people with a diagnosis of schizophrenia."*

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[12] SIGN sign.ac.uk

We are concerned that where different psychiatrists choose to take different approaches the outcomes for individuals will differ accordingly.

Mr E regularly DNA (did not attend) appointments, accept input, or respond to letters sent, and was regularly referred back to the GP with instruction to re-refer if required. This CMHT approach ultimately simply transferred responsibility back to the GP and, in our view, reflected a failure on behalf of CMHT services to engage with Mr E. We agreed with a comment from one of the doctors interviewed:

> *"…I know from reading the notes that he was discharged from psychiatry in 2017 and it looks like it's just because the psychiatrist and CPN weren't allowed access to the house, which seems like a fairly weak reason for discharging."*

Records indicate there was a difference of opinion between professionals in the CMHT when nursing staff wanted to discharge Mr E in 2016 but the psychiatrist did not agree. This was escalated to the CMHT team leader who supported the decision for discharge. The psychiatrist told us he did not feel he had the authority to do anything about this.

In trying to understand why Mr E, with his known history and associated risks, was discharged from secondary mental health services, we were advised by nursing staff that it would not be appropriate for someone to be open on a CMHT caseload if they were not able to access them as:

> *"Some people might confuse that as our ability to do something."*

We heard that the CPN tried to visit so many times that it became "embarrassing".

We were told when individuals were discharged, they were supported to complete a Staying Well Plan. This is a support tool to help people identify and manage common triggers and spot early warning signs or changes in their mental health. In Mr E's case, the Staying Well Plan was completed by the CPN and sent to the GP; there was no involvement of Mr E or his family members as there should have been.

We heard that the CMHT operated a 'fast track' system where individuals can refer themselves back to the CMHT via telephone. This negates the need for them to go to their GP and wait to be referred. However, as Mr E was lost to follow-up for years at a time, the GP was advised that Mr E had to be seen and assessed by the GP first before a formal referral could be sent. There was a difference in opinion between the staff that we interviewed as to whether this delayed access to secondary mental health service was really necessary for someone so well known to the service and where there were significant concerns.

We were told that the CMHT had a gap in psychiatry cover when the substantive psychiatrist retired in 2017/18. We heard about variation in the practice of psychiatrists with some reports of frustration about limited active involvement by some psychiatrists in patient care.

There was a strong view that psychiatrists have to have a presence, they cannot "delegate and disappear" and it was felt by those involved that this practice played a role in some of the deficits in Mr E's care.

As noted previously, we got little sense of CMHT support extending beyond nursing and psychiatrist expertise.

Occupational therapy support did not appear to have been offered to Mr E whilst he was in the community. This seemed to have been a missed opportunity, particularly in 2015/16 when he was still physically able to leave the house. Support with accessing activity, education, or employment opportunities are important factors in aiding a person's recovery and integration in their community.

Both SIGN and NICE[13] guidelines emphasise the importance of psychological approaches and highlight the role of family involvement when supporting a person with schizophrenia.

During the period from 2015 to 2020, we could find no reference in the CMHT notes to psychology or family interventions such as psychoeducation or related approaches having been offered, or considered. The lack of consideration of the value of intervention by allied health professionals in Mr E's care was a missed opportunity throughout the years we examined[14].

4.3 Social work

Social workers are trained to take a holistic approach, viewing all major facets of a person's life to better understand why a person behaves in a certain way, to then work in partnership to support the person to maximise their strengths and abilities to achieve desired outcomes. Building trusting relationships is at the core of social work practice.

A Council Officer is defined according to section 53(1) of the ASP Act and should have at least 12 months' post-qualifying experience of identifying, assessing and managing adults at risk of harm; social workers are key professionals who fulfil this safeguarding inquiring and investigating role.

MHOs are experienced social workers who have undergone additional specialist mental health related training in the use of the individual acts (Mental Health Act, AWI Act and ASP Act) but also in working across these acts to ensure a person-centred lawful solution to complex circumstances.

Social workers should be trained and skilled in working with families who are uncooperative; this may be as a result of the family's previous experience, lack of insight, or cultural differences. The social worker's expertise in working on an interagency basis ensures that agencies do not simply 'back off', leaving the child or adult unprotected.

All of the functions of social worker, council officer and mental health officer were important in Mr E's care.

What we found

It was evident from reading health and social work case records that Mr E had support needs from approximately 2007. We were concerned to discover that a social work assessment was not completed until he was admitted to hospital in 2020.

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[13] NICE nice.org.uk

[14] http://www.ahpf.org.uk/files/AHPS%20Compendium%202023%20e-use.pdf

Section 12a of the Social Work (Scotland) Act 1968 places a duty on the local authority to complete an assessment of need where it appears that the adult is in need of support. Case records note multiple requests for assessments made by Mr E's family and other agencies over the years however these assessments were not progressed. Social work notes regularly record that Mr E's family were meeting his support needs; however, we know from reading the case records and speaking to Mr E that his views on this arrangement were never sought and also there were difficulties around family relationships, that is, potential undue pressure and control.

During interviews, we asked social work staff about the social work assessment process. The responses from staff portrayed a complicated system of referral and assessment. We were advised that HSCP A had 'cluster and hub' teams and following an initial look at new referrals, decisions would be taken to class the request as 'social work A' (which was the priority list) and 'social work B'. We were told that if adults were placed on the social work B waiting list:

> *"You didn't get seen, because there was always social work As."*

We were also told by staff that different geographical patches operated different allocation systems leading to inconsistencies.

In Mr E's case, referrals for support were generally managed by a duty intake team. We were told that the social work intake team manages the presenting issue and short-term pieces of work only.

Case records evidenced that the intake team reviewed each concern raised in relation to Mr E and would attempt to manage the issues. Given the nature of this 'duty' or 'responding team' it meant that a number of different staff tried to address the issues as no worker was allocated to work on issues on an ongoing basis (given the short term interventions this team was set up to deliver).

We were concerned that this approach to social work referrals and allocation, did not promote consistency of care and support for Mr E, nor did it promote relationship-based practice which "is essential to achieving successful safeguarding outcomes" [15](2018 MacIntyre et al). Given the intake team's role was to primarily consider presenting issues, there was a missed opportunity to allocate a named social worker to take a longitudinal view of Mr E's history, cumulative risk and need, and indeed corporate appointeeship arrangement (as noted previously). The short-term nature of the intake team's work meant that social work closed Mr E's case without fully taking account of which agency or agencies remained involved, rendering Mr E without support and protection for prolonged periods of time.

We were told that HSCP A did have a dedicated mental health social work team however, Mr E did not meet the criteria for this team. During interviews we asked what the criteria was for this team:

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[15] MacIntyre, G,. Stewart, A,. and McCusker, P. (2018) Safeguarding adults – key themes and issues. London: Palgrave Macmillan.

> *"…the criteria in HSCP A is that social workers that work within the mental health and addiction area normally work with people that are known to our secondary adult mental health services. If they have an ongoing active involvement. If they haven't and they're normally managed through primary care or other kind of services, they would sit within the hub or the cluster team."*
>
> *"I did always find it a little bit curious that some of the most challenging and chaotic people with mental health presentation, because they didn't fit the criteria and engagement for mental health, ended up in a generic social work team…"*

We found that Mr E was never in fact offered specialist mental health social work services. The reason given for this appeared to relate to the fact that, unless Mr E was an open case to the CMHT, social work mental health services would not respond. The CMHT's decisions therefore to routinely close Mr E's case meant that Mr E, in turn, was prevented from accessing specialist mental health social work support.

5. Multidisciplinary working

A key strength of multidisciplinary teams is that the combined expertise of a range of professionals is used to deliver seamless, comprehensive assessment, care, and support in partnership with the individual, their relatives, and those closest to them. Working together to ensure that care and support is co-ordinated is crucial.

For care to be co-ordinated effectively, it is important that the roles of professionals are defined, that everyone involved knows what role they should fulfil and that all communicate regularly to avoid duplication and assumptions on what each other is doing, rather than fact. There is an assumption in Scotland that multidisciplinary working in mental health services is well established.

What we found

In relation to multidisciplinary working, there was some evidence in the clinical records of good written, email and verbal communication between the CMHT, primary care and, at times, with social work. However, this tended to be only for brief intervals when there were heightened concerns about Mr E's care and this co-ordinated approach was rarely formalised in a multi-professional forum, apart from times where ASP processes were instigated.

There seemed to be a lack of space for collective thinking and looking holistically at Mr E's situation and complex needs. There was little evidence of a consistent cohesive multidisciplinary approach across professions, despite repeated acknowledgement by those involved in Mr E's care that he had complex needs with a severe and enduring mental illness, poorly managed insulin-dependent diabetes, and family dynamics which significantly impacted his access to care and support.

We found that there was no clear framework in place to support multidisciplinary working.

Care Programme Approach

The Care Programme Approach (CPA) was developed originally for use at a local level in Scotland for people with severe and enduring mental illness in 1996[16]. Unlike in England, where CPA was mandatory, CPA was simply recommended for use in Scotland. There has therefore been inconsistent implementation and investment in the CPA approach across Scotland since 1996 (this statement refers to CPA in relation to non-restricted patients[17]).

We were provided with a CPA process document and associated blank care plan, neither of which were dated or sufficiently detailed to guide operational practice in HSCP A. We were told that:

> *"It's not something that we have ever used in HSCP A"* and then *"it had been used in the past but only in certain geographical areas."*
>
> *"Historically we had the CPA just in one sector."*
>
> *"CPA, in my experience within NHS adult mental health has not been potentially encouraged or embraced as a constructive framework to use."*

Getting It Right for Everyone (GIRFE)

In the absence of an embedded CPA, we learned that other approaches were taken in an attempt to facilitate multidisciplinary working.

Getting It Right For Every Child (GIRFEC) is the Scottish Government's commitment to provide all children, young people and their families with the right support at the right time - so that every child and young person in Scotland can reach their full potential[18]. We learned that, in HSCP A, an attempt was made to implement a similar policy and approach to adults, known as Getting It Right for Everyone.

From email communication received, we noted that GIRFE templates were shared in HSCP A in 2016. We found no evidence of policy development or training to supplement and embed this approach however.

Once again we heard a range of experiences regarding GIRFE.

> *"It [GIRFE] is supposed to be used when somebody doesn't meet the criteria for adult protection. So it's just a case management model...My issue with it from an adult protection point of view is that I've seen it too often used when it actually should have been adult protection…"*
>
> *"We drifted away from it [GIRFE] a bit because people were using it instead of adult support and protection measures but we still use it occasionally. We have all the templates."*
>
> *"I've not heard the language of GIRFE being used…I've not heard it for years."*

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[16] The purpose of implementation of the care programme approach is to ensure multidisciplinary working, care coordination, an agreed care plan and regular review.

[17] The Care Programme Approach is mandatory for restricted patients. Memorandum of Procedure on Restricted Patients - gov.scot (www.gov.scot)

[18] www.gov.scot/publications/getting-right-child-girfec-policy-statement/

With no clear framework supporting multidisciplinary working, we learned that individual staff tried to set up their own meetings (core groups) whilst others felt there was little point, the rationale being that other agencies would not attend if they did. Even where it was explained that professionals worked in the same building, we were told that joint working was not a strong feature and that partnership was "just a word" in HSCP A.

Although at interview, we did hear one report of good information sharing by social work, the overall context of multidisciplinary working was described as fragmented within and across services, challenged by staff changes and restructuring processes.

This led to the development of local practices, apparently driven by individual practitioners. For example, as noted previously, we learned that practice had evolved whereby psychiatrists expected GPs to undertake initial emergency assessments under the mental health act, contrary to the code of practice.

> *"I think it is good you're investigating this case because obviously one of the things is what do GPs do, what do mental health services do?...It is the way that HSCP A tends to organise things, whether it's right or wrong."*

We learned that this practice appeared to be borne out of a commitment to managing psychiatrists' workloads rather than a commitment to multidisciplinary working based on the needs of the individual and their right to timeous care, support and rights afforded by mental health law.

Other local practice of note was reference to MHOs undertaking social circumstances reports (SCR) "when asked" to do so by the psychiatrist (there was no SCR completed in Mr E's case). It is the case that MHOs should not require to be asked but should follow legislation and indeed the Commission's *Social circumstances reports, good practice guide*[19]. There was also a sense that MHOs felt they could not initiate requests for psychiatrists to undertake joint assessments for short term detentions believing this "has to come from the consultant". This feedback of practice in HSCP A was not in keeping with the critically important role of the MHO as an autonomous decision maker and active and independent participant in the care of individuals.

The lack of co-ordination and ownership meant that the combined expertise of a broad range of professionals was not realised for Mr E. Instead silo approaches resulted in variations in practice, and his case being closed or referred on without an understanding of whether this was appropriate in light of the roles or activities of others.

Given the persistent concerns about Mr E's lack of engagement, poor adherence to medication, and co-morbid physical health problems, in our view, the single agency decisions (without reference to multidisciplinary colleagues) to repeatedly discharge him back to primary care constituted serious deficiencies in care, and evidenced missed opportunities to work with Mr E holistically to achieve outcomes for him as a unique individual.

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[19] SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf (mwcscot.org.uk)

Taking these complex factors and challenges into account, the lack of formalised multi-professional meetings over the years, or use of a framework such as CPA to provide a robust structure for review and multi-agency planning was concerning. We think this lack of a cohesive multidisciplinary approach contributed to the risks in Mr E's care and enabled him to repeatedly slip through the gaps of services. Had such structures/fora been in place, it seems less likely that Mr E would have suffered the degree of physical harm and poor long-term mental health outcome that he did.

6. Mechanisms for internal learning and improvement

6.1 Initial and significant case reviews

With the implementation of ASP legislation came the creation of Adult Protection Committees in each local authority area. The law encourages Adult Protection Committees "to evaluate and learn from critical incidents." The Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (2019) states that "the learning from Significant Case Reviews needs to inform the way in which agencies work together to deliver joined up safeguarding and support and care to those who need it". Any agency with an interest in an adult's wellbeing and safety can request that a case be considered for review.

We would have expected either health or social work staff (or both) to request a review in Mr E's case.

What we found

We found no reference to consideration of a case review according to ASP legislation in any health records nor in any interviews of staff working in health services.

We did locate a critical incident form completed by a member of social work staff in March 2020, which raised concern in relation to harm and deficits in care which was escalated to senior managers within the social work service.

The criteria for progressing to an initial case review (ICR) or SCR according to local procedures in HSCP A include that the incident or accumulation of incidents gives rise to serious concerns about professional and/or service involvement or lack of involvement, also when an adult has sustained significant harm. This criteria appeared to be met based on the content of the completed critical incident form we viewed.

Case records confirmed that a meeting was arranged to discuss progression to an ICR in Mr E's case but there was no record of this meeting and staff interviewed either could not recall the content or were not invited. It remains unclear what happened next but there was a belief from staff interviewed that very senior managers within social work made a decision not to progress to an ICR.

> *"Because the argument that was being made was that we had caught it in time and there was good work ongoing…to me it wasn't. It was a miss, not a near miss actually when you looked at it."*

We learned that although an ICR/SCR was not progressed an 'internal review' was completed following the concerns raised regarding Mr E's care and treatment. The sole focus was the corporate appointeeship arrangements within the local authority however, not safeguarding practices and not multidisciplinary working. We asked for a copy of the internal review report and to date have not been provided with this due to the absence of a member of staff with access to this.

An ICR/SCR is a multi-agency approach to review with an emphasis on learning, examining facts, and identifying any deficiencies in care, to inform continuous improvement in practice and in outcomes for individuals. This is good practice.

Some of the people interviewed suggested that had there been a robust internal approach to learning, the Commission would not need to be undertaking this investigation now. We agree.

> *"You could argue this is why we're having a chat here. We could have been having these conversations in July 2017 and asking the same questions, couldn't we?"*

6.2 Reporting of adverse events

An adverse event is defined as an event that could have caused a near miss, or did result in harm to people or groups of people. Harm is defined as an outcome with negative effect[20].

We would expect NHS boards and HSCPs to have an adverse events policy to support a consistent approach to the identification, reporting and review of all adverse events, both clinical and non-clinical. Policies ensure adverse events are managed in a timely and effective manner, are reviewed openly in partnership with individuals, families, carers, staff and professional organisation representatives, as appropriate, in a way which identifies the strengths and weaknesses of systems in order to make improvements that enhance the safety of care systems, work activities and work environments for everyone.

We would expect all incidents with a major or extreme outcome to be subject to either a local adverse event review (LAER) or significant adverse event review (SAER).

Duty of candour

The Health (Tobacco, Nicotine etc. and Care)(Scotland) Act 2016 introduced a new organisational duty of candour on health, care and social work services. The duty of candour provisions came into effect on 1 April 2018.

Duty of candour is a professional and legal obligation for workers to be open and transparent when something goes wrong. It includes providing an explanation of what happened, making an apology, and offering treatment or support to remedy the situation.

What we found

Professionals who visited Mr E at home on 10 June 2020 described the situation as "quite shocking".

Mr E was admitted to hospital on 27 August 2020. We heard from professionals in the ward that they were "stunned into silence" at his presentation on admission. We heard he had faeces on his body and he had open wounds which were bleeding. We were told that his schizophrenia had been untreated and was probably partially or completely treatment resistant as a result. His reduced mobility had led to contractures and the lack of diabetic

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[20] https://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=968c1d9d-7439-41d7-83d5-531afebaebcc&version=-1

eye care resulted in him becoming registered blind. Despite the obvious concern by professionals on admission, a Datix[21] report was not completed and submitted until 29 September 2020. We heard that attempts had been made to raise concerns through other fora but these were not taken seriously.

We were told that when a Datix report is submitted, timely feedback is not received in HSCP A, sometimes people said they waited months before being informed of the initial review outcome. We heard this has led to a lack of faith in the reporting system and it being described as "not fit for purpose". On this occasion, we were told that there was an expectation that the Datix submitted in respect of Mr E would have led to an investigation, however no feedback had been received.

We learned that the Datix relating to Mr E had been submitted to the social work department and not to any managers in health, despite information in the Datix indicating that Mr E had been lost to both CMHT and psychiatry follow-up.

A feedback message was sent on 14 October 2020 to the person who completed the Datix report advising the Datix had been submitted to the wrong division and location. The Datix was not opened again until 23 February 2022 when a further feedback message was sent to the member of staff who reported the concern advising there was an outstanding adverse event on Datix which required investigation and review. To date, it does not appear that this has commenced.

As it was recognised that harm sustained was potentially related to both health and social work services, we would have expected a Datix to have been submitted to managers in both services. However, once again, this was a missed opportunity for those organisations involved in Mr E's care to work together and jointly take account of the seriousness of the impact on Mr E's life, to reflect, and to learn.

Duty of candour obligations were never considered in Mr E's case. It was not clear from interviews or records that there was knowledge or understanding of the associated professional and legal obligations.

7. Family

Mr E told us that his family has always been very important to him:

> ***"I lived with my parents and 2 brothers throughout my childhood, we were and continue to be a very close family. I have always had a particularly close relationship with my mother. I have fond memories of life growing up. One of my favourite pastimes was spending time with my mother, chatting, preparing meals, and eating the food she made. I always hoped I would live with my mother for the rest of my life. I miss my mother every day and still hope one day we can live together again."***
> **Mr E, 2023**

The Mental Health Act, the AWI Act and the ASP Act, are all underpinned by principles which recognise the importance of family and their views.

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[21] Datix is the software used by NHS Boards for clinical and non-clinical incident reporting and forms part of the risk management strategies.

Families often have a comprehensive and unique knowledge of how an illness affects an individual that they care for. Whether this is a physical or mental illness it is imperative that services engage with families and carers to get a true picture of the individual and the challenges they face.

Where concerns have been raised and services are working with an individual, we would expect them to actively seek out family members and carers who are involved, to gain a holistic and fully informed view of how a condition impacts the individual and those around them.

The Commission's *Carers and confidentiality good practice guide*[22] clearly states that family and carers should be consulted as soon as possible and their opinions on the health of their relative sought, with the permission of the individual.

Where carers are identified, the Carers (Scotland) Act 2016 places a duty on local authorities to provide an adult carer support plan (ACSP) and/or a young carer statement (YCS) for anyone providing unpaid care to an individual and we would expect to see implementation of these in practice.

Mr E told us he was born in Scotland and his family originated from Pakistan. We reflected on the Scottish Mental Health Law Review report[23] and its reminder of the importance of cultural competence and how a universalist approach leaves some groups with poorer outcomes. To this end, we took advice to inform our investigation, learning for example, that there is not a Punjabi word for schizophrenia. There is only one word that covers all mental illness and equates to schizophrenia/dementia/autism and means someone who has lost their mind or whose mind is broken. Specialist advice aided our understanding and we would expect services to address any gaps in their learning and understanding too.

What we found

From case records and interviews, it was clear that there was little engagement with Mr E's mother, the person he reports having a particularly close relationship with. Police records confirmed that Mr E's mother spoke English, CMHT staff believed his mother's English was limited and a GP said she was incredibly deaf. There was a file note regarding sourcing an interpreter but health staff thought social work staff were organising this and it seemed that this never happened. Some staff we spoke to believed Mr E's mother was much older than she actually was.

Although Mr E's older brother prevented entry to health and social work staff into the family home at times, he also repeatedly wrote to health and social work professionals seeking care for his brother's mental health and diabetes (also notably taking him to hospital when in England seeking diabetic care). He also raised a number of concerns about the absence of care for his brother, both for his mental health and diabetes. Again, this suggested a complex dynamic, but one in which there may have been windows of opportunity to try to work positively and perhaps in a more systemic way with the family at times.

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[22] 2018_update_carers___confidentiality_final_draft_16_oct_2018.pdf (mwcscot.org.uk)

[23] Scottish Mental Health Law Review report September 2022: https://mentalhealthlawreview.scot/

When the CPN, MHO, psychiatrists and GPs did manage to see Mr E at home, a common theme was the length of time often spent talking to his brother, rather than speaking or seeing Mr E himself.

"Many of the staff who visited my home ignored me and instead spoke to my brother who did not always give the response I would have given."
Mr E, 2023

There was no evidence that attempts were made at these times to offer psychoeducation or psychological supports.

Whilst we recognise that Mr E's brother's preoccupation with perceived negligence from health services in the past may have made such an approach challenging, discussion with psychology colleagues about the complex family situation could have been useful. Formulation may have added a different perspective and could perhaps have led to a different way of approaching the family and trying to engage with the brother, in particular to work more collaboratively in Mr E's support.

Instead, those charged with assessing and protecting Mr E, often did not meet with Mr E or take time to engage.

> *"One got the sense quite often that when [the brother] was present that it was his agenda that was being pushed forward."*
>
> *"I think what happened is that people allowed [the brother] to control what was happening too much. If there's one you know retrospective thing that I would say is that if you're not speaking to the patient themselves then that's a situation of concern and I think people spoke to [the brother] but not Mr E. So in a sense they got [the brother's] views but not Mr E's views."*

Mr E's right to health care also appeared to be compromised by consideration of his older brother's needs and wishes.

> *"It was quite clear because that by taking Mr E to hospital we were going to be rupturing this whole family unit and it was going to bring a lot of distress for all of them because [the brother] was so invested, his only purpose seemed to be his brother and we were going to remove that from him, bearing in mind his massive fears in relation to that because of his previous believed experiences or experiences."*

Although at the same time, there was no evidence of a carer's assessment being undertaken or an adult carer's support plan being developed to support Mr E's brother or indeed his mother in their caring roles.

Whilst some of those we interviewed reflected and agreed that the number of complaints raised by Mr E's older brother may have made them less likely to challenge his resistant behaviour, no one suggested that there were any cultural issues that impacted the approaches and interventions made.

On the occasion when Mr E requested a Muslim doctor, we were told there was no Muslim doctor available, however this was not thought to impact on the care and treatment received by Mr E. The specialist advice we received however suggested that a person may be more likely to trust and speak to someone who understood their religion and way of life.

One doctor told us:

> *"I can't help but notice that patients coming from a minority ethnic background are getting poorer care. I'm absolutely certain that my colleagues are not racist…I think it's multi-factorial, what is happening is these patients like Mr E and their families, they are not very keen or able to access the service and there is such anxiety on our part not to cross culturally sensitive boundaries, that the net result is poor care."*

No staff interviewed suggested this was the case for Mr E, however this view is worthy of everyone's reflection and consideration. We know from our own work that there are gaps in training on ethnicity and diversity across Scotland[24]. Whilst there is no evidence that race directly played a part in the management and outcomes of Mr E's case, there is also no evidence that a proactive approach was taken to identify, recognise and understand the potential influence of culture and race on the circumstances which were presented.

"My family and I have had involvement with health and social work services at various stages in life. I have not found this to be positive. My father died many years ago which was a very sad time for me and my family. After the death of my father, my family were wary of working with health and social work services, we did not trust them."
Mr E, 2023

8. Participation

The Commission's *Human Rights in Mental Health Services good practice guide*, states: "mental health care practitioners must both allow and encourage individuals with mental health issues to participate in every decision about their care and treatment, ranging from attendance at multi-agency meetings, to involvement in their own care planning"[25].

The Mental Health Act gives anyone with a mental illness, learning disability, dementia, and related conditions the right to independent advocacy support.

This was strengthened in the revision of the Act in 2015 and health boards and local authorities must now also inform the Commission on how they ensure access to services and how they will do so moving forward.

We expected every effort to be made to include Mr E and maximise his participation in informing decisions about his care and treatment.

What we found

We found no invitation to attend meetings throughout 2015-2020 nor any individual discussions seeking Mr E's views either about his care and treatment or how best he would wish to engage in such discussions. Mr E told us that he felt "ignored".

We did find reference to a Living Well plan but this did not invite Mr E's participation as the process dictates should happen and an assessment order which supported access to Mr E

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[24] www.mwcscot.org.uk/news/racial-inequality-and-mental-health-services-scotland-new-report-calls-action

[25] Human Rights in Mental Health Services good practice guide, 2017, Mental Welfare Commission for Scotland.

under direction from a sheriff facilitated the taking of blood and only “a couple of minutes” chat with Mr E.

The advocacy service that is available in HSCP A, to people in the community and in hospital, is well organised and responsive according to the people we interviewed.

Records confirm that Mr E was supported by advocacy and had a good relationship with his worker in 2013 but no further advocacy support was evidenced after this time until April 2020.

At that point advocacy services received an “alarming” referral from social work and tried to engage with Mr E, recognising from the detailed referral they received that there were significant difficulties.

Unfortunately, they were unable to make meaningful contact with the family or Mr E in 2020.

> *“We struggled, we really struggled to engage with Mr E at that point.”*

Advocacy offered to re-engage, if appropriate, going forward but were not asked to do so.

Summary and Recommendations

> ***"I am now in a care home and I don't really know why. I feel lonely and no longer have any goals in life. I am completely blind which I find difficult to accept. Most of the things I enjoy in life require sight. If I could see I would have a much better life. I want to return to live with my family. I know I would need care and support if I were to go home. I would be happy to accept this if it meant I could be with my family."***
>
> **Mr E, 2023**

Recommendation 1

The Care Inspectorate should take account of the content of this report in full as it monitors the progress of the HSCP A's improvement plan in response to inspection activity. This report will also inform improvement plans of all other HSCPs in Scotland. It will be of interest for phase 2 of the joint inspections of adult support and protection undertaken by the Care Inspectorate, Healthcare Improvement Scotland and His Majesty's Inspectorate.

Mr E's experience and life changing negative outcomes have arisen from structural weaknesses in the assessment, planning and delivery of integrated services in HSCP A. Mr E received no social work or health care assessment, there was no assertive outreach or evidence of relationship based practice and no account was taken of the needs of his brother or mother as carers. We learned that there has been a failure to implement legislation, a failure to manage significant organisational change and a failure to embed standard operating practices leading to inconsistencies of practice across geographical patches and variations of practice within professional groups. This raises significant questions regarding senior leadership and connection with front line service delivery and outcomes for individuals.

Recommendation 2

HSCP A should work with NHS Education Scotland to commission a training needs analysis and a delivery plan of multidisciplinary training to support health and social work staff to feel confident and competent in the implementation and crossover of the three key acts to support and protect people (Mental Health (Care and Treatment)(Scotland) Act 2003, Adults with Incapacity (Scotland) Act 2000 and Adult Support and Protection (Scotland) Act 2007).

We were told of practice that had evolved in HSCP A where GPs required to undertake emergency detention assessments rather than consultants assessing for short term detentions. We learned of the poor commitment to completion of social circumstances reports in HSCP A despite the law requiring this. There were further views expressed that the three pieces of legislation were the responsibility of different agencies rather than taking a collective approach to ownership and exploration of the interrelationship of various aspects of the laws. We learned that staff are working in very difficult and changing circumstances and require investment in their training to support them to work in an environment of consistency and support.

Recommendation 3

HSCP A must ensure an agreed framework for multidisciplinary working is communicated, embedded and audited across health and social work.

The lack of formalised multi-professional meetings, or use of a framework such as the care programme approach, to provide a robust structure for review and multi-agency planning was concerning in Mr E's case. This lack of a cohesive multidisciplinary approach meant collective expertise was not harnessed and indeed missed (lack of psychology, occupational therapy, physiotherapy consideration) and this contributed to the risks in Mr E's care and enabled him to repeatedly slip through the gaps of services.

Had such structures/fora been in place, silo working and failure to assertively engage would have been less likely and Mr E may not have suffered the degree of physical harm and poor long term mental health outcome that he did.

Recommendation 4

HSCP A must review its duties and responsibilities in relation to models of learning and duty of candour. The clinical and care governance committee, together with professional leads for social work, medicine and nursing must take action to address the failure to do so in Mr E's case and avoid repetition.

There were a number of missed opportunities to prevent Mr E from living a life which was not of his choosing, a life contained in a single room as a result of the combination of his deteriorating mental and physical health conditions. The staff we spoke with reflected on what could have been done better, they spoke of the lack of confidence in the reporting systems (according to Datix and adult support and protection), they reflected on some learning in relation to corporate appointeeship which was good but single agency driven.

An integrated approach to learning from case reviews must inform the way in which HSCP A's services work together to deliver joined up safeguarding, support and care to those who need it. Mr E's experience and poor outcomes should have initiated such learning. This did not happen, neither did anyone consider legal responsibilities according to duty of candour.

Recommendation 5

HSCP A should review Mr E's current care, accommodation and finances to ensure his fundamental rights are promoted and protected and the failures identified in the provision of his care and treatment throughout 2015-2022 are not continuing.

Mr E tells us he is not happy living in his current care setting. He is in his late 50s and living in a setting for older people with dementia who do not necessarily share his interests. He tells us his mood is low and there is little stimulation. Whilst the care home staff are aware of what is important to Mr E, it is not clear if anyone else has asked him. The appointment of the chief social work officer as guardian, in law, should afford Mr E protection. HSCP A requires to give assurance of this protection and commitment to respect Mr E's rights.

Conclusion

We investigated Mr E's care and treatment during the seven-year period 1 January 2015 to 31 July 2022. Mr E supported this investigation process as he was keen for there to be learning and for his experience not to be repeated. We are grateful for Mr E's engagement throughout this process and the particularly positive relationship he has developed with our social work officer.

During this period of investigation, we found that Mr E was defined by whether he was an "open case" or more often a "closed case". However, Mr E was more than a "case", he was an individual with hopes and aspirations, with interest in his music, writing lyrics, and a strong commitment to his family and a particularly strong bond to his mother. His mental health and physical health conditions combined to create barriers to Mr E living the life of his choosing. The lengthy gaps in care, treatment and support to address these barriers, impacted negatively on Mr E's relationships and led to Mr E's poor mobility, loss of sight, and partial treatment resistant mental illness. The following is a quote from a member of staff we interviewed, however this view was shared by a number of those we spoke with and we are grateful to those interviewed for their thoughtful and honest contribution to this investigation process.

> *"We didn't need hindsight. We knew when Mr E was discharged from follow up that he had paranoid schizophrenia, we knew his compliance was erratic, we knew that he had medical comorbidity...So these are all known facts.*
>
> *"Had Mr E received adequate care you and I would not be having this conversation today."*

We conclude by making reference to Scotland's Health and Social Care Standards[26] which set out expectations of health, social care, and social work services. The standards aim to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that basic human rights are upheld and lead to high quality care. A basic principle of these standards is for the person to be included. Mr E was not included. The standards were not realised for Mr E. Mr E did not receive the high quality care to which he was entitled.

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[26] Health and Social Care Standards: my support, my life - gov.scot (www.gov.scot)

Appendix 1

Chronology from CMHT and GP records in relation to Mr E's mobility and eye health.

Mobility

- Jan 2015: On examination GP finds reduced sensation and absent pulses in both feet. Notes 'left foot moderate risk R diabetic foot moderate risk'.
- Feb 2015: Brother concerned about Mr E's physical health - has lost a lot of weight & lying in bed.
- June 2015: Admitted to hospital in England for treatment of bilateral foot ulcers. Insulin restarted.
- July 2015: Symptoms of peripheral neuropathy affecting hands and feet.
- July 2016: Now unable to walk 10 minutes, aches in feet and feeling lethargic.
- Oct 2016: Mr E cannot walk down the stairs.
- Dec 2016: Letter from physio, offered appointment, declined. Discharged from waiting list.
- June 2017: Concerns about feet, now too painful to walk on. Not letting nurses/physios attend.
- June 2017: Complaining of sore feet and numbness. Overgrown toenails.
- July 2017: Adult Support and Protection Case Conference: Assessment order granted due to adult at risk. "Seems well looked after in terms of food and warmth...brother keeps good record of bloods & insulin level." Removal for assessment did not happen.
- May 2018: Younger brother contacts GP with concerns re: Mr E's welfare, GP notes "I've simply encouraged brother to get patient to attend here for review".
- March 2020: Mr E was in a very poor state of physical and mental health on home visit with mobility issues resulting in him having to crawl to toilet.
- June 2020: Mr E in bed with contractures.
- August 2020: Admission to hospital. Not suitable for rehabilitation.

Eyesight

- January 2015: Letter to GP surgery advising that Mr E had failed to attend 3 appointments for retinopathy eye screening and that he would be offered another appointment next year (NB. GP records made available to the Commission began in 2010, identical letters had been received annually by the GP surgery during each of the previous 4 years).
- March 2015: Seen by GP. BMI 24, Blood tests showed glucose high at 22.
- Sept 2015: Further letter re: Mr E not attending for eye screening.
- June 2016: Letter from Optometrist to GP practice for action. Mr E, with help of his brother, attended for routine eye test. Complaining of dramatic change in near vision over 2 weeks. On examination he was found to have a significant level of cataracts in both eyes and significant visual field loss. He had not had retinopathy screening for 3-4 years. Recommended ophthalmology.
- Oct 2016: Letter ophthalmology appointment (Mr E did not attend).
- July 2017: Adult Support and Protection Case Conference. Assessment order: removal for assessment did not happen.

- March 2020: Social work staff called Duty GP – concerned on home visit Mr E possibly blind from cataracts.
- June 2020: Home visit nurse and doctor *“all he could see was a light coming from the window, he wasn’t able to actually see any more than that.“*
- August 2020: Admission to hospital. Ophthalmology review: eyesight will not be improved by an operation. Registered blind.

npm
national
preventive
mechanism

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