mental welfare commission for scotland

Closure report

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

January 2025

# Our mission and purpose

## Closure report

### *"They didn't ask me": Investigation into the care and treatment of Mr E (2024)*

**Executive lead:**
Julie Paterson, chief executive

**Investigation team:**
Gillian Gibson, nursing officer; Kathleen Taylor, engagement and participation team manager; Juliet Brock, medical officer; Kathleen Liddell, social work officer; Mark Manders, investigations casework manager.

**Date of executive leadership team approval of investigation:**
June 2022

**Date of commencement of investigation:**
Letter sent to leaders of HSCP A to advise of decision to investigate June 2022

**Date of publication of investigation report:**
25 January 2024

**Date of closure report:**
October 2024 (completed within the 15-month KPI standard)

**Purpose of a closure report**
The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned.
The report must summarise the findings and recommendations made in the themed visit/investigation report and identify the organisations and individuals to whom the recommendations were made.
The report should also identify the follow up actions and activities of the Commission in gathering in responses to the recommendations, and once in, identify how these responses were evidenced, assessed for impact and their success measured.
The report should assess whether the activity was worthwhile in terms of impact, resource commitment and outcomes and met organisational standards and expectations.

## Summary of recommendations made in the investigation report and the organisations and the individuals asked to respond

The investigation into the care and treatment of Mr E was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. 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 Mental Health Tribunal for Scotland (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 sought to identify what lessons could be learned from the experience of Mr E and his family for local authorities, health boards and health and social care partnerships (HSCPs) across Scotland, as well as those organisations directly involved in Mr E's care.

The following five recommendations were made and were noted to be 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 2015-22 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.

## Summary of responses (including decision as to whether they are satisfactory and how this decision was evidenced and measured)

The Commission received responses from HSCP A and the Care Inspectorate within agreed timelines.

The responses were scrutinised by the Commission's investigation team and the Commission then wrote to HSCP A and the Care Inspectorate in August 2024 noting that much work was being progressed. A follow up meeting was held with senior leaders of HSCP A in October 2024 to receive further updates on progress.

In October 2024, the Commission welcomed confirmation that some changes had been made to allow the clinical director to focus on ensuring consistency of approach by psychiatrists working in the community in terms of both thresholds and responsiveness to legislation.

We were pleased to hear that this work will include standard operating procedures which will extend to expectations of response in relation to disengagement and non-engagement.

Whilst we were informed about a range of key activities which have been progressed evidencing strong leadership and commitment to change (interagency adult support and protection procedures in place, investment in key professional leadership roles, restructuring plans to ensure consistency of approach, delivery of training across all three acts, quality assurance audits, shift towards a learning culture and stronger governance processes in place) the Commission acknowledges that it will take time to evidence measurable actions or impact given the scale of systemic change required in HSCP A.

The Care Inspectorate, as regulator, will have a key role in working in partnership with HSCP A to monitor progress towards these measurable actions and the Care Inspectorate's letter to the Commission dated 2 July 2024 confirmed their ongoing role to this end.

Whilst there is an organisational re-structuring process underway, HSCP A acknowledged that restructuring in itself will not achieve the necessary changes and there requires to be investment in culture and commitment to partnership working across health and

social work/social care. The chief officer articulated that it would take time to 'reset that identity'. The Commission welcomes this insight, commitment and transparent approach.

The Commission's focus is very much on individuals and doing so, sometimes highlights systemic issues as noted above. Recommendation 5 of Mr E (2024) brings the focus back to Mr E and the importance of work being progressed to realise improved outcomes for him as a unique individual.

Page 4 of our investigation report states:

> *"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's report was titled "They didn't ask me" because no one tried to get to know him. Our Commission social work officer evidenced that a focus on relationship-based practice led to full engagement with Mr E. We are pleased that, over the past six months, HSCP A have evidenced strong relationship-based practice leading to good partnership working with Mr E both with social work and third sector providers. These trusting, positive relationships have ensured what matters to Mr E is more clearly understood. Mr E's finances have also been appropriately used to meet outcomes.

It is the case that Mr E unfortunately still remains in an inappropriate care home placement. HSCP A do not dispute this fact and are actively pursuing an alternative placement. One alternative option has been considered to date however, the CSWO as guardian, did not progress following full consideration of the principles of the AWI Act. Active pursuance of an alternative remains ongoing and whilst this is being progressed additional 1:1 support has been commissioned to mitigate the current placement's ability to meet Mr E's outcomes.  It is the HSCP A's intention that the service providing additional 1:1 support will also support Mr E in any new placement and this focus on continuity and maintaining relationships for next steps is welcome.

Mr E's reported physical health has improved with HSCP A confirming a 'visible difference in his physicality' thanks to regular physiotherapy involvement and regular monitoring of his diabetes condition.

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

As well as the publication of the full investigation report, an easy read version of Mr E (2024) was also published at the same time on 25 January 2024.

The Commission has followed up actions in relation to all five recommendations made; recommendation 1 was for the Care Inspectorate and recommendations 2-5 for HSCP A. A final meeting was held with HSCP A in October 2024 to review progress of their action plan submitted in July 2024.

When the Commission undertakes investigations under section 11 of the Mental Health Act, the learning identified may also be relevant across Scotland, further activity has therefore included:

- Mr E's case was presented to the National Adult Protection Convenors' group in February 2024. A follow up email received from one of the Chairs noted, "Thought the Mr E report was excellent, and challenging. I suspect it reflects practice in many areas of Scotland and I worry about mental health services at the moment as this report reflects what I hear and see in the world of safeguarding. I have it on the Chief Officers Group agendas in my local areas".
- Mr E's case and associated learning was highlighted at the national Scottish Association of Social Work MHO Forum in February 2024.
- Mr E's case and findings were also shared at a learning event within the Commission in February 2024.
- The findings of Mr E's case will be reflected upon at end of year meetings with all HSCPs towards the end of 2024.

## Summary of the impact of the investigation report with particular reference to media as at March 2024

This report was published with an easy read version and a news release on Thursday 25 January 2024.

### Media

The investigation was carried online by:

Disabled man 'prisoner at home for five years' due to care failings - report (Web) The Scotsman - 25/01/2024
A disabled man was "trapped in his bedroom for five years" due to care failings, a report has revealed.

Disabled man 'prisoner at home for five years' due to care failings - report (Web) Ireland Live - 25/01/2024
A disabled man was "trapped in his bedroom for five years" due to care failings, a report has revealed.

Disabled man 'prisoner at home for five years' due to care failings - report (Web) Sunday Post - 25/01/2024
A disabled man was "trapped in his bedroom for five years" due to care failings, a report has revealed.

Disabled man 'prisoner at home for five years' due to care failings - report (Web) The Courier UK - 25/01/2024
A disabled man was "trapped in his bedroom for five years" due to care failings, a report has revealed.

Disabled man 'prisoner at home for five years' due to care failings - report (Web) The Press and Journal - 25/01/2024
A disabled man was "trapped in his bedroom for five years" due to care failings, a report has revealed.

Disabled man 'prisoner at home for five years' due to care failings (Web) STV - 25/01/2024
A disabled man was "trapped in his bedroom for five years" due to care failings, a report has revealed.

Disabled man 'prisoner at home for five years' due to care failings by 'every agency involved' (Web) Care Appointments - 26/01/2024
A disabled man was trapped in his bedroom for five years due to care failings, a report has revealed.

Disabled man 'trapped in bedroom for five years' due to care failings (Web) The Daily Record - 25/01/2024
A disabled man was left "trapped in his bedroom for five years" due to care failings, a report has revealed.

## Social media

### Twitter (aka 'X')

The reports original tweet received 183 engagements (liked, retweeted, or otherwise interacted with it) on publication. 145 users clicked on the link to the news story, and 20 retweeted it directly to their own followers. This made it the most-engaged Commission tweet in the week of publication and the second most-engaged Commission tweet in the month of publication.

### LinkedIn

The Investigation report was the first posted by the Commission on this platform. With recipients reposting the report, identifying it as liked and accessing the related news reports.

## Website

In the seven days following publication, the news story on the report was viewed 222 times.

## Mailing list

We sent the report to 618 subscribers on our mailing list. It was opened 180 times in the first week following publication an open rate of 29.1%.

## Conclusion

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

No significant adverse event review (SAER) or significant case review (SCR) 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.

Mr E himself wanted there to be learning so that no one else had to experience what he did.

There is clear evidence that the five recommendations made within the Mr E (2024) investigation report are being acted on and addressed by both the Care Inspectorate and HSCP A. A detailed action plan is in place and is being monitored via HSCP A's clinical and care governance arrangements. It will take time to shift the culture in HSCP A and embed practice and learning which is truly integrated and focussed on continuous joint improvement to achieve improved individual outcomes for some of the most vulnerable adults in our communities. However, the direction of travel is being led at the highest level and we are hearing positive reports from those working within HSCP A that they are noting welcome changes.

The Commission continues to visit HSCP A as part of our routine visiting programme and looks forward to continued positive feedback on the changes being made.

**Identify any out-standing actions and recommendations and any future activity or options to satisfy these, if any? (Identify learning points for future investigations/visits and things to do differently?)**

HSCP A continue to address learning in partnership with the Care Inspectorate and through its own governance processes. Work is progressing to ensure that Mr E's individual needs and outcomes are addressed. The Commission's investigation role is therefore now concluded.

Given that Mr E is subject to a guardianship order, the Commission will however retain an interest as it does with all those made subject to AWI orders relating to welfare matters.