Summary of Mental Welfare Commission Reports - Mr E & AB

Highland Summary

What happened to Mr E (summary)

- Mr E was in his mid-50s when he was detained in hospital under the Mental Health Act in August 2020.
- Mr E had a known physical health condition (diabetes) and mental illness (schizophrenia)
- A history of non-engagement with services
- Mr E Lived with his mum and older brother (*concerns were noted regarding his brother*)
- Mr E's finances were managed by social work services under corporate appointeeship since at least 2007. (*The reason for this was concern regarding his older brother causing financial harm).*
- 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.
- Mr E is now subject to a local authority welfare guardianship order and is living in a dementia unit receiving 24-hour care - His mental illness is now regarded as partially treatment resistant.

What happened to AB (summary)

- AB was a middle-aged adult with a mild to moderate learning disability who died in 2019 in an orthopaedic rehabilitation ward, following a fall in which they sustained a fracture
- In February 2014 concerns were raised with social work about AB who was estranged from their family and moved away from their home area in the 1990s with CD. (*Family were unaware of their location*)
- AB had changed their name to that of CD's deceased sibling
- AB had serious physical health issues that were difficult to manage due to the involvement/influence of CD
- Just before AB's death their carer, CD, was charged with culpable and reckless conduct towards AB while in hospital, a charge that was subsequently dropped due to lack of evidence to support criminal intent.
- There were serious concerns over CD involvement and influence that they held over AB
- AB was known to services

Focus & Lines of enquiry

Mr E

1. To investigate the care, treatment and support given to Mr E
2. Knowledge, practice and application of the 3 key pieces of safeguarding legislation
3. Integrated multidisciplinary working across health and social work services
4. Financial management; and Meaningful engagement with Mr E's family
5. The failure to carry out a comprehensive local learning review of Mr E's care and treatment by any agency

AB

1. The use of the AWI 2000 Act.
2. The decision-making processes
3. The actions taken to address the serious issues
4. Whether appropriate interventions were timeously considered.
5. Why there was no local significant case review or significant adverse event review following AB's death.
6. Why notification requirements on revocation of AB's detention were not followed

Findings – Mr E

1. Mr E's experience and life changing negative outcomes have arisen
2. No social work or health care assessment, there was no assertive outreach or evidence of relationship-based practice
3. No account was taken of the needs of his brother or mother as carers.
4. Failure to implement legislation,
5. GPs required to undertake emergency detention assessments
6. Poor commitment to completion of social circumstances reports in HSCP

1. Views expressed that the three pieces of legislation were the responsibility of different agencies
2. The lack of formalised multi-professional meetings,
3. Lack of a cohesive multidisciplinary approach meant collective expertise was not harnessed and indeed missed
4. Several missed opportunities to prevent Mr E from living a life which was not of his choosing,
5. Lack of confidence in the reporting systems (according to Datix and adult support and protection)

Findings – AB

1. Missed opportunities for application welfare guardianship order been in place at an earlier stage
2. More could have been done to promote AB's safety during the inpatient stays
3. The difficulty in engagement, and concern that AB and CD might leave the area,
4. AB's unwillingness to engage made capacity assessment difficult but no less important.
5. AB was put at unnecessary risk because there was no learning from previous admissions.

1. Missed opportunities to action Protective Legislation (ASP) to safeguard AB
2. Missed opportunities to undertake a capacity assessment (no 2nd Doctor) - system failure
3. No challenge to the OPG regarding CD's appointment as attorney
4. Little recorded discussion in any ASP of the concept of undue pressure
5. lack of working knowledge by key professionals on aspects of the three key pieces of legislation and how they interacted
6. Failure to carry out a local learning review
7. The focus was on immediate management

How can we learn & Improve? (All Services, locally)

Multi-disciplinary approach

Improvement in communications between services, more awareness from services of protective legislation and legislative responsibilities to ensure multi-agency approach.

How can we do this?

- Training
- Devlopment sessions
- Sharing information widely to the workforce
- Initial Referral Discussion (IRD) to become standard practice (where appropriate)
- Consideration of how an adult at risk of harm is identified in hospital

Adult Protection is everyone's business