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INVESTIGATION

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Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

This investigation was conducted under Section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 gives the Mental Welfare Commission (the Commission) the authority to carry out investigations and make related recommendations as it considers appropriate in a number of circumstances. Among these circumstances are those set out in section 11(2)(d).

Section 11 (2) d relates to circumstances where an individual with mental illness, learning disability and related conditions may be, or may have been, subject, or exposed, to ill treatment, neglect or some other deficiency in care or treatment.

The events took place in a remote area of Scotland. We learned of Mr JL's situation from a GP who called for advice about his admission to a general hospital on 4th May 2012 and various concerns surrounding this. We asked to be kept informed and were later told that he died in the hospital on 6 May 2012 at the age of 65.

We advised that his death be reported to the Procurator Fiscal. The Procurator Fiscal sought further information and concluded that further investigation by the Fiscal's office was not needed.

The Commission wanted to find out more about what led to Mr JL's poor physical condition before his admission to hospital. We decided to review the care, support and treatment he received in the period prior to his death. We were concerned that he seemed to have eaten very little and had little fluid over an extended period of time, despite receiving care at home from a registered care provider. On admission to hospital Mr JL was found to weigh 29kg (4½ stone).

Mr JL had a known mental illness and there had been previous concerns about his capacity to give consent in certain circumstances. He appeared to make a decision to die and refused food and most fluids. He also refused medical intervention from the general practitioner. He had a huge physical deterioration over a four week period resulting in his distressing and chaotic death.

We had concerns that Mr JL may not have had the capacity to consent to or refuse medical treatment. Social care and health service staff may have missed opportunities to intervene and afford him the benefit of a new assessment and, if necessary, a palliative care plan to give him as comfortable and dignified a death as possible. We decided to investigate further.

The Commission investigation team comprised Mrs Alison Thomson, Executive Director(Nursing), Mrs Alison Goodwin, Social Work Officer, Dr Steven Morgan, Medical Officer, and Dr Donald Lyons, Chief Executive.

Reason for investigation

To examine in detail the care, treatment and support Mr JL received in the 18 month period prior to his death on 6 May 2012.

We gave particular attention to:

- the assessment of Mr JL's capacity in relation to making decisions about medical treatment;
- the eight weeks prior to his death and the actions taken by care staff and the multidisciplinary team in response to his changing physical and mental presentation;
- the knowledge and understanding of capacity and consent to treatment of the care staff and multidisciplinary team caring for Mr JL during this period of time;
- making recommendations about the medical care and treatment of people where mental illness may impact on their ability to make decisions about their medical treatment.

Method of investigation

We obtained case records from NHS Board A and Council A. We received information about the enquiries made by the Crown Office and Procurator Fiscal's Service in Area A. We reviewed these records and also the critical incident reviews that had been conducted by the services following Mr JL's death. We then visited Area A to interview those we identified as key staff members.

The staff members we interviewed were:

- the advocacy worker
- the solicitor
- the social care service manager
- social care worker A
- social care worker B
- the senior social care worker
- the mental health officer (MHO)
- the senior social worker
- GP A
- the consultant hospital physician
- the nurse specialist
- the consultant psychiatrist.

We met these individuals privately and considered beforehand the questions that we wanted them to address.

We arranged to have these interviews recorded and a transcript of each was sent to the relevant interviewee to check for accuracy.

We greatly appreciate the cooperation of all the organisations and staff in assisting us with this investigation. We also spoke with and took into account the views of Mr JL's ex-wife and informed her of our findings.

Given that much of this investigation related to the social care service Mr JL received at home, we thought it was important to involve the Care Inspectorate. We were joined on some interviews by Mr Brendan McCabe, Care Inspectorate Officer. Mr McCabe was involved in our interviewing of the social care and social work staff.

We would like to thank the Care Inspectorate and Mr McCabe, in particular, for assisting our investigation team. In addition to adding his expertise to our interviews, it helped us to achieve a better understanding of the Care Inspectorate's inspection methodology and the standards expected of a regulated care provider.

This report draws on the findings and recommendations of the internal critical incident review and the further investigation by the Commission on this case.

Background information

We obtained much of Mr JL's personal history from his second wife, from whom he was divorced. Little was known by services about his life before his arrival in the area A.

Mr JL was raised by his aunt from the age of six because of his mother's mental illness and admissions to hospital. It was described as a physically and emotionally impoverished childhood. As far as we know, Mr JL first came into contact with mental health services in England in 1984, when he was treated for depression. He had a six week admission to hospital for depression and had further contact with GP and community psychiatric nursing services in England for depression and anxiety over a number of years.

Mr JL worked in various jobs, the longest one being as a chauffeur. His second wife described him as someone who often had long periods of depression leading to self isolation and physical neglect. She also described a complex man with a history of alcohol misuse and self destructive, chaotic and, sometimes, obsessive behaviours.

Following the end of this marriage, his second wife moved to area A. Mr JL initially remained in England with a friend but was not coping. He then moved to area A to be nearer his wife and children. She offered him emotional and practical support.

She later moved away, with her children, from area A, but Mr JL remained there. She, and the children, remained in occasional contact with him. It appeared, perhaps due to his communication difficulties, that she mainly initiated this contact in relation to discussions about the children.

Chronology of Events

In 2006, Mr JL was referred, by his GP, to the community mental health team in area A for anxiety and depression and was seen by a community psychiatric nurse.

There was no further contact, until **April 2009**, when the local police contacted the social work department about Mr JL. He was living in, what was described as, a dilapidated caravan, without adequate heating or facilities. Police were concerned that he often left the caravan door open and seemed disorientated on occasions. The police referred him to the out-of-hours social work service. Mr JL was visited the same evening by a mental health officer (MHO) and general practitioner who felt no urgent action was required, but referred him back to the community mental health team.

However, the following day he was admitted to hospital after being found disorientated at the local post office. He was assessed by a doctor and MHO who found him to be confused, cognitively impaired, severely aphasic but not psychotic. It was thought he needed neurological assessment and he was admitted to a general hospital. His second wife was contacted at this point by the MHO allocated to do a single shared assessment and she was able to provide some background information on Mr JL.

A CT scan provided a provisional diagnosis of cerebral atrophy consistent with ischaemic change or small vessel disease. Mr JL was offered admission to a stroke rehabilitation unit for further assessment, but he refused this. Various assessments were carried out, including occupational therapy (OT) and speech and language therapy (SALT). He was noted to have severe difficulties with comprehension and communication of both written and spoken language. He was seen by a psychiatrist who confirmed the earlier diagnosis and identified the need to assess capacity.

In May 2009, a case conference was held with Mr JL present. Although no definite diagnosis was confirmed, it was thought he had some form of dementia. A referral was made to advocacy services. Outreach staff, from a social care provider, were allocated for one hour daily to monitor his medication, nutrition and self care as he was still living in the caravan. This social care provider is part of the local authority social work services and is not an independently commissioned service. They also assisted him in keeping some contact with his family. He regularly sent birthday cards to his children and received letters and cards from his ex-wife and children. He was very proud of his children and would show staff photos of them and cards he received. However, staff understood that Mr JL did not want his ex-wife to be given information about him and he appears to have become more adamant about this as time passed.

In June 2009, Mr JL was referred to a neuropsychologist. The assessment report noted cognitive difficulties and significant receptive and expressive language deficits.

It also identified the need for occupational therapy (OT), SALT input and increased social opportunities and improvement in his housing situation.

In **July 2009**, a review meeting noted the lack of hot water, a working shower, and laundry facilities in his caravan. Mr JL would not consider alternative accommodation. He also needed staff support with paying bills and other financial matters. Staff, with the support of the SALT, were developing a communication book to help him communicate with them.

In **October 2009**, his GP noted that he was sad and tearful on occasions with low mood, but he had no suicide plans.

In **December 2009**, he was found unconscious at a bus stop with a minor head injury. There were concerns that he was drinking again but he denied this. In **January 2010**, concerns about his capacity and the possible need for welfare guardianship were discussed at a case conference. It was decided that an assessment of his capacity should be pursued.

In **March 2010**, he was seen again by the neuropsychologist but formal assessment proved difficult. It was the neuropsychologist's view that there was some deterioration in functioning. Social care staff, however, reported he was developing good relationships with them and with advocacy. Although, the situation with the caravan remained concerning, there was no urgent need to remove him. He was discharged from neuropsychology.

From around **March 2010**, it appears that staff who worked closely with him and his advocate were coming to the view that he did have capacity. They felt he was able to make his wishes known, showed good short and long term memory and expressed consistent views and decisions.

In **July 2010**, an assessment by the consultant psychiatrist, on a joint visit with his MHO, found Mr JL to be cognitively impaired, and possibly vulnerable regarding his finances. Formal assessment was again very difficult and Mr JL did not engage with the process. The psychiatrist diagnosed a fixed dementia of mixed aetiology (permanent, rather than fluctuating with alcohol intake or mood) and it was determined he was likely to lack capacity in various areas and should be assessed where appropriate. This information was put in a letter from the consultant psychiatrist to the general practitioner.

In **September 2010**, Mr JL moved to a new tenancy after staff worked hard to persuade him of the benefits of this. He appeared to settle quickly into his new sheltered housing with continuing support from his social care workers, employed by the local authority. This outreach service specifically provides support at home to people with mental health conditions to enable them to live as independently as possible. It supports people to maintain, and develop, their life and social skills such as cooking, budgeting, shopping, anxiety management, hygiene etc. The service is

inspected by the Care Inspectorate against the National Care Standards and Quality Statements.¹

The National Care Standards set out what should be expected from a care service. The standards are based on six main principles - dignity, privacy, choice, safety, realising potential and equality and diversity. The quality statements and themes are informed by the National Care Standards and cover quality of care and support, quality of environment, where applicable, quality of staffing and quality of management and leadership. Each theme examined during inspection would be graded 1-6 with 1 being unsatisfactory and 6 excellent.

The service providing care to Mr JL has consistently received high scores following inspections from the Care Inspectorate.

In **November 2010**, the MHO decided to close Mr JL's case following his move to his new tenancy and it is reported that he was keeping well at this time; the only problem recorded being occasional pain in his legs. There was daily contact from social care staff and they noted continuing improvement in his speech and understanding. Although the MHO/social worker had no contact thereafter, the case was not formally closed and coordination of his care passed to the care provider until **July 2011**.

In **December 2011**, staff noticed that Mr JL might be developing an abscess in his mouth but he did not want to go to the dentist.

The last 3 months of Mr JL's life

In **February 2012**, Mr JL, with support from social care worker A, contacted a solicitor to make a will. With staff assistance he had recently sorted out his work pensions and lump sum. He was still noted at this time as having a swollen cheek.

The solicitor was told by the social care worker, who accompanied Mr JL, that Mr JL wanted to make a will so his affairs were in order before he died. The solicitor, on speaking with Mr JL, considered he had the capacity to do this. The draft of the will was sent to Mr JL on 26 March.

In **March 2012**, one of the social care workers phoned the GP without Mr JL's consent as the workers were concerned about the swelling on the left side of his face, his weight loss and a decline in his wellbeing. Mr JL had refused to make an appointment to go to the GP, despite many attempts to persuade him by the social care staff. It is around this time that there appeared to be a marked change in his mental wellbeing as well as his physical condition. Mr JL was visited by GP A on **16**

¹ The Care Inspectorate was formed under the Public Services Reform (Scotland) Act 2010. The function of the Care Inspectorate is to regulate a range of care services, undertake strategic inspections of local authorities' social work departments and it is also responsible for the scrutiny of children's services as set out in the Act.

March 2012. He refused examination of the swelling but agreed to take a course of antibiotics.

Mr JL agreed to see GP A again as the antibiotics had finished and there had been no improvement.

On **30 March 2012**, he was seen by GP A on a home visit. It was noted that the swelling looked no better, but he again refused an examination, bloods or a dental referral. A second course of antibiotics was prescribed and he reluctantly agreed to take these.

On **6 April 2012**, he was seen again by GP A at a home visit. Staff had asked GP A to complete a do not attempt cardio-pulmonary resuscitation (DNACPR) form but GP A was reluctant to do this as he was not clear if Mr JL had capacity to make this decision. The social care worker present indicated that he was refusing food in order to die. GP A wrote a letter of referral marked 'urgent' to the community mental health team (CMHT). He sought advice about Mr JL's capacity to request the DNACPR, his capacity to instruct a solicitor and his concerns that Mr JL was refusing food so he could die. There were conflicting accounts of the sending and receiving of this letter, which we were unable to determine satisfactorily. We know that it was not processed by the CMHT and GP A did not follow up the lack of response from the CMHT.

Between **6 April and 3 May 2012**, Mr JL cancelled many of his daily visits from the social care staff. In the last three weeks of his life he was receiving only three visits per week from the same member of staff, social care worker A.

On **3 May 2012**, another social care worker was called to help social care worker A, who was trying to assist Mr JL to sit up in bed to drink. When she reported the situation back to her line manager, the senior social care worker, he called GP A against Mr JL's expressed wishes. He told GP A that Mr JL had last eaten something three weeks previously and that he wanted to die and did not want to go to hospital.

GP B, the duty GP, made a home visit later the same day. Mr JL was lying in bed and GP B was reportedly shocked by what he saw. He described Mr JL as 'skin and bone with a large abscess on his chin which was weeping'. Mr JL refused hospital admission and GP B did not know if he had capacity to refuse medical intervention. He decided to leave it until the next morning to discuss with his colleague, GP A.

Social care staff made three visits to Mr JL on 3rd May and the senior social care worker and manager of the service made four visits the following day to support Mr JL.

On **4 May 2012**, GP A visited with the duty MHO as he was unsure about his legal authority to admit Mr JL to hospital.

Following discussion with the duty MHO, Mr JL agreed to being admitted to hospital. He was taken by ambulance to a general hospital. He was not accompanied by any

staff from the care provider. There was confusion at the hospital as to whether they needed to inform and involve his next of kin and whether they were expected to actively treat Mr JL or not.

The consultant hospital physician told us she wanted to discuss the situation with the next of kin to find out if they knew about any previously expressed wishes but was told categorically by the social care provider that he did not want this. The social care provider told us they had not said this.

The consultant physician took the decision to make him comfortable as she did not believe she could save his life by this point.

He died on **6 May 2012**. The post-mortem concluded that the cause of death was pneumonia and carcinoma of the tongue and floor of the mouth.

Findings

A. Before March 2012

Initial assessment of need

We considered that the initial assessment of Mr JL's needs was good. When he was brought to hospital on 1st May 2009, he presented as confused, cognitively impaired, severely aphasic but not psychotic. Initially his identity was unknown and appropriate efforts were made to gather information on Mr JL, involving the Caldicott Guardian² in the process.

Following assessments by SALT, OT, medical staff and the stroke nurse, the MHO completed a Single Shared Assessment and he returned home with a package of care of one hour per day, seven days per week, provided by a social care team within the Council. They were to support him with medication, shopping and monitoring of his nutrition, self care and general safety. A pictorial communication book was completed with the assistance of the SALT.

The outstanding issues on discharge were:

- An assessment by neuropsychology with regard to the benefits of a stroke rehabilitation programme. Mr JL was seen several times by the neuropsychologist, in 2009, following his discharge from hospital. Despite assistance from social care workers, the psychologist had difficulty in assessing Mr JL due to his receptive and expressive language deficits, his reluctance to engage in the assessment process and his antipathy to medical and social work professionals. His recommendations were for continued input from SALT, an OT referral and community support to develop his social and recreational opportunities. These were followed up. The possible benefits of an inpatient rehabilitation programme were not pursued, as Mr JL did not want to consider this.
- An assessment of his legal capacity to make welfare decisions.

Capacity and Intervention under the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act)

There was dubiety on his discharge from hospital, in 2009, about his legal capacity. The social worker met with social care workers, in January 2010, to discuss Mr JL's ability to make decisions about his accommodation, which was in a poor state, about financial matters and about making a will. Concerns were also raised by the MHO about the potential for exploitation by another person living nearby.

² <http://www.scotland.gov.uk/Resource/Doc/340362/0112733.pdf>

A Caldicott guardian is a senior person in an NHS organisation responsible for protecting the confidentiality of a patient/service user and enabling appropriate information sharing.

Very patchy and poor case recording by the MHO/social worker made it difficult to evidence her contacts with Mr JL and with the professionals involved with him. However, we gathered from copies of correspondence and speaking to her that she had made efforts following this case conference to get an opinion from Mr JL's GP at the time and from the neuropsychologist. She then made a joint visit with the psychiatrist in July 2010.

We discussed the consultant psychiatrist's assessment of Mr JL with her. The psychiatrist recalled that people were concerned about Mr JL's capacity in relation to decisions about where he was living and the people who were gaining access to him and perhaps taking advantage of him financially. She said the MHO/social worker had also wondered about his loneliness and depression and if they should be using the Mental Health (Care and Treatment) (Scotland) Act 2003.

She did not consider Mr JL very depressed, but it was hard to tell as communication was very difficult. There were no new findings. She had not been asked to assess capacity in relation to **specific** decisions at that time. His score on the mini-mental state examination (a test used to assess cognitive function) was very poor. He was not communicating well and tended to "perseverate". This means that he gave the same answer (in this case, his date of birth) to several different questions. Also, he appeared not to want to talk to the psychiatrist. He seemed to communicate much better with his social care worker.

The psychiatrist concluded that Mr JL had a fixed dementia of mixed causes (ischaemia/stroke and atrophy associated with alcohol), was 'likely to lack capacity in various areas' and 'should be assessed where appropriate'.

Having received this assessment, a case conference should have been reconvened to formalise what, if any, action was to be taken under the 2000 Act or the Adult Support and Protection (Scotland) Act 2007 (the ASP Act) and the reasons why. This might have reinforced that the social care team could refer back to social work, or the CMHT, for further assessment, where any of Mr JL's future decisions gave them cause for concern. Nor was there any case recording as to the reasons for taking no further legislative action. It appears that by the time the psychiatrist had been approached for an assessment, the presenting issues had resolved themselves and this did not seem necessary. After discussion with her senior, the MHO eventually closed the case. Care management responsibility transferred to the manager of the social care team.

The social care workers and Mr JL's advocate had developed a good working relationship with him and had a reasonable understanding of his communication. They felt that Mr JL was able to make, communicate and, with some practical assistance, act on decisions on most day-to-day matters in his life.

They felt Mr JL had largely opted out of formal capacity assessments by the neuropsychologist and psychiatrist. In their continuing work with Mr JL, the social

care provider felt he had capacity to make decisions. Mr JL was very clear from the outset that he wanted to get his affairs in order and would then be happy to die. Social care staff and his advocate worked closely with him to dispose usefully of his collection of tools, move him to a warm and comfortable house, try to involve him in local activities and organise his financial affairs. They supported him, along with his advocate, in his contact with his solicitor to make a will in February 2012. His solicitor had no concerns that he was unable to instruct him and his advocate ensured he understood the instructions he had given his solicitor.

B. March/April 2012

Medical care and treatment

Mr JL died from pneumonia secondary to cancer of his mouth and tongue. The first signs of problems with his mouth became apparent in December 2011. From then until his death in May 2012, there were opportunities to determine the medical care he needed. In the event of a capable refusal, there were also opportunities to plan in advance should his physical condition worsen.

We heard that, although there are named doctors at the Health Centre, very few people get to see their own doctors. Mr JL had been registered with another GP and in the previous year he had seen six different GPs.

GP A saw Mr JL, on 16 March, at the request of care workers. He clearly had a red swelling on his jaw that looked infected. Mr JL just shook his head at first when GP A asked if he could help him. He seemed annoyed that he was there, though he accepted a course of antibiotics.

GP A found out later that Mr JL told the social care workers that, if they brought other people in to see him, he would not let them back in.

He said that they agreed jointly that the social care worker would call him back if there was no progress. He added that when he left at the end of that first meeting the understanding was that the social care workers would get back in touch with him, when they were permitted to, should there be any further treatment or help needed. This was also GP A's understanding after his next examination on 30 March, when Mr JL accepted a further course of antibiotics.

He again saw Mr JL at the request of one of the social care workers on 6 April and had concerns about his capacity, his apparent wish not to be resuscitated and his possible mood disorder. GP A was told by the social care worker that Mr JL was refusing food and wanted to die. GP A dictated an urgent letter to the person he thought was manager of the community mental health team (CMHT) about these concerns. This letter was apparently never received. Unfortunately, GP A went on leave the day he sent the letter.

This was a crucial point at which a multi-disciplinary discussion should have taken place. Although there had been assessments by the neuropsychologist and the psychiatrist there was no specific assessment as to whether Mr JL did or did not have the capacity to refuse medical treatment.

A multi-disciplinary case discussion should have taken place to consider:

- his capacity to consent/refuse medical treatment
- the possibility of a mood disorder or other mental health issues affecting his will to live
- the potential need for an anticipatory or palliative care plan.

GP A or the social care provider could have triggered a multidisciplinary discussion at this or any point in the following four weeks, as Mr JL's health rapidly declined.

Instead, GP A told us he sent a letter marked 'urgent' electronically to the CMHT about Mr JL not eating and his capacity. GP A did not send this on the recommended electronic referral template on the SCI system, though we understand from the psychiatrist he had been previously advised to use this system. Unbeknown to GP A, the SCI system was not in operation that day as it was being upgraded. However, GP A has since told us that one of his reception staff delivered a paper copy by hand to the CMHT reception in the same building. The CMHT maintain they did not receive his letter. There have therefore been conflicting versions of these events and we have been unable to determine this issue. The referral was not acted upon.

GP A failed to follow up on this referral or to visit the patient again as he had no alert system in place to remind him of outstanding issues with patients. Had the referral been received, the consultant psychiatrist told us that she would have responded to a request for a capacity assessment. She would have probably offered to visit jointly with GP A. The social care team told us they expected to hear again from GP A but when they did not, they failed to pursue this with him. GP A said he had advised them to get back to him if there were further concerns.

GP A now sends urgent communications electronically to the team mail box and staff check that urgent referrals are transmitted within the day. Additionally, a paper copy is delivered to the mental health team by hand, as the team is in the same building. We also understand that GPs in this practice will have dedicated time each day they are not acting as duty doctor to undertake planned follow up home visits.

Assessment of capacity

We found that the lack of clarity on Mr JL's capacity to make certain decisions about his care and medical treatment had an impact on the last few months of his life. The assessment of his capacity was, however, very difficult.

When Mr JL refused to allow social care staff to contact his GP, from January 2012 onwards, they considered he was making a valid choice. They largely accepted and respected his decisions, despite concerns about his health. However, they did disregard his views in mid March 2012. Although he did not allow the GP to examine him, take bloods or make a dental referral, he did accept two visits and the courses of antibiotics the GP prescribed for the swelling on his face and what was possibly an abscess. It is not known whether Mr JL had suspicions or was informed that it was likely that he had a more serious condition.

On 6 April 2012, GP A visited Mr JL again and was concerned when he was told Mr JL was refusing food in order to die. Social care workers continued to inform GP A that Mr JL's wishes were that he did not want medical treatment. GP A was also concerned about Mr JL's capacity to complete a DNACPR form which social care worker B had asked GP A to complete on Mr JL's behalf.

GP A told us that he could not imagine how Mr JL could communicate a decision about resuscitation. On this occasion he completely refused to respond and just sat there. He thought that if Mr JL had asked not to be resuscitated, it would have meant that he had far more capacity than he had been able to determine.

Overall, GP A felt that Mr JL had capacity. He was communicating and making decisions and acting and recalling those decisions. He also understood the consequences of what he was doing. He was organised and seemed to be 'on the ball' and, up to the time GP A last saw him, he had looked quite healthy, apart from the swelling on his face which GP A felt was almost certainly going to be malignant. GP A said that Mr JL would not let anyone open his mouth or shine a torch into it and on that day he had just sat and shrugged occasionally. That was the only communication he got from him. He said that the staff were doing their best to stay on his side to help him as much as possible

GP A did not find any outward signs of depression, but, because of the way Mr JL was trying to avoid interacting with him, it was very difficult to determine. GP A had asked for help from the psychiatrist who might have been able to tease out more than he could.

We conclude that there was a general view held by those who knew Mr JL best that he had capacity to make his own decisions about his welfare and his medical treatment. This was called into question when he refused examination and intervention for what turned out to be a serious illness. It was never properly resolved.

It was not possible to assess fully his reasons for refusal because Mr JL did not communicate with medical practitioners. It is possible that he had significant depression that was interfering with his decision-making. It is also possible that he suspected the presence of serious illness and made a judgement that he just wanted to be left alone to die at home. While this may have been unwise, it did not itself mean that he lacked capacity. The 2000 Act specifies that an adult does not lack capacity merely by “acting as no prudent person would act”. Under the circumstances, we think it would have been very difficult to make this distinction. A case conference convened under Adult Protection procedures would have helped by gathering a wider variety of information to arrive at a considered view.

Sole workers

Where social care workers are dealing with difficult situations, allocating one worker to provide most of the support to an individual limits the perspective of the presenting issues. Workers can get very involved with the service user, their needs and wishes and fail to see the overall situation. The service needs to ensure that their staff have the necessary training and understanding to be aware of the threshold for reporting serious concerns back to management and their responsibility to the service, alongside their responsibility to the service user. Crucially, this failed to happen in the case.

Mr JL had a key worker (social care worker A), from the social care team, who provided most of his care and support. Mr JL initially had visits seven days a week but generally cancelled weekend visits and reduced this to five. Over the last four or five months of Mr JL’s life, these visits were generally from his key worker. He only had occasional visits from other social care workers, when his key worker was not on shift, was sick or on leave. Like other workers in the service, his key worker was very caring and supportive of Mr JL. The worker had provided considerable assistance in helping him sort out his affairs and set up his new home and felt dedicated to supporting his wishes, including his wish to have no medical intervention. In addition, Mr JL was strong-willed and, if his wishes were not adhered to, he would be displeased and exclude workers for several days.

In the last four weeks of his life, Mr JL cancelled more visits than usual, so his key worker was only visiting three times per week. As Mr JL stopped eating and his physical health further deteriorated, his key worker continued to ask Mr JL whether he wanted to see his GP or the nurse about the weeping swelling on his face and his increasing breathing difficulties. He accepted Mr JL’s refusals. Although he detailed the deterioration in the daily records he completed, he did not communicate his concerns to his line manager or raise them at the daily handover meetings. It was not clear that he had given any thought as to how he, or the service, was going to manage Mr JL’s care, as his condition got steadily worse.

There were two occasions when the service overrode Mr JL's wishes and contacted his GP due to concerns about the service's duty of care to him. On both occasions, 16 March 2012 and a few days before his death, it was other social care workers who visited Mr JL and were immediately concerned, if not alarmed, at the deterioration in his condition.

Whilst we would not necessarily expect social care workers to have in depth knowledge of mental health problems or of issues around capacity to make decisions on medical intervention, we would expect that all workers communicate basic concerns about a service user's health and welfare back to their line manager. Whilst we would acknowledge the importance of key staff establishing good relationships with individual service users, the risks to a service user and to the service itself of having support largely provided by one worker are evident in this case.

Mr JL had undiagnosed advanced mouth cancer, which was unlikely to respond to treatment, had he accepted any, and earlier intervention was unlikely to change the outcome of this. However, had he had a different condition, he might have been persuaded to consider and have benefited from earlier intervention. Additionally, both the hospital physician and the manager of the social care service who saw Mr JL in the few days before his death thought he was in pain. We consider he could have been afforded an easier death, had the service been aware of the rapid deterioration in the last four weeks of his life and taken action to put an anticipatory care plan in place.

An anticipatory care approach, which may lead to a palliative care plan, supports important outcomes:

- Person centred care, dignity, choice and control
- Effective co-ordination and communication between the individual, their family and the health and social care professionals involved
- Care at home, where appropriate, or more somewhere local and closer to home³.

Management of the social care service

It is easy, with hindsight, to identify opportunities when a multidisciplinary case conference might have been triggered to discuss his capacity in terms of medical treatment and to look at an anticipatory or palliative care plan. However, we consider the management of the social care service, GP A and the social care worker A,

³<http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/12575/Anticipatory%20Care%20Planning%20-%20Frequently%20Asked%20Questions.pdf>

missed some obvious opportunities to provide the support Mr JL needed in the last weeks of his life.

The service managers were aware Mr JL had been treated in the past for depression and anxiety and was assessed following his admission to hospital in 2009 as having cognitive impairment due to ischaemic disease and past alcohol abuse. They were aware there was some dubiety about his decision-making capacity expressed by some professionals involved with him, although he appeared to have capacity in making most day-to-day decisions.

Where it is not clear that a service user has capacity and there are welfare concerns, a service needs to be alert to the need to involve other professionals to ensure a vulnerable service user, and the service itself, are not left at risk. Although his key worker did not pass on crucial information about the deterioration in Mr JL's condition, in the last month of his life, the senior social care worker, who was the key worker's line manager, decided on 16 March 2012 to override Mr JL's wishes and contact his GP, due to their concerns about the swelling on his face, his weight loss and the general decline in his wellbeing. He was also aware, from social care worker B, that GP A had sent an urgent referral to the CMHT regarding his capacity to make medical decisions and his failure to eat as he wanted to die.

We think the line manager could have been more proactive in enquiring from his key worker as to what was happening with Mr JL in those last 4 weeks and also in pursuing advice from GP A, from whom they were expecting some response. We were told by the service manager that workers were waiting for GP A to get back to them and we consider they had a responsibility to be more proactive in contacting GP services.

There was also an opportunity for the senior social care worker to pick up on concerns from the visit records completed by Mr JL's key worker. These made clear the decline in his health and, had these been read, should have prompted further contact with GP A and multidisciplinary discussion about managing his end of life care.

These clearly recorded:

- the decline in his mobility and strength,
- his lack of interest in food
- his inability on some days to get up and get dressed and to answer the door
- latterly, his difficulties in breathing and in taking other than a few sips of liquid.

Whilst a line manager may only read the ongoing case records when they are made aware of an issue by the social care worker, we consider the service had some awareness of the concerns about Mr JL and should have kept abreast of the situation via the records.

The social care worker's line manager would also have known about Mr JL cancelling visits and that he was only having three visits a week. This should have alerted him to ask questions about the ongoing situation. Where a service user, who is vulnerable and at risk, is disengaging with his care plan, the reasons for this need to be explored proactively.

There had been no review of Mr JL's care and support package for 11 months. The last one was in June 2011 when the MHO closed the case and transferred care management/coordination responsibility to the social care team. A review would have been due around December 2011/January 2012. However, the issues of the last few months of Mr JL's life would not have been apparent at that time. It remains unclear to us whose responsibility it was to arrange six monthly reviews and whether the management of the service checked that these were happening for all their service users.

Mr JL's key worker received regular two-monthly supervision and had completed all the basic training required for workers in a regulated social care service. This included attendance at Adult Support and Protection training on 1 March 2012.

The effectiveness of this training may need to be looked at as it does not seem to have raised questions for the social care worker about the potential adult protection issues he was dealing with in Mr JL's case. We consider Mr JL met the definition of an adult at risk in terms of Section 3 of the Adult Support and Protection Act⁴ and had that been recognised by the social care worker, or the senior social care worker, there would have again been an opportunity to examine the issues through an ASP case conference.

It was clear, from our interviews, that the social care service is now aware of the issues below:

- the risk of having one worker providing nearly all the support to an individual
- the need for workers to understand the benchmark for sharing issues with their line manager
- the need for line managers to be proactive when a service user is disengaging with their care plan
- the need to trigger multidisciplinary discussion where there are concerns particularly where there is doubt about capacity or possible adult protection issues, or the potential need for an anticipatory/palliative care plan
- the need to be proactive in follow up with other agencies.

⁴ <http://www.legislation.gov.uk/asp/2007/10/section/3>

Palliative care planning

A palliative care plan would have straightened out some of the miscommunication that took place in the last few weeks of Mr JL's life. It might well have enabled him to die at home with the appropriate palliative care, including pain relief, and there would have been clarity about contact with his family who have been distressed that they were not told he was dying and that they did not know of his funeral until after it had taken place.

NHS palliative care guidelines⁵ specify that an anticipatory care plan to ensure continuity of care between professionals should cover:

- Next of kin and details of any welfare attorney
- Level of intervention for expected clinical deterioration
- Preferred place of care
- CPR status
- Wishes on tissue donation
- Medication prescribed for use if required.

C. May 2012

Medical care and treatment

After 6 April, there was no further medical intervention until 3 May 2012. When seen by the on-call GP, Mr JL refused admission to hospital. He agreed to admission when seen by GP A the following day. GP A was concerned that he had not been called sooner. Mr JL was in very poor physical condition and had not eaten for three weeks or drunk anything for three days. Mr JL appeared to be in considerable pain. GP A thought he should have been admitted the previous day.

At first, GP A did not think Mr JL would agree to admission. He phoned the consultant psychiatrist, explained Mr JL's condition and asked if she would go out to see him. The psychiatrist was busy on an existing urgent detention. She advised that GP A would need to decide whether to allow Mr JL to die at home or admit him to hospital. She suggested that GP A should visit along with a MHO.

There was some discussion and confusion amongst the professionals about the possible use of legislation to admit Mr JL to hospital and to treat him. This was largely due to the uncertainty as to whether he lacked capacity to consent to medical treatment or not.

Under the common law 'doctrine of necessity' it would have been reasonable in an emergency, such as this, to take the necessary action to safeguard a person who was unable to consent and without treatment would come to significant harm. This

⁵ <http://www.palliativecareguidelines.scot.nhs.uk/careplanning/>

could have resulted in Mr JL being admitted to hospital under common law and then possibly treated under Part 5 of the 2000 Act.

If, however, he was considered to have capacity to consent to treatment and was refusing this, he could only have been admitted to hospital and treated against his will if he met the criteria for detention under the 2003 Act . Where a physical disorder is a *direct cause or consequence of mental disorder*, treatment for the physical disorder can be given under the 2003 Act.

There was also some initial misunderstanding about the legal basis of providing artificial nutrition. If the hospital doctor had considered that he lacked capacity to consent to artificial nutrition, this could have been given under a Section 47 certificate and a Designated Medical Practitioner opinion from the MWC would not have been required. If Mr JL was detained under the Mental Health Act, and was refusing artificial nutrition, a DMP opinion would be required, though he could have been treated initially on an emergency basis until this could be arranged. As Mr JL agreed to go to hospital, this situation was resolved. The Commission's "Right to Treat?" guidance would have been helpful had Mr JL refused to go to hospital.

When Mr JL agreed to hospital admission, GP A phoned the consultant hospital physician and wrote a brief letter to accompany Mr JL to hospital. His recollection was that admission was for palliative care as Mr JL was in pain and probably dying.

It appeared that the receiving consultant hospital physician initially thought from contact with GP A that Mr JL was being admitted with a view to rehydrating and possibly giving him artificial nutrition. He was severely emaciated on admission, weighing 29 kilos. Although the consultant's initial feelings were that he was dying, they managed him, giving him fluids, antibiotics and vitamins, and excising the facial swelling. Treatment was carried out under Part 5 of the 2000 Act (Section 47) as he was incapable of speaking or making decisions. It might have been helpful had one of the social care staff accompanied him as they would have been able to maximise any communication that he had. As his prognosis was so poor, the consultant completed a DNACPR form and made him as comfortable as possible. He died on 6 May 2012.

From the medical evidence available, it is clear that Mr JL had been losing a significant amount of weight and had probably been in pain and discomfort for some time before 3 May 2012. This is a matter for significant concern. The consultant hospital physician was so concerned that she made the decision on the advice of one of the Commission's medical officers to report Mr JL's death to the Procurator Fiscal. In our view, this was entirely appropriate. The list of deaths that must be reported to the Procurator Fiscal is not exhaustive but includes "any death involving fault or neglect on the part of another" and "deaths which are apparently associated with lack of medical care". It would not be for the consultant hospital physician to make a judgement as to whether neglect or lack of medical care existed or

contributed to Mr JL's death. It would have been irresponsible of her not to report his death under these circumstances.

Knowledge of relevant legislation and guidance

GP A had particular difficulty when Mr JL was seriously ill in May. He was uncertain how to proceed. We felt it was important to comment on knowledge of relevant legislation and guidance. As more remote areas often need to recruit staff from beyond Scotland, it would be helpful to have access to basic information on local services and relevant legislation. However, it is the GP's own responsibility to ensure his Continuing Professional Development (CPD) includes knowledge of basic legislation related to incapacity and consent to medical treatment and the basics of mental health legislation.

GP A had previously worked for 20 years in England. He had looked on the internet for information and had downloaded the 2000 Act. He could not find anything that quite covered this situation and had then downloaded the shorter AWI form and guidance notes. He had also contacted the General Medical Council (GMC) and they pointed him to their handbook, and he noted at the bottom of the AWI form a list of contacts and that had included the Commission.

He first called the duty mental health officer asking whether he could use the 2000 Act to admit Mr JL to hospital and organise nutrition. He advised her that Mr JL was to be seen by the psychiatrist, to assess his mental health, if he were admitted to hospital. The MHO and her colleague read through the Act and Code of Practice. They did not think that artificial feeding could be carried out under Section 47 of the Act without a second opinion but advised him to phone the Commission. The MHO also arranged to meet GP A at Mr JL's house. She was clear when she saw Mr JL that, if unattended, he would have died within a few days. She discussed the use of common law versus the use of the Mental Health Act with GP A as she felt they could not use the 2000 Act as they were unable to assess his capacity. At this point Mr JL agreed to go to hospital and no decision as to the use of legislation was necessary.

Later in the day, GP A discussed the situation with the Commission. We discussed the use of common law for emergencies, treatment under Part 5 of the AWI Act if Mr JL lacked capacity and informed him that no second opinion was required from the Commission for artificial nutrition where this was under the 2000 Act for physical disorder. We referred him to our Right to treat? guidance for more detailed information.

GP A told us that this was the first occasion he considered using the 2000 Act and he had been in Scotland for about seven years. This is surprising considering the need for GPs to regularly use Part 5 of the Act when considering the capacity of patients to consent to their treatment. He was sure very few of his local colleagues understood the Scottish legislation compared to the English legislation.

He explained that things had moved on since Mr JL's death. Communication between primary and secondary care and with the local authority services had improved. Section 47 certificates to authorise medical treatment for individuals who lack capacity to consent were not being completed routinely by GPs for individuals who lacked capacity in care homes or the community at the time. They are now. The primary care team now have weekly educational meetings and once a quarter discuss complex cases. GP A had not read our "Right to treat?" guidance, so we provided him with a copy.

It is important that GPs as well as hospital physicians are aware of legislation on incapacity. With sufficient education and experience, they can determine capacity/incapacity in relation to medical treatment and certify as appropriate. In some cases, other assistance, e.g. from psychiatry, psychology or speech and language therapy, may be needed. At certain points, it was difficult to determine Mr JL's capacity to refuse examination or treatment. Specialist assessment may have helped.

It is also important that they have basic knowledge of the Adult Support and Protection Act, including the definition of an 'adult at risk', and understand the responsibilities on NHS Boards.

While it is beyond the scope of this investigation to comment in detail on the mental health service in this area, we came across some concerns. The area has limited access to consultant psychiatry. It is unreasonable to expect psychiatrists to perform routine capacity assessments within general medical care. It is therefore important that general practitioners and hospital medical practitioners are competent in assessment of capacity and understand the law in this area, so the psychiatrists can focus on the more complex capacity assessments. The NHS Board may need to consider this.

Communication with relatives

We heard conflicting accounts of why his next of kin was not contacted. NHS staff recorded in the medical notes that they were told by the social care provider that they should not contact Mr JL's ex-wife and children, but the provider denied this. However, Mr JL's ex-wife gave a different account. She told us that the manager of the social care service reported that the hospital had said not to contact her as that was Mr JL's expressed wish.

This confusion could obviously have been avoided with forward planning. We were also disturbed and saddened to hear that Mr JL's ex-wife and his children did not know of his funeral, which took place three weeks after his death. The solicitor who was the executor of his will told us he informed the family's solicitor of the date as soon as he was notified of it by the funeral directors. It is not clear why the information did not get to his family.

The next of kin should have been notified by hospital staff of the death of Mr JL.

Summary of findings of the critical incident review (CIR)

We asked for all the relevant documents from health and social work in relation to Mr JL. We had some concerns about the quality of the CIR which consisted of a timeline of events, minutes of two multi-agency meetings and a brief summary of the learning and actions points.

Our concerns were as follows:

- There were no written terms of reference;
- It was not clear whether this was a joint review by health and social work as both had significant roles in the events leading up to Mr JL's death, or a health led review where social work had agreed to accept the findings and action required. There did not appear to be a separate serious case review by the local authority;
- There was no consideration of whether or not Mr JL's next of kin should be notified, involved or subsequently informed of the findings of the CIR
- There were inaccuracies in the timeline with regard to some dates and the significant visit by GP A and referral to the CMHT on 6 April 2012 was not included in the timeline;
- The root cause of some of the contributory factors does not seem to have been identified: for example, the lack of a system for multi-disciplinary; discussion/ case conference and recording of this, where there has been consideration of possible use of legislation;
- Many of the learning and action points are very generalised and there appears to have been no subsequent meetings or agreement on identifying the specifics of how these general recommendations are to be met. For example, 'capacity issues need to be reviewed regularly for at risk patients' – responsibility 'all'. This may be acceptable as a first step but there needs to be a specific plan as to how these patients are identified, whether this extends to social work service users, who reviews their capacity, how often, in relation to what decisions etc;
- There are no timescales for implementing any of the identified action points.

We are not aware of any multidisciplinary or multiagency follow up on the implementation of the recommended actions points and their effectiveness. This is vital to ensure corrective action will prevent the recurrence of a similar event. Since the CIR on Mr JL was held, there has been considerable focus nationally on critical incident or significant adverse event management that provides a basis for improvement in the future.

In September 2013, Healthcare Improvement Scotland published its "Learning from adverse events through reporting and review: A national framework for NHS

Scotland”.⁶ It provides useful learning points for all NHS boards in Scotland and for NHS Scotland as a whole, though has no reference to multiagency working or to local authority responsibilities under Adult Support and Protection legislation which will include serious case reviews carried out by local authorities.

The Board concerned have told us they are now following the HIS recommended processes.

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http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx

Summary and conclusions

Mr JL died of cancer of his mouth and tongue. In the last month of his life and possibly before that, he did not, in our view, receive appropriate medical care.

The causes of this were:

- the failure of GP A to arrange follow up action when he was concerned about Mr JL's condition, in particular when he was told he was not eating in order to die. He also failed to follow up an urgent referral he made to the CMHT.
- the failure of the social care provider to identify and escalate concerns about an adult at risk, partly due to their reliance on a sole worker and partly due to ineffective supervision and management of that worker
- the failure of both agencies to initiate multidisciplinary discussion about the issues with Mr JL – his deteriorating health, his failure to eat and his expressed wish to die, the dubiety about his capacity in specific areas and his reluctance to accept medical treatment. Crucially there was a lack of communication between GP A and the care provider and between GP A and the CMHT
- the failure to put a palliative care plan in place despite a general view that Mr JL wanted to die at home
- poor knowledge on the part of some key medical staff of the relevant legislation and the options available under the legislation
- the uncertainty over Mr JL's capacity to consent or refuse consent to medical treatment. Despite the need for assessment of capacity having been raised on three occasions and the psychiatrist's view that "he was likely to lack capacity in various areas and should be assessed where appropriate", no specific assessment was carried out on his capacity to refuse or consent to medical treatment
- the lack of effective governance arrangements within the local authority which was responsible for assessment, care management and service provision.
- Mr JL's reluctance to accept medical intervention and the pressure he exerted on care workers in order to avoid visits that he did not want.

In addition we had concerns about:

- the quality of the Critical Incident Report(CIR) and the lack of a clear action plan and time scales for addressing the issues above to ensure corrective action has been taken by health and social work
- the failure to provide information to Mr JL's next of kin, including the funeral arrangements.

Recommendations

We make the following recommendations to the care provider, local authority, the NHS Board responsible for Mr JL's care and treatment and the Scottish Government. Other similar organisations across Scotland should also take note of our findings and recommendations in this case.

A. General medical practice

- The practice should ensure that there is an effective system in place for follow-up where patients have ongoing issues of urgent concern.
- Whilst we appreciate that the practice has made improvements, for instance in the completion of certificates of incapacity under Part 5 of the AWI Act, we recommend a training needs assessment for all relevant members of the primary care team in relation to assessment of incapacity and the requirements of incapacity
- Again, whilst noting improvements, for instance, in their referral systems and availability of time to follow up patient issues, the practice should ensure that there is an agreed method of referral to mental health services and that this is operating efficiently.

B. NHS Board

- The NHS Board should ensure that medical practitioners in the area have sufficient training in incapacity legislation and the basics of mental health and Adult Support and Protection legislation to understand their functions and responsibilities under the Acts.
- The NHS Board should review the role and function of consultant psychiatry in the area and focus their expertise on the more complex aspects of incapacity and mental health assessments. The NHS Board should ensure access to peer support and access to a greater range of expertise via an obligate clinical network.⁷

⁷ Obligate networks should be established between NHS Boards to sustain core services and ensure access to four key specialist services not routinely available in Rural General Hospitals (RGHs), including Child Health, Mental Health, Radiology and Laboratories

C. Local authority

Governance

- The local authority must review governance arrangements to ensure clarity in line management responsibilities and better communication within and between assessment and care management services and those responsible for service provision.

Social Care Provision

- Sole working should be kept to a minimum as it can increase the risk to the service user and the provider. Team working allows cross checks to be put in place and avoids singleton workers getting so involved with a service user that they lose perspective on the situation. While sole working may be appropriate or necessary in certain circumstances, nevertheless, the management of the social care service needs to ensure measures are in place to safeguard the service user in such situations. Spot visits by managers, checking with other professionals where they are visiting, reading daily records, and more frequent supervision are among the measures that should be considered.
- Line managers must be proactive in investigating the circumstances when a service user is disengaging with their care plan by, for instance, cancelling visits or cancelling visits by particular social care workers. In such circumstances line managers should be enquiring further into the circumstances from the social care worker, reading the daily records or visiting the service user themselves to assess the situation.
- Managers of the service need to be proactive in referring to social work services or triggering a multidisciplinary discussion where there are concerns, particularly where there is doubt about capacity or possible adult protection issues, or the potential need for an anticipatory/palliative care plan.
- Training is required to ensure social care workers understand the threshold for sharing issues with their line manager.
- The local authority should ensure that Adult Support and Protection training and refresher training provided is meeting the needs of all their staff in order that they can recognise and alert their line managers to situations where an adult is at risk of harm or neglect.

We are aware that the local authority social care provider has identified and is acting on most of the recommendations above. Other social care providers should take note of these recommendations

Assessment and care management services

- Multidisciplinary case discussions, where an adult is at risk, should always review the relevance, need and potential usefulness of incapacity or adult protection legislation. The reasons for using or deciding not to use such legislation should be clearly documented following such discussions.
- There needs to be clarity within the local authority on the respective roles and responsibilities of social work assessment and care management services and their relationship with the council's social care providers. This should include, on an individual case basis, details regarding communication between different parts of the council when concerns arise about individuals and the support they are receiving.
- The service should audit case records to ensure these are of an acceptable standard and indicate the contacts with other professionals and with the service user.

D. NHS Board, local authority and the Adult Protection Committee

- The NHS Board with their local authority colleagues, including the Adult Protection Committee, should review their system for critical incident reviews to ensure it meets the recommendations of the 2013 HIS report. In relation to Mr JL they should, with their social work colleagues, ensure that a detailed action plan is in place and the implementation of this is reviewed and updated.

E. Healthcare Improvement Scotland

- Healthcare Improvement Scotland (HIS) should review "Learning from adverse events through reporting and review: A national framework for NHS Scotland" to take account of the national guidance on serious case reviews which is being developed by the Scottish Government. In particular, HIS should make reference to local authority responsibilities under Adult Support and Protection legislation and carry out its stated intention to integrate the management of adverse events across health and social care. Where the adverse event involves social care management or takes place in a social care setting a social work professional with experience relevant to the event being reviewed should be involved in the review.

F. Scottish Government

- The development of national guidance on serious case reviews for local authorities should make reference to Healthcare Improvement Scotland's "Learning from adverse events through reporting and review: A national framework for NHS Scotland" and consider the integration and coordination of these processes wherever possible.





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