Investigation into the care and treatment of Mr Q

mentalwelfare commission for scotland

Summary of investigation into the care and treatment of Mr Q

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Who we are

We are an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental health and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are service users or carers.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to ethical and lawful treatment and to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits his or her needs;
- Be enabled to lead as fulfilling a life as possible.

What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Background to our investigation

Mr Q is a 35 year old man with Asperger's Syndrome, normally resident with his parents, who was detained in hospital from July 2004 until April 2008. We undertook this investigation because we had some concerns about whether Mr Q's hospital based care and treatment was ethical, legal and in line with good professional practice.

We produced this report to help other services learn from the issues we identified in Mr Q's case and to help improve the care and treatment of people like Mr Q who experience Asperger's Syndrome or other Autistic Spectrum Disorders (ASD).

Problems with Mr Q's care and treatment were brought to our attention by Mr Q's mother, who consistently tried to raise these with the professionals and services who were providing Mr Q's care and treatment.

We also made recommendations to improve Mr Q's care on numerous occasions and met with a similar lack of responsiveness, particularly from local NHS services.

We think this case highlights the poor and inappropriate care and treatment received by someone with Asperger's Syndrome when placed in a non-specialist hospital facility, where little effort is made to access specialist advice and input. Our investigation reveals a lack of coherent joint planning which kept Mr Q in hospital for almost 4 years with little obvious benefit to him.

About Asperger's Syndrome

Asperger's Syndrome is a mental disorder that falls within the autistic spectrum.

People with Asperger's Syndrome will experience difficulties with:

- Social interaction e.g. inability to pick up social cues and successfully navigate social situations, often giving the appearance of being self-focused and lacking in empathy; difficulty in making and sustaining personal relationships;
- Social communication e.g. whilst having good language skills, there is often difficulty in grasping the underlying meaning of conversation, understanding gestures, facial expressions, jokes, idioms etc. This can lead to inappropriate behaviour;
- Thinking flexibly and in abstract ways e.g. inability to understand others' points of views, difficulty in imagining alternative outcomes to situations or predicting what will happen next, a tendency to pursue narrow, sometimes obsessive, interests.

Most people with Asperger's Syndrome need a highly structured, predictable environment and rely on others to create a sense of order in their lives.

Unpredictable situations and changes can cause the person considerable distress and the poor organisational skills that are associated with the disorder can cause further confusion and anxiety. The specific features of Asperger's Syndrome and ASD can present mainstream mental health services and learning disability services with considerable challenges.

About our investigation

The investigation team consisted of a Mental Welfare Commission social work and a nursing officer and our chief medical officer.

Our investigation was based on a comprehensive reading and analysis of all the relevant case record material from health and social work services involved in Mr Q's care between July 2004 and April 2008. We also reviewed our own casework records in relation to Mr Q.

About Mr Q

Mr Q is in his thirties and has always lived at home with his parents. He experienced developmental problems in his early years and in 1997 was diagnosed by Mr J, a clinical psychologist, as having a borderline IQ and Asperger's Syndrome.

Due to difficulties accessing day services Mr Q had a small package of care at home from 1997 onwards organised by the social work department (SWD) which increased to 12 hours per week in 2003. He also had input from forensic psychiatry, regular sessions from the clinical psychologist and speech and language therapist (SALT). His care was managed by regular Care Programme Approach (CPA) meetings.

Most of Mr Q's difficulties are in relation to social interaction. The stress and anxiety that can arise for him in unfamiliar situations – when things do not go as he predicts, when he misinterprets social cues, or he feels he does not fit in – can lead to angry and aggressive outbursts. Most of the time Mr Q presents as a pleasant, polite young man. However, a number of incidents have occurred over the years where he has assaulted others and made threats of extreme violence, some of a sexual nature.

From 1994 until 2004 these incidents averaged one a year. The most serious were an assault and attempt to strangle a nurse and later sending her threatening letters and secondly, in June 2002, attacking a doctor at the local mental health resource centre. Mr Q had been waiting for some time and was reportedly agitated because the routine was not as it had been previously. When the doctor called him in, Mr Q suddenly attacked her, punching her on the face and head and causing her severe injury.

In July 2004 Mr Q's mother said that he had reported having dreams which made him have 'bad thoughts' about harming the same doctor he assaulted in 2002. Mr Q then made a number of phone calls to the psychiatry department in the hospital where she worked, threatening to kill her. He also sent similar threatening emails. The police and relevant professionals were advised of these threats. Mr J, a clinical psychologist, visited Mr Q at home and was concerned at the change in his behaviour and mood, which he felt was more aggressive and menacing than he had previously seen. He was concerned that Mr Q posed a risk to other people, though did not consider the doctor herself to be at risk because Mr Q isolated himself in his home environment. Dr D, the forensic psychiatrist and a mental health officer (MHO) then carried out a home assessment on 14 July 2004 and, due to his mental state and the potential high risk to others, decided to detain Mr Q under Section 24 of the Mental Health (Scotland) Act 1984.

In order to manage the risk to the doctor who had returned to work in the local hospital NHS Board 1, Mr Q was admitted to an intensive psychiatric care unit (IPCU) in a neighbouring NHS Board area (NHS Board 2). Dr M who worked in this hospital took on the role of responsible medical officer (RMO). Mr Q was then detained under Section 26 of the 1984 Act and placed on constant observation.

What happened to Mr Q?

The first six months

Shortly after his admission Mr Q told staff that he was anxious and having 'bad thoughts' about two female nurses. He was started on medication and was nursed at the back of the ward, where there was a bedroom on its own. Female staff were to avoid contact with him. However a week later when a female nurse entered his room to change his bedding, Mr Q assaulted her by punching her in the face and head. Mr Q was placed on special observation with two male staff. Two referrals were made to the State Hospital who assessed him and decided that he did not require the level of security they provided.

Mr Q's care and treatment over the next six months remained largely unchanged.

- The nursing care plan was very basic and based on poor information about his needs. There was no systematic compilation of information from his family or the professionals who knew him about his communication, behavioural triggers or even his likes or dislikes.
- There was no risk assessment or risk management strategy to inform the nursing care plan.
- There was no written structured activity plan.
- The clinical psychologist continued to see Mr Q every three weeks, but did not appear to be regarded as part of the care team or to have much input into Mr Q's management on the ward.

- The speech and language therapist was not allowed access to Mr Q, as the RMO considered she would be at risk. The psychologist requested SALT input and assessed the therapist was not in the category of those at risk from Mr Q i.e. young females.
- CPA meetings were cancelled and social work indicated to the MWC that they would not be involved again until Mr Q was 'ready for discharge'.
- The support workers who had provided a service for Mr Q at home continued to see him twice a week. The funding for this came from the social work department but this was stopped on his admission. Mrs Q decided to continue to fund this herself, due to her concerns about her son's need for support in an unfamiliar environment, where staff were not accustomed or trained to care for someone with Asperger's Syndrome.
- Family visits took place with two staff present at all times.
- Mr Q spent large parts of the day confined to his room with a very limited period outside each day for exercise or in the activity room. His mother felt these restrictions were counterproductive, increased his anxiety and did little to distract Mr Q from sexual and obsessive thoughts.
- Ward staff did not access any training on Asperger's or ASD, though this would have been available from the SALT and the psychologist.

Mrs Q got in touch with us about some of the above concerns regarding her son's care and treatment and her difficulty in accessing the RMO to discuss these. We asked the RMO for a risk assessment and risk management plan which would demonstrate the need for the level of restriction. We also asked for a care plan to be provided. We asked for this in September, November, December 2004 and again in January 2005, with no response. In February 2005 we then asked the medical director of NHS Board 2 to ensure this was provided. This led to a response from the RMO about future plans, but no risk assessment or management plan.

In December the RMO agreed Mr Q could have more time out of his room and told Mrs Q on 8 December 2004 that he was referring him to Dr D, the forensic psychiatrist in NHS Board 1, for future planning. This referral was eventually received by Dr D on 26 January 2005.

The next year: 2005

Mr Q was detained for a further 6 months in February 2005. Mr Q alleged the RMO had not seen him in this process, as required by the 2003 Act. There was no documentation in the medical notes to support the RMO's statement that he had seen him.

Mrs Q continued to raise the same issues about her son's care and treatment and the lack of future planning with health, social work and with us. In April 2005 she decided to challenge her son's detention, saying he could be at home while alternative accommodation was considered. Her lawyer arranged for an independent social worker's report which was completed in April 2005. The independent social worker consulted all the relevant parties but noted that Dr M

had refused to respond, despite repeated attempts to contact him. She made the following points in her report:

- While Mr Q posed risks, particularly to young females, it was clear that he was inappropriately placed in an IPCU.
- Ward staff reported that there was no treatment plan for Mr Q and they were simply providing a secure setting until a suitable plan was formulated.
- There was a lack of any therapeutic input, except from the psychologist.
- Mr J had also reported difficulty engaging with Dr M and that offers to provide input to nursing staff on Mr Q's particular needs had been declined. In her opinion there was a lack of engagement with other professionals by the RMO.
- She strongly recommended a multi-agency case conference be convened to begin to make future plans.
- With all three of the possibilities for future care she identified (discharge home with a care package, a tenancy with a care package, or placement in a specialist residential unit), there was a requirement for a high level of supervision to minimise the risk to others. A full risk assessment was therefore required before proceeding with any care plan.
- Funding issues needed to be addressed.

During this period Mr Q's nursing care plan remained largely the same with 2:1 male staffing at the end of the ward. It was frequently recorded in nursing notes that Mr Q posed 'no management problem' and he was allowed home visits from April onwards. In September and October he was spending time in the main part of the ward with other patients and 'with female staff to some extent'.

Increased socialisation in the main area of the ward was added to Mr Q's care plan. However, following the clinical psychologist's advice on the need for strict guidelines if staff were to do this – and bearing in mind the risk he posed to young females – this was discontinued after ward staff discussion some weeks later.

Dr D, the forensic psychiatrist from NHS Board 1, did not pursue alternative arrangements for Mr Q until he received a referral from Dr M at the end of January 2005. In March 2005 Dr D began exploring the possibility of a new specialist ASD resource for Mr Q. He also initiated an HCR20 risk assessment, with the assistance of Mr J, clinical psychologist, and Professor O, a forensic clinical psychologist. We had contacted Dr D about this, the Independent Social Worker had noted this in her report and the residential unit which was being considered for Mr Q had also requested this. The HCR20 risk assessment covered Mr Q's impulsive, sexual and obsessive behaviours and set out possible management strategies for these. The document was circulated to the relevant professionals, though there was no record that the clinical team in the IPCU had discussed the HCR20 risk assessment, or changes in the nursing care plan that might be made in response to it. We continued to request a risk management plan for Mr Q's care on the ward that reflected the contents of the HCR20 risk assessment.

An application and risk assessment were sent to the residential unit in July 2005.

Dr D then contacted the local authority to discuss funding of the residential placement and was told that, as the social work department had not been involved in the assessment, or discussion on the appropriateness of the placement, they would not consider contributing to the funding. In October the residential unit said they were unable to provide the appropriate resources and skills to offer Mr Q a placement at that time.

Mr Q was allowed home for Christmas day. At that point he had been in hospital for a year and a half, there was no discharge plan in place and indeed no joint working between health and social work to progress this.

The next year: 2006

On the ward, the nursing care plan was reviewed in January 2006. It remained largely the same, although it did state that Mr Q was to have NO contact with female staff or patients. When we visited in February 2006, we noted there was some limited contact with female staff, though none with female patients. Many of the same issues remained, among them the lack of a structured activity plan and lack of staff training on ASD. We wrote to Dr M again, requesting a care plan including an explicit risk management plan and raising concerns about the lack of a written crisis plan, as Mr Q was now going home on an overnight pass fortnightly. We also highlighted the lack of any consent to treatment documentation. Again no satisfactory reply was received and we then contacted the Medical Director of NHS Board 2 to try to resolve issues with the RMO. Mrs Q had by this time involved her MSP, who met with managers in NHS Board 2.

The range of possibilities that were now being considered for Mr Q included a more secure option south of the border; a further approach to the ASD unit; a 24 hour supported tenancy; or a support package at home. Dr D arranged a meeting to discuss these options in January 2006. Social work were not invited to attend this meeting. Mr D corresponded with the Medical Director of the Mental Health Partnership in NHS Board 1, about community options, but Dr L made it clear she did not favour this idea.

Mrs Q's lawyer requested a Community Care Assessment (CCA) from the local authority in March 2006. In addition, the Independent Social Worker prepared a report for the Tribunal hearing. This outlined two community options of support at home, or in a tenancy and again commented on the urgent need for a multi-disciplinary case conference and joint planning between health and social work.

Dr M, the RMO, now favoured a community option and he too requested a CCA in May 2006. The Tribunal in May also made it clear they expected some cooperation, absent to date, between health and social work. A social worker was allocated in June 2006 to complete this assessment, which looked at the two community alternatives, subject to an updated risk assessment. The first multi-agency case conferences were held in June and August 2006 to progress plans and funding. This was two years after Mr Q's admission to the IPCU.

On 8 June 2006 patients in the IPCU were moved to another ward for about two weeks. As a result Mr Q was less isolated and was nursed in the main body of the ward, with

increased contact with patients and staff, both male and female. According to nursing notes this continued to some extent on the ward's return to the IPCU, though there was no documented change in the care plan at this stage. On 26 July the care plan was changed and specified that Mr Q was to be reintroduced to the main areas of the ward over the period 31 July to 18 August 2006, though the overall goal of 'NO contact with female patients and staff' remained.

On 21 August 2006 Mr Q assaulted a female staff nurse in the IPCU. As Mr Q was walking down the corridor, he saw the nurse talking to a male patient, lunged at her and punched her in the face, causing her to collapse. He was restrained on the floor by two nurses. The nurse required treatment in hospital for bruising and swelling to the side of her face and eye and had several teeth dislodged. Relevant parties were informed and it was decided that Mr Q should be nursed in his room on 2:1 observations. Mr Q was charged with assault.

Following this incident Mr Q was confined to his room, his clothes, personal belongings and drawers were removed, his curtains remained shut, his family visits were supervised and he was allowed 15 minutes on the patio once or twice a day. Towards the end of September there was some relaxation of these measures and Mr Q was allowed his radio in his room, mornings in the activity room and could see his family without staff supervision. Mrs Q voiced her concerns about the lack of adherence to the nursing care plan, contact with female staff and lack of training in ASD, which she felt had contributed to the incident. She was also unhappy about what she felt was punitive treatment of her son following the assault.

A further referral was made to the State Hospital and the psychiatrist recommended a medium secure unit in England. A doctor from that unit visited Mr Q and said he considered him suitable for their facility. Meanwhile, Mrs Q sought an independent medical opinion from a specialist in ASD from Wales. The Tribunal also requested an updated risk assessment, which Dr D had been preparing. The risk assessment was completed in December 2006 and again indicated the chronic risk of intermittent impulsive violence, despite periods of apparent improvement. He reiterated the need to control Mr Q's environment and support and advised a referral to a 'specialised ASD unit'.

The next year: 2007

Mr Q remained on 2:1 observation at the end of the ward. His family continued to have unsupervised visits twice a day. The support agency continued to visit twice a week. Their visits were supervised, though Mrs Q had requested otherwise and this had been refused by Dr M. The OT who attended the ward also spent time with Mr Q in activities. He now had access to the activities room most of the day and three hours in the evening, except when other patients wanted to use the room. At the end of January he was allowed time on the patio for 15 minutes twice a day for outdoor exercise. Mr Q's weight had increased by a stone and a half since his admission. The psychologist continued to visit every three weeks.

Four tribunal hearings to consider Mrs Q's appeal against her son's detention in hospital were scheduled in January and February 2007. In addition to all the documentation that was provided, evidence was heard from Mrs Q (named person), Dr M (RMO NHS Board 2), Mr J (clinical psychologist), Dr D (psychiatrist in forensic services NHS Board 1), Dr C (consultant in forensic psychiatry at the State Hospital), Professor B (independent psychiatrist in learning disability), Mr G (social worker), the ward manager, Mr Q's advocacy worker and the MHO as the applicant. Differing views were expressed to the Tribunal; with Mrs Q, Mr J and Professor B largely supporting an intensive home based community package.

The Tribunal decided firstly to refuse Mrs Q's appeal to revoke the CTO and secondly that Mr Q should be transferred to the medium secure unit in England. Mrs Q decided to appeal the Tribunal's decision to the Sheriff Principal, on the grounds that evidence had not been heard from Dr K. She also argued that exploration of the medium secure unit option had not been scrutinised to the same degree as the other options. Any move was therefore put on hold.

On 7 March 2007 Mrs Q sent a formal complaint about her son's care and treatment to the Complaints Manager in NHS Board 2, with copies to Dr L, Medical Director of the Mental Health Partnership NHS Board 1, Ms N, the General Manager Adult Mental Health NHS Board 2, the Medical Director Psychiatry NHS Health Board 2, her MSP, the Commission, and the RMO who was acting in Dr M's temporary absence. The complaint covered nine areas:

- punitive treatment of Mr Q since the assault;
- the inaccuracy of historical recording;
- the incident in August 2006 and lack of adherence to the risk assessment of June 2005;
- the citation to appear in court;
- the management of his care in particular the lack of visits from his RMO and his long periods of isolation;
- the lack of autism specific input in terms of training for staff;
- the lack acknowledgement of Mr J's input by the RMO prior to January 2006, despite his years of work with Mr Q;
- Dr C's visit and report; and
- the emotional and financial costs to the family.

The General Manager of Adult Mental Health in NHS Board 2 was asked to investigate and co-ordinate a response to these complaints. Although there were informal discussions with Mrs Q about her complaints, she had not received a formal response by the time Mr Q was discharged.

We again asked to see the risk assessment that informed Mr Q's current care on the ward. Dr M replied that he clinically assessed Mr Q as requiring 2:1 staffing and there were no plans for him to be given time at home.

In June 2007 the Medical Director of Mental Health Partnership NHS Board 1 became more involved in trying to move the situation forward for Mr Q. At a meeting of NHS managers it was decided to look at longer term community options, perhaps with support from the learning disability forensic

service, rather than pursue the medium secure unit originally proposed. The reason given was that 'the clinical circumstances had changed'. It had also become apparent that the medium secure unit had limited experience in dealing with people with Asperger's. The possibility of an interim move to another ward was discussed, medication was to be reviewed, home visits were to be restarted and training for staff was to be taken forward by Mr J.

On 30 August 2007, the Sheriff Principal upheld Mrs Q's appeal and the Tribunal was required to reconsider the options for Mr Q's care and treatment.

It appeared that the more active involvement of the Medical Director NHS Board 1 moved the situation forward. In July 2007 Dr M agreed to home passes of 8 hours on a weekly basis, with Mrs Q acting as escort. There was initially no written risk assessment, management plan or crisis plan for these home visits. At the end of September 2007 Dr M agreed a crisis plan with Mrs Q for home visits, which was then included in the nursing care plan.

In September 2007 a meeting was held between Dr L, Medical Director NHS Board 1 and Ms F, Fieldwork Operations Manager in the Social Work Department. Social work felt they were not able to give a view on a return home without a risk assessment. They also requested that the Criminal Justice Service Manager was involved in any risk assessment group. The In Patient Services Manager in NHS Board 2 was also tasked with arranging multi-disciplinary meetings to look further at the community options for Mr Q.

In October 2007 Dr M asked three forensic consultants to report their views on a community based option for Mr Q. One of these, Dr A, agreed to meet the patient with the forensic psychologist, CPN and OT from his team to consider this. This led to him chairing a risk assessment meeting of the health and social work professionals in January 2008.

In November 2007, the first multi-disciplinary meeting of health and social work staff was convened by the In Patient Services Manager. Notes suggest that it concentrated on issues relating to Mr Q's care on the ward, rather than joint planning for future care. The action points were that ward staff should receive training on ASD, Mr Q's medical notes relating to his physical health should be sought, and his cholesterol should be checked (this was originally requested by Mrs Q in December 2004).

The next year: 2008

On 31January 2008 Dr A chaired a clinical risk assessment meeting, attended by the relevant professionals from health and social work. The discussion focussed on a community option and the key elements that would be required to successfully manage the risks around that. The physical requirements of a tenancy were considered. The need for 24 hour support with two male workers, replicating the hospital situation, plus other clinical and social work support, the need for training for staff and funding were also discussed. It was thought that this package could possibly take almost a year to set up. Overall, Dr A was in favour of 'fleshing out the care plan and then looking at it from a risk perspective rather than updating the risk

assessment at this stage'. Social work later expressed some concern following this meeting as to whether it had focussed on planning for a community placement, rather than being a risk assessment group, and whether social work's views were adequately reflected.

The Tribunal again heard evidence in December 2007, January 2008 and March 2008 from all the previous parties and again competing views were expressed. Dr C still supported a medium secure unit, Dr A and Dr M supported eventual discharge to a very restricted community based setting – described as 'a one person hospital'. The social worker and the MHO did not support discharge at this point; Professor B, the independent psychiatrist from Wales, supported discharge to the community, following a period of planning; Mr J felt Mr Q could have been discharged in December 2005 and still broadly supported this with the right package of care; Mrs Q supported discharge home, with the interim package of care she had proposed to the Tribunal. She offered to fund this herself until social work allocated funding.

The Tribunal decided to vary the order, removing the requirement for detention in hospital, for a period of 28 days. However they asked Mrs Q to ensure that her son remained in the IPCU on a voluntary basis except for his weekends at home, to allow time for the social work department to carry out a community care assessment and for the RMO to amend the care plan. The Tribunal convener expressed his lack of confidence in the social work department providing a package of care in terms of timescale or funding. The next hearing date was set for April 2008. As both the RMO and MHO felt it was impossible under the terms of the law, to have Mr Q in such a restricted environment on a voluntary basis, he was therefore detained on a short term detention certificate on 12 March 2008.

A meeting was convened by Dr A on 2 April 2008 to consider Mr Q's future care but both the social worker and MHO were unable to attend. On 7 April 2008, the Tribunal decided to vary the CTO to a community based order and Mr Q returned home with the interim package of care that his mother had proposed.

Events since discharge

Mr Q is currently supported at home by family members and a 35 hour per week care package, with restrictions on his leaving the house. In the initial stages the package was managed and funded by Mrs Q, but is now jointly managed by Mrs Q and the social work department. Funding is provided by the social work department and the Independent Living Fund. Mr Q was allocated to a new social worker in July 2008.

Mr Q is supported by a community psychiatric nurse, a psychologist, speech and language therapist, MHO and forensic consultant psychiatrist from the community forensic team.

Care is managed by the CPA involving professionals from health and social work. Mr Q's risk management plan and care plan are regularly updated.

The Council appealed the Tribunal's decision to the Sheriff Principal and hearings took place on 14 July 2008 and 15 July 2008. The Sheriff did not uphold the Council's appeal and the CTO was extended in August 2008 for a further year.

Mrs Q submitted an application for welfare guardianship. The MHO and forensic consultant psychiatrist did not support this application on the grounds that there was a more appropriate piece of legislation in place for managing some aspects of Mr Q's care. Dr M's opinion was also included in the application. Mrs Q made a formal complaint about this to NHS Board 1, due to the outstanding complaints about his role in Mr Q's care and treatment. The guardianship order was granted.

The charge of assault has been dropped by the Court.

To date, there have been no incidents of concern since Mr Q was discharged.

Summary of key findings

A number of factors adversely affected the quality of Mr Q's care during his admission, these may have contributed to some of the significant events during his time in hospital and could have contributed to his extended stay in the IPCU. These factors included the lack of an appropriate therapeutic environment and care regime for someone with his diagnosis, the lack of joint working between health and social work and poor communication between professionals involved in his care, the quality of risk assessment and management on the ward and the standard of some of the documentation.

Care and treatment in hospital

- We found little evidence that the clinical team actively considered how they could provide a therapeutic environment and a care regime suited to someone with ASD.
- There was no systematic collation of the detailed information, available from Mr Q's family, or professionals previously involved in his care that would have informed a comprehensive nursing care plan.
- There was no risk assessment and management plan or behaviour management plan for his day to day care, despite our repeated requests. The detailed risk assessment (HCR20) completed in June 2005 did not appear to have been discussed by the ward team, or to have influenced Mr Q's nursing care plan.
- There was no activity timetable or written daily programme to provide important structure and predictability to Mr Q's day.

- There was no specialist ASD input into Mr Q's care. The only ASD specialist involved was Mr Q's clinical psychologist. The psychologist's knowledge and skills were not accessed by the ward team, who did not regard him as part of the care team. They did not access any training on ASD until December 2007, two and a half years after Mr Q's admission.
- Contact with female patients and staff was not properly managed, despite identified chronic risk. What was specified in his care plan was often inconsistent with actual nursing practice on the ward.
- For almost four years Mr Q was largely confined to living in two rooms at the end of an IPCU with limited access to outdoor space. Following the assaults his regime was more restricted. Given the lack of any records to set out the reasons and necessity for this, and the lack of appropriate Specified Person documentation under Section 286, we have some sympathy with Mrs Q's interpretation that this was more for punitive than clinical reasons.

The role of psychiatrists

- Mr Q and Mrs Q reported difficulties in communicating with the RMO. This was echoed in the experience of other professionals involved in Mr Q's care. Documented contact between Mr Q and his RMO was also limited.
- We found no evidence that the RMO had seen Mr Q prior to the extension of his compulsory treatment order. Good practice would dictate that the RMO should document when he has seen a patient to consider extension of detention.
- Until shortly before March 2006 the RMO was prescribing medication for Mr Q without knowing the reasons for the treatments. He thought these were for the treatment of physical disorders (epilepsy and cardiovascular problems), when they were actually for mental disorders (mood and anxiety).
- It was not clear from the outset who in Mr Q's home NHS Board was responsible for monitoring the placement and liaison with the RMO in NHS Board 2 regarding future care plans.
- A cholesterol check requested in December 2004 did not take place until January 2008.

Other services

- Mr Q did not appear to have a designated MHO for eight months of his detention. Section 32(1) requires a local authority to appoint a sufficient number of persons to discharge the functions of Act, the Criminal Procedure (Scotland) Act 1995 and the Adults with Incapacity Act (Scotland) 2000.
- Despite considerable social work involvement prior to his admission, social work were not involved in Mr Q's care for almost two years after his admission. It is not clear why such a complex case had been closed when it was likely to require multi-disciplinary planning and joint funding.
- When asked to part fund Mr Q's residential placement in a specialist ASD unit, the fieldwork manager did not even consider looking at the NHS assessment of the placement, but simply refused to support it.

Joint working

- Despite the need for a multi-disciplinary forum to coordinate input across all responsible organisations, CPA meetings stopped when Mr Q was admitted. No other mechanism for joint working and planning was put in place. Although discussion of discharge planning began in January 2005, CPA meetings did not restart.

Having a regular pattern of multi-agency meetings would have minimised the difficulties and delays that resulted in trying to bring a considerable number of professionals together on an ad hoc basis. The absence of a regular multi-agency forum for discussion and planning meant there was no mechanism to resolve the conflict of opinion and work towards some consensus on the way forward.

- The lack of cooperation and communication between health and social work over the first two years had a significant impact on discharge planning for Mr Q. Social work contact with him ceased abruptly from admission until June 2006. Health, particularly NHS Board 1 as the lead authority, failed on a number of occasions to involve social work in key planning discussions.

Risk assessment and management

- Mr Q was initially placed on constant observation. When he expressed his anxieties about having feelings towards female staff, he was moved to a bedroom at the end of the corridor, away from the main body of the ward. The decision on the observation level and restriction to the end of the ward was largely the extent of the risk management in Mr Q's case.
- After the second assault, Mr Q was initially nursed in his room with limited access to other areas, activities, outside space and unsupervised time with his family. Positive means of minimising risk such as increased understanding of his communication needs, or a written activity timetable were not evident.
- Despite our repeated requests for a thorough risk assessment which would inform the risk management plan on the ward, Sainsbury Risk Assessment and Management tools were only partially completed by nursing staff. These seemed to be used to confirm observation levels rather than to identify specific risk management strategies.
- Despite his specialist knowledge of ASD and long therapeutic relationship with Mr Q, the psychologist was not involved by the clinical team in any structured discussion or assessment of risk.
- A HCR20 risk assessment was not compiled until a year after Mr Q's admission. It was a comprehensive and useful document for future planning. It could also have informed Mr Q's day to day care but we found no evidence that

it influenced his care and treatment on the ward. Had the management strategies discussed in the HCR20 been embedded in the nursing care plan, and had staff adhered to the stipulation in the January 2006 nursing care plan that there should be NO contact with females, there may have been less likelihood of the second assault occurring.

Documentation

- Medical records were inconsistent. Some senior house officers (SHOs) made regular entries, others did not. It was not always clear from both RMO and SHO entries whether Mr Q had been interviewed or not. The recording of examination for detention was inadequate and should have been clearly documented. Consent to treatment authorisation was not completed until March 2006 and should have been completed in September 2004 under the legal requirements of the Mental Health (Scotland) Act 1984. Documentation relating to Section 286 (Safety and Security in Hospital) was not completed.
- Records of clinical ward meetings were poor. Significant events were sometimes documented in nursing notes, sometimes in medical notes, sometimes in ward meeting records and sometimes not at all. For example the change of ward would have been a potentially difficult transition for someone with ASD. However there was no documentation of any discussion about how this would be managed.
- Nursing care plans were poor in content for someone with such complex needs. Core elements of the care plan were completed on standardised forms and were not individualised in any way. A meaningful care plan for someone with ASD to address issues such as communication, anxiety, potential aggression would have involved gathering and recording specific and detailed information to develop clear guidance and protocols on interventions.
- There were minimal changes in the nursing care plan during the three years nine months that Mr Q was an inpatient. It might have been expected that his care plan would have developed substantially as staff expanded their knowledge and experience of him, or when the HCR20 risk assessment was completed and gave additional insight into his behaviour and management strategies.
- The nursing care plan was not always kept up to date or alternatively was not adhered to. Of particular concern was the change in care from the 8 June 2006 when Mr Q was to be nursed alongside other patients during the decanting of the ward and on his return to the IPCU. This change was not documented in the nursing care plan until the 26 July 2006. Whilst it then said he was to be integrated into the body of the ward, the care plan still stated that he should have no contact with female staff or patients.
- The critical incident report on the second assault in August 2006 failed to examine the adequacy or adherence to the nursing care plan, the management of risk and the contribution this made to the likelihood of the incident occurring.

- Some historical inaccuracies were repeated from one report to another.
- Social work case notes were relatively detailed and kept up to date. However there was no closure summary, or reason for closure in the social work notes following Mr Q's hospital admission. Similarly there was no explanation in the case notes for the lack of MHO involvement between August 2005 and June 2006.
- We found some excellent reports in the files. The social circumstances report prepared by the MHO following Mr Q's admission provides a very detailed record of his background and the significant events leading up to his detention. The HCR20 risk assessment provides good information and analysis of the risks and the management of these. Reports by the clinical psychologist used in the compilation and updating of the risk assessment very clearly sets out his observations and professional opinion on Mr Q's communication, behaviour and the risks posed. This information did not, however, seem to influence Mr Q's care plan.

Use of Appropriate Adult Scheme

- Mr Q was charged by police for the first assault without the involvement of an appropriate adult. This seems to be contrary to guidance on 'Interviewing People who are Mentally Disordered: Appropriate Adult Schemes' 1998, updated in 'Guidance on Appropriate Adult Services in Scotland November 2007'.
- People with Asperger's Syndrome tend to be very suggestible, compliant and courteous, quick to confess and justify their actions. They may lack understanding of the significance of what they have done, describe events without emotion or remorse, and may present as more able, giving expectations of social competence they do not have. The availability of an appropriate adult with the relevant experience in ASD is therefore important to aid police understanding of the disorder and the most effective approach to interview.
- There was confusion on a number of occasions as to whether Mr Q was required to appear in court in relation to the second assault charge. This caused him considerable anxiety as the dates for court hearings approached. Consideration did not seem to be given to any specific arrangements that might be necessary for him as a vulnerable adult – preparatory visits to court, familiarity with the proceedings, the possibility of a supporter or appropriate adult in court etc.

The role of the MWC

- We repeatedly requested care plans, risk assessments and risk management plans from Mr Q's RMO. These requests were on many occasions ignored or responded to superficially. Whilst an HCR20 risk assessment was completed almost a year after his admission and updated in December 2005, there was still no effective management plan on the ward informed by these assessments, despite our interventions.
- We raised matters with the Medical and Clinical Directors of NHS Board 2 on three occasions (February 2005, February 2006 and April 2006) and this brought some response from the RMO, but never the specific documentation and plans requested.
- Our concerns about other aspects of Mr Q's care such as the lack of a structured activity plan and the lack of specialist training and support on ASD for staff were only actioned when the Medical Director of the Mental Health Partnership in NHS Board 1 became more involved from June 2007 onwards.
- On reflection, we could have escalated issues to the managers of NHS Board 1 and NHS Board 2 at an earlier stage, rather than simply repeating our requests to the RMO.

Recommendations

The Royal College of Psychiatrists published a report on psychiatric services for adolescents and adults with Asperger's Syndrome and other Autistic Spectrum Disorders in April 2006. It highlights the shortfall in service provision, particularly for Asperger's Syndrome and makes a number of recommendations that we consider relevant to Mr Q's situation:

1. Individuals with Asperger's should have access to expertise across a broad range of therapeutic approaches, There should be specific planning and investment to enable services to absorb this patient group and /or the development of specialist tertiary services.
2. Each NHS Board should have a specialist who has specific responsibility for advising on treatment options for adults with ASD. In most NHS Boards, where people with a learning disability or young people with mental health problems are placed inappropriately in an acute ward, specialist input is arranged from learning disability or children and adolescent mental health services. A similar notification or alert system could ensure specialist advice and treatments are delivered to those with Asperger's placed in non-specialised settings.
3. Psychiatric training should include experience in the diagnosis, assessment and management of individuals with ASD and in particular there should be some supervised experience with adults of normal cognitive ability who have ASD. This may also be relevant to the content of mental health nurse training.

4. For those with ASD who become involved with the legal process, psychiatric services should recognise the impact of ASD on responsibility, mental capacity, fitness to plead and ability to bear witness, encourage awareness and provision for ASD in court processes and develop appropriate interventions and therapies in forensic settings.

In addition to the recommendations set out in the College's guidance and in light of specific findings in relation to Mr Q NHS Boards should:

1. Look at how to address the shortfall in specialist hospital provision for those with Asperger's Syndrome.
2. Review all those with Asperger's Syndrome who are placed in non-specialist hospital facilities to ensure they are receiving treatment appropriate to their needs. This should include auditing nursing care plans to ensure risk assessments have been completed where appropriate, that they are properly documented and that risk management strategies reflect these assessments and are incorporated in these plans. Where patients are on periods of suspension of detention, this should have been risk assessed, written crisis plans should be clear and appropriate care considered to support carers.
3. When patients are placed out with their own NHS Board, a consultant from their home NHS Board who has responsibility for monitoring that placement, liaising with the RMO and for future planning should be clearly identified. Whilst this may seem self evident, it is the our experience that this is not always the case. The patient and carer should be aware who has this role and if it is transferred to another consultant.
4. Review the need for in service training on Asperger's Syndrome and ASD to acute and forensic sectors both for trained and support staff.
5. Where patients are subject to restrictive measures, ensure reasons for each of these are documented in clinical notes, the appropriate legal documentation is completed and patients and named persons are advised of their rights to request a review of the measures.
6. Issue guidance to medical staff to ensure it is evident from case notes when a patient has been interviewed and when their mental state has been reviewed, particularly with regard to extension of detention.
7. Ensure consent to treatment authorisation required under Part 16 of the Mental Health (Care & Treatment) (Scotland) Act 2003 is completed and is up to date.

8. Ensure adherence to the minimal standards for physical health screening for longer term patients, as set out in Delivering for Mental Health.
9. Provide structured daily activity plans for patients with ASD and ensure staff are aware of the importance of these and adherence to them.
10. Review the robustness of clinical supervision when issues arise with regard to the clinical practice of medical and nursing staff.
11. Review critical incident review procedures with regard to the guidance on the conduct of reviews as set out in the Mental Health Reference Group document on Risk Management (October 2000).

The social work department should…

1. Review the need for continuing involvement on the patient's admission to hospital, where cases are complex and involve multi-agency input and/or have been managed through the CPA. Where it is likely that joint planning, input and funding may be required for discharge, we consider it good practice for social work to remain involved.
2. Where the decision is that input is no longer required, ensure the reasons for closure of cases are evident in case files.
3. Ensure all those subject to the 2003 Act have a designated MHO as required by the law.

The NHS Board and social work department should…

1. Review joint working protocols where service users have complex needs, have been managed jointly by the CPA and are likely to require a multi-agency approach on discharge. Mechanisms should be in place for regular multi-agency reviews during hospital admission.
2. Ensure there is a dispute resolution protocol in place between health and social work.
3. Ensure significant facts are checked to prevent inaccuracies being repeated from one report to another.

The Police should…

1. Consider the use of an appropriate adult with understanding of Asperger's Syndrome or ASD when charging or interviewing a vulnerable adult with these disabilities.
2. With partner agencies examine the functioning of the Appropriate Adult Scheme, particularly in respect of the availability and training of appropriate adults. They should audit and ensure the pool of appropriate adults include the knowledge and skills to respond to adults with ASD who are referred to the service.

Other…

1. The Mental Welfare Commission should review its escalation policy and ensure it applies to all aspects of its work.
2. The Postgraduate Medical Education and Training Board and the Royal College of Psychiatrists should review current input on Asperger's Syndrome to psychiatrists' training.
3. The Nursing and Midwifery Council UK and Scottish universities should review the input to the training of registered mental health nurses (RMNs).

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