Investigation into the care and treatment of Ms L

Findings and recommendations

2008

Contents

Who we are

The Mental Welfare Commission is 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 illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

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 treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the best care and treatment that best suits her or his needs; and
- 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.

Our investigative role

Section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 authorises the Mental Welfare Commission to carry out investigations and make recommendations about the care and treatment of people who have a mental disorder. The Commission may investigate any situation where the person appears to have been improperly detained or suffered abuse, neglect or deficiency of care and treatment.

Section 1: The context in which the investigation was undertaken

1.1 Introduction

1.1.1This MWC investigation was instigated following reports of a number of incidents involving Ms L, a young woman with a severe learning disability and severe challenging behaviour, in an independent hospital providing assessment and treatment for people with a learning disability (Unit X). The final incident, where Ms L was apparently bitten by a fellow resident overnight, resulted in a Vulnerable Adults Case Conference being called. Ms L had already been assessed as ready to move on and a place identified for her to go to. This move was therefore brought forward by about 2 weeks.

1.1.2 All serious incidents involving people with a mental disorder should be reported to the Mental Welfare Commission. Guidance has been issued to statutory and voluntary/independent care providers regarding the circumstances in which the Commission would expect to receive a report. Providers registered with Care Commission are also required to inform them of incidents involving people in their care. At the time the incidents involving Ms L were reported to the Mental Welfare Commission, the Care Commission had expressed significant concerns about the unit and had issued an enforcement notice. We were concerned about the number of incidents which appeared not to have been reported to us, the quality of the organisation's critical incident review process, including the lack of detail there appeared to be in those reports we received, and the apparent lack of any changes being put in place as a result of the incidents being reviewed.

1.1.3 A report was therefore submitted to the Commission's Investigations and Inquiries Group where it was agreed that a more detailed investigation into the care and treatment of Ms L and Mr T (the other party) was required.

1.2 Our investigation team

1.2.1 The investigation team consisted of Mrs Margo Fyfe, Nursing Officer, Dr Ros Lyall, Chief Medical Officer, Mrs Susan Tait, Commission Officer and Mrs Carol Dobson, Part Time Commissioner.

1.3 Terms of reference

1.3.1 The investigation was directed to address the following issues:

a. All relevant aspects of the care and treatment of Ms L leading to her admission as an informal patient to the assessment and treatment resource in August 2002 and all relevant aspects of her care and treatment there until she left in February 2006
b. All relevant aspects of the care and treatment of Mr T, the alleged perpetrator of the assault on Ms L, since his admission in July 2003.

c. To identify any lessons which might be learned for the care and treatment of other patients in the resource and also for the care and treatment of patients with similar needs elsewhere in Scotland
d. To examine how planning for the future care of Ms L was affected by the strategic planning of services for people with a learning disability and high support needs in local authority A.

1.4 Method of undertaking the investigation

1.4.1 All the notes pertaining to Ms. L were requested from Unit X as were her Social Work and Health notes from local authority A and NHS Board A. Mr T's notes were also requested from Unit X.

1.4.2 Following a review of all the relevant material a draft Statement of Facts was prepared and sent to the relevant local authority, NHS Board and Unit X for comment. All parties accepted the statement as an accurate account.

Section 2: Statement of Facts

2.1 Background and initial placement in Unit X

2.1.1 Ms L is a 23 yr old young woman with severe learning disabilities, challenging behaviour, cerebral palsy and possible autism. She originates from the North of Scotland and spent most of her adolescence in a children's home as a voluntary "looked after" child as her parents were unable to manage her.

2.1.2 Ms L displays severe challenging behaviour. She has been involved in incidents where it is recorded that she hit people, bit them, pulled their hair and threw objects at them. She has also displayed self injurious behaviour.

2.1.3 Discussions regarding her future placement on leaving school began in 1999. She was referred to the Adult Community Learning Disability Team in February/March 2000 and a SW allocated to her case. Prior to this, Ms L's mother had visited a number of potential resources as she was keen that Ms L should remain within the local area.

2.1.4 During 2000/2001 a number of referrals were made to providers of residential care for people with learning disabilities in local authority A. Her mother's preference was for Ms L to move to Resource A, a new resource which was due to open locally in 2002, and to attend Centre B for day care.

2.1.5 A period of assessment was arranged at Resource A but after a series of introductory visits, they declined to accept Ms L as her behaviour was seen as too disruptive. A referral to Resource D was also made but it was not thought to be an appropriate resource.

2.1.6 As there were now no resources within local authority A which could provide the care and treatment she was assessed as needing, Ms L, was referred to Unit X, an independent hospital in another NHS Board and local authority area. This referral was agreed as appropriate by the Health Board and local authority and was jointly funded.

2.1.7 Following referral she was assessed by the staff from the hospital, who felt she would be appropriate for an assessment admission. This would last for up to 12 weeks and there would then be a case conference to discuss whether her continued placement at Unit X would be suitable.

2.1.8 Prior to her admission to Unit X she had been seen on a number of occasions by local psychiatric services for people with a learning disability and had been prescribed antipsychotic medication.

2.1.9 On admission to Unit X on 22nd August 2002, as an informal patient, she was taking Olanzapine at a dose of 10mg daily and was prescribed Chlorpromazine and Lorazepam in small doses on an "as required" basis.

2.1.10 She was placed on "red" observations (a term used in Unit X as part of their observation procedures) where 2 members of staff observe all those residents in one place who are on this level of observation.

2.1.11 A first case conference was held in October and it was agreed that Ms L's placement at Unit X should continue as long as it was effective. This was further reinforced at a subsequent case conference in December 2002.

2.2 Progress in Unit X

2.2.1 Her initial assessment and treatment plan consisted of observation of her behaviours and a planned reduction in olanzapine which was stopped by December 2002 with no adverse effects. Her behaviour continued to be variable and was managed by a combination of redirection and, when required, physical restraint.

2.2.2 During the first year of her admission, Ms L was physically restrained on 51 occasions. These episodes were in response to Ms L trying to bite/hit/pull hair of other residents or staff or linked to incidents of self-injurious behaviour.

2.2.3 A Clinical Psychologist attempted to assess Ms L's level of intellectual functioning but no meaningful results could be obtained. The Clinical Psychologist appeared not to have made any attempt to provide a wider assessment of her challenging behaviour to assist staff and thus assessment of her behaviour was largely nursing based. This was done using the "Research and Development in Psychiatry Social Functioning

profile" which is a standard assessment used by Unit X. Management strategies included a Positive Incentive scheme and "Active Management" of any challenging behaviour.

2.2.4 Local authority A Social Work Department and representatives from NHS Board A were involved in a number of case conferences and planning meetings throughout Ms L's stay in Unit X. These happened at approximately 6 monthly intervals.

2.2.5 In November 2003, a request was made by local authority A Social Work Department for a "service specification" to be completed for Ms L in order to inform their planning for her return. It was recognised that she would require a specialist resource and that it would take time to plan as there were no existing suitable resources. In the meantime, application was made for her to have her own tenancy and she was placed on a Housing Association waiting list in May 2004.

2.2.6 The following years (2004 – February 2006) saw a significant reduction in the number of incidents requiring physical restraint. By this time Ms L was largely responding to verbal prompts and redirection and to the structure provided by Unit X. There were still issues with unforeseen circumstances which might arise and concerns as to how she might respond. Trips out of Unit X were very limited as a result as she required at least 3 members of staff with her at all times.

2.2.7 Discretionary medication (as required medication) for managing challenging behaviour was rarely used. This was in accordance with her mother's wishes in respect of Ms L and also reflected the policy of Unit X. Latterly, her mother also stated that she did not wish physical restraint to be used with Ms L at any time. It was not clear what legal authority staff believed Ms L's mother had in respect of these issues as she did not, at that point, have any powers under the Adults with Incapacity Act and had no authority under Mental Health legislation.

2.2.8 In total, we counted that Ms L was involved in 426 incidents during her stay:

- Incidents directed at other patients:188
- Incidents directed at staff:100
- Other incidents of challenging behaviour:41
- Self injury:48
- Incidents where Ms L is the victim:49

2.2.9 By July 2005, a planning and review meeting attended by her parents, the consultant psychiatrist responsible for Ms L, staff from Unit X and representatives from local authority A concluded that Ms L's placement at Unit X was no longer necessary or appropriate. It does not appear that the representative from local authority A had care management responsibilities for Ms L. As the reason for referral had been for assessment and treatment, the psychiatrist felt that she "had now

reached a plateau" and her challenging behaviour was at a manageable level. However, it was noted that her case was no longer allocated within local authority A Social Work Department and this would have to be remedied. It is not clear for how long a period Ms L's case had not been allocated to a care manager within local authority A. A Person Centred Plan was prepared by her key worker in Unit X

2.2.10 An assessment by Speech and Language Therapy was carried out in 2005 following the planning meeting in order to inform her future support needs.

2.2.11 In September 2005, concern was expressed by her consultant that Ms L was being targeted by a specific individual in Unit X as she had been bitten 4 times over a period of a month and it was requested that they be kept apart and be well supervised.

2.2.12 By early February 2006 it was reported that Ms L was to go to Resource C in and her discharge date had been set as 4th/5th March 2006. A social worker had finally been allocated and her parents were making an application for guardianship. However, it was also clear that there were significant concerns on the part of clinical staff in NHS Board A who felt that the placement was totally unsuitable for Ms L.

2.2.13 On the evening of 13th February 2006 it was noted that Ms L had three serious bite marks on her upper arm and shoulder. These had been noted in the morning and a body map completed but no mention is made in the nursing notes until the evening. It was not known how these had occurred although it was thought to have happened overnight. Ms L was able to indicate that the incident happened in her bedroom. The police became involved as her mother raised the possibility of sexual assault although there was no evidence to suggest that this had happened. Her level of observation was increased although there were concerns that Ms L would regard this as a "punishment". Ms L then went home on 17th February for a week's (previously planned) holiday.

2.2.14 Following these events, an urgent case conference was called under the Vulnerable Adults guidelines and chaired by the local Social Work Department. At a subsequent meeting attended by her mother, social worker and advocate along with representatives of Unit X it was agreed that Ms L would not return to Unit X but would take up her place at Resource C earlier than intended.

2.2.15 Investigations carried out by Unit X found that there were no faults in the nurse call system on Ms L's door which would have alerted staff to the door being opened. Other sources of evidence refer to the system not working properly some 48 hours later. They concluded that Mr T, the resident who had previously bitten Ms L was the most likely perpetrator but there was no firm evidence to confirm this. Ms L was noted to be happy in his company and showing no signs of distress. She continued to display

infrequent episodes of challenging behaviour, pulling other residents' hair, attempting to bite and hit herself.

2.3 Mr T

2.3.1 Mr T was admitted to Unit X in 2003. He is a young man with severe learning disabilities and autism with severe challenging behaviour. He often spends a large part of his day in very little clothing and displays similar behavioural patterns to Ms L.

2.3.2 During the period when they were in Unit X together, there were 7 incidents where Mr T hit or bit Ms L and 5 or 6 where Ms L bit or hit him. On at least two occasions where Ms L was bitten it was recorded that this was in retaliation for her having previously hit him.

2.3.3 In the days before the incident where Ms L was bitten, it was reported that Mr T had been out of his room at night and had been found in the laundry. There was no recorded evidence of him being found in any other resident's bedroom.

2.3.4 It is also clear from the incident reports that a number of other patients were also the subject of attacks by Ms L, and were equally involved in attacking her. As can be seen from the breakdown of figures above there were also a significant number of incidents directed at staff. The majority of the incidents in which Ms L is the perpetrator involved her biting or attempting to bite, hitting or pulling hair. The notes made reference to the difficulties of disentangling her when she was pulling someone else's hair.

Section 3: Analysis of problem areas

3.1 General comments and findings on good practice

3.1.1 Ms L was a person with learning disability who presented significant challenges tom carers. In several settings, she appeared to behave aggressively, placing others at risk but also placing herself at risk from retaliation. Unit X was identified as a resource that would be able to manage the problematic behaviours that Ms L displayed.

3.1.2 Ms L lacked capacity to make decisions about the care, treatment and support she should receive. From examining her care, we thought that attempts to intervene usually accorded with the principles of the Adults with Incapacity (Scotland) Act 2000. Staff did their best to act for Ms L's benefit and tried their best to minimise restriction on freedom by only intervening to restrain her when absolutely necessary. In accordance with her mother's wishes, the use of medication was kept to a minimum.

3.1.3 In our experience, Ms L's difficulties are not uncommon and are very difficult to manage. Our findings and recommendations should be read in the light of this. While we have some criticisms of policy and procedures in unit X, we think that any care service would have found Ms L very difficult to manage. Our report is intended to help unit X improve the care of people with learning disability and challenging behaviour and will be of interest to other services trying to help people with major care needs and behaviours that make the provision of care difficult.

3.2 Individual Risk Assessment and Management.

3.2.1 A "physical intervention risk assessment" appears to have been carried out in 2004. This was neither dated nor signed and was accompanied by a number of "Identified Risks-Action Plans" again from 2004 and 2005. The level of detail contained in them suggests that staff did not really understand their function. However, they do refer to the need for Ms L to be supervised at all times to protect other residents and also for her own protection. The assessment stated on the back page- "*It is the responsibility of the key worker to ensure that all staff are aware of this document. It is the responsibility of all staff to sign to indicate they understand and agree to the findings and strategies of Company X Physical Intervention Risk Assessments"*. The assessment was not signed and dated although there was a note that it had been discussed with two other staff members. There was a further, undated and unsigned copy with some handwritten amendments. As these were the only documents relevant to risk assessment found in the notes, it is clear that review and reassessment had not been carried out in a structured way on a regular basis.

3.2.2 The volume of documentation to be completed by staff was huge and it is clear that most of it was not used to inform any care plan. Often it was

only partially completed, undated, unsigned and not subsequently reviewed. We received four ring binders of documentation to cover the time of Ms L's stay of 3½ years, two of which were nothing but incident reports and body maps. There were some missing case conference minutes between 2003 and 2006 and duplicate copies of other minutes.

3.2.3 There is a general trend in all services, whether they are statutory or independent, to have significant amounts of documentation to complete. Whilst this is intended to provide a better assessment of an individual, if they are not fully completed, not reviewed regularly and not used to inform a person centred care and/or treatment plan then their utility is significantly reduced. In our opinion, the volume of documentation produced does not equate to good and effective care and treatment and in many cases, including this, is counterproductive and leads to poor care. Completing the mountains of documents also removes staff from their front line responsibilities.

3.2.4 Involvement from Clinical Psychology and Speech and Language therapy was only evident on an ad hoc basis, on a couple of occasions from Speech and Language and once from Clinical Psychology with a very cursory report in the latter case. Whilst nursing staff and medical staff may be skilled in the management of people with learning disabilities and challenging behaviour, there are specific and relevant skills only available from these professions. In our opinion, the lack of involvement on a regular basis from staff with this expertise is concerning in a facility which is meant to be for assessment and treatment.

3.2.5 We concluded that, despite the large volumes of clinical information, there was a lack of clarity over actions to reduce the risk to Ms L and to other people

3.2.6 As noted above we could find no evidence that care plans or risk assessments were amended as a result of discussions with medical staff. We noted the request for a member of staff to be placed outside Ms L's room following the overnight incident appeared to have been countermanded by the unit manager as being unnecessary. Management plans were not reviewed, and it is not clearly documented when decisions about observation status were made, nor is it clear who was or should have been involved in the decision making process.

3.2.7 Unit X has a policy on observation. This states that "*all changes of observation category can only be made following a review held by at least three Senior Staff"* and, *"a Review of Observation Category form must be completed at each review and one copy put in the resident's file and a second filed sequentially in the Observation Category File".* We found no evidence in the case notes we received of formal reviews of observation and no copies of the appropriate forms.

3.2.8 Observation is carried out in groups, Red, Yellow and Green. Those in the Red group "must have constant 1:1 supervision in an area specified

by the Nurse in Charge". This is implemented by having all those on "Red" observations placed in the same area with a number of staff providing observation. There is no requirement for a member of staff to be assigned to one resident only.

3.2.9 We have serious concerns about this practice. It does not comply with best practice guidelines (*NHS Scotland Clinical Research and Audit Group "Engaging People" Observation of people with acute mental health problems: A good practice statement. (2002) The Stationary Office)***.** This guidance is adopted throughout NHS Scotland. Heightened observation categories require one identified member of staff to keep the person within sight and sound at all times (constant observation) or, if the risk is very high, within arm's length at all times (special observation). Failure to adhere to this guidance increases clinical risk and may lead to misunderstandings with NHS Boards and Local Authorities over the type of observation that is provided.

3.2.10 In addition, we believe that there is an inherent risk in placing a number of people with significantly problematic behaviour in close proximity to each other. From examining Ms L's care, we are not convinced that the number of staff available was sufficient to safeguard Ms L and others in this situation.

3.3 Policies and Procedures regarding Adverse Incidents

3.3.1 From reviewing the notes, the identification and recording of incidents was carried out albeit with a lack of detail. A few incidents were not reported and were only documented in the nursing notes.

3.3.2 The majority of incidents were reported by staff using incident report forms. These document the type of incident, the response by staff and, in some cases, comments about the possible antecedents. There were different versions of the form in use throughout Ms L's stay. Where physical intervention is required to manage the incident the form in use from May 2004 runs to 9 pages and includes body maps etc. In addition there are statements from staff involved in the incidents.

3.3.3 The information contained on the forms varied in both quantity and quality. On many occasions it appeared that not all relevant or mandatory parts of the form had been completed. There was frequently no evidence that a manager had been informed. Although it was evident from the forms that many had subsequently been seen by a senior member of staff, often the consultant psychiatrist, there was no clarity about what happened as a result of the incident being noted.

3.3.4 The medical notes recorded when the incidents were discussed with the consultant and what changes were to be made to the care plans, if any, as a result of the incidents. We could find no evidence that the incidents were discussed at multidisciplinary meetings involving other professionals such as speech and language therapists or clinical

psychologists or at periodic case reviews where information over a period of time was discussed. We could not find evidence that care plans were amended as a result of the discussions with the consultant or any evidence that any change to her management plan was considered. There was no clear documentation regarding her observation status in either nursing or medical notes and, until the last incidents, no suggestion that she was targeting anyone or that she was being targeted herself by an individual. Changes to care plans or requests for specific monitoring required by the consultant were often not implemented or only implemented after a further request.

3.3.5 We could find no evidence that the incident report forms were reviewed on a regular basis by any local or company wide group. We were advised that the forms are all seen by a governance committee located at the company's headquarters, but there is nothing on the form to say that this is the case, no indication as to whom the form is to be sent to and no sense that the information in the form is there for any other purpose than merely to comply with policy The completion of the forms appears to take place in a vacuum.

3.4 Deprivation of Liberty

3.4.1 Deprivation of liberty, whether intended or unintended, is a significant infringement of an individual's human rights. There are many ways in which an individual may be deprived of their liberty; being unable to leave of their own free will because a door is locked is an obvious example, being restrained either by the use of physical interventions from staff or the use of medication are others. For people with a learning disability who require support in activities of daily living, the fact that they can only safely go out with a member of staff, who may not be available to assist immediately, may lead to unintended deprivation of liberty.

3.4.2 For people with mental disorder, there are criteria under which they can lawfully be deprived of their liberty and treated against their will. The legislation which permits this contains important safeguards, particularly in relation to a right of appeal. This is the case for both the Mental Health (Care and Treatment) (Scotland) Act 2003 and The Adults with Incapacity Act 2000.

3.4.3 In 2004 the European Court of Human Rights issued an important ruling in the case of HLvUK. The "Bournewood judgement", as it became known, made it clear that incapable people who were "detained" informally in care settings, whether they be health or social care settings, where there were significant restrictions on his or her freedom, were held there unlawfully because there was no mechanism for review of and appeal against their position. In other words, there should be legal safeguards for all circumstances where an adult is deprived of liberty.

3.4.4 Unit X is a secure environment in so far as the entrance to the unit is locked. It is clear that staff would not have allowed Ms L to leave the unit

had she wished. On all occasions outside Unit X she was accompanied by at least 2 members of staff.

3.4.5 Unit X has a policy in on restraint. This has not been updated to reflect changes in Scottish mental health legislation since 2005. Physical restraint of Ms L involving floor restraint was documented on 65 occasions, the remainder recorded as holding hands. Records which just reported "restraint" were counted as floor restraint. As noted above, these mostly occurred in the first year of her admission (51 occasions). The incidents were largely in response to her attempting to bite/hit/pull hair of other residents or staff or linked to incidents of self injurious behaviour. This amounts to once a week.

3.4.6 Physical restraint was part of the management plan to minimise the impact of her challenging behaviour. There is no evidence in any of the notes reviewed of any discussion regarding possible use of mental health legislation such as detention under the Mental Health (Scotland) Act 1984 or the subsequent 2003 act.

3.4.7 In effect, Ms L was detained in Unit X, but was not subject to any legal order which authorised her detention or her physical restraint. Although the incidence of physical restraint reduced significantly in 2004/5, she was still subject to detention without any legal authority.

3.4.8 We believe that where physical restraint is a part of the care plan in a hospital or care setting in which it is anticipated it will be required on a recurring basis there should be consideration of the legal safeguards necessary for the patient and the staff.

3.4.9 The Mental Welfare Commission have previously issued guidance – **Rights Risks and Limits to Freedom**, which will provide assistance in determining whether a particular situation requires legal authority to allow the use of physical restraint and the restriction of liberty. The Commission will also be producing specific guidance on issues relevant to Deprivation of Liberty which will also be of help in these and similar circumstances. **Mental Welfare Commission for Scotland (2006) *Rights, Risks and limits to freedom* MWC Edinburgh.**

3.5 Communication and Continuing Involvement of Local Authority A and Health Board A

3.5.1 There is a general lack of communication with the family and with local authority A with regard to the incidents. However it is not clear what the threshold had been agreed for reporting incidents to either the family or the local authority. There are minutes of case conferences which record the satisfaction of the family with the amount of communication and others which indicate that all is not well. There is no mention, in the notes that we have seen, of local authority A expressing concern until the last series of incidents. At one point the notes record that Ms L's mother "wishes a monthly resume of how Ms L has been and not too much attention to the

detail of incidents. She continued to request a weekly phone call from Ms L". This suggests there was some ambiguity on the family's part regarding the amount and content of communication and that agreed arrangements within Unit X for communication with Ms L's family were not clearly documented and known to all staff. However, the issue of communication with the family remained a major area of concern noted in some case conference minutes although others clearly state the Ms L's parents were happy with the amount of contact. The Care Commission have already investigated the issue of communication contained in a complaint from Ms L's parents following the incidents in November 05/February 06 and have upheld the complaint. We endorse the legal requirements they made and see no need to repeat them in this report.

3.5.2 Case conferences and planning meetings are recorded as happening at approximately 6 monthly intervals although there is not always documentation to support this. Meetings appeared to alternate between local authority A and Unit X. Where we had minutes of these meetings, Social Work representation appeared consistent, if only at planning and commissioning level, but the "planning" meetings, held in local authority A had only key worker representation from Unit X. On one occasion they involve local specialist medical staff (Doctor B). Case Conferences (with the exception of the first one) at Unit X do not appear to be attended by any representatives from NHS Board A.

3.6 Strategic Planning and the Provision of Resources in Region A

3.6.1 As a looked after child, Ms L was known to services. Discussions regarding her future placement started in 1999 and a referral made to the Community Learning Disability Team in February/March 2000. A Social Worker was allocated to her case.

3.6.2 Planning for her future placement on leaving school had preceded this with Ms L's mother being to visit a number of options. In 2000/2001 a number of referrals were made to providers in local authority A.

3.6.3 Ms L's mother clearly wanted her to remain within a reasonable distance of home, this added to the difficulties in finding a suitable resource. She had decided that she wished Ms L to move to Resource A, a new resource for young people with Learning Disability due to open in 2002, and to attend the Centre B for day care. However, Resource A declined to accept Ms L after a series of introductory visits as they felt her behaviour was too disruptive.

3.6.4 It is clear from the medical notes relating to Ms L prior to her transfer, that health professionals believed that she could not be managed in any existing resource and that an "out of area" placement was the only option.

3.6.5 During her placement in Unit X, planning for her move back to local authority A began in 2003 although it was clear from the medical notes and from case conference minutes that the local NHS psychiatrist, Dr B, was, like his predecessors, seriously concerned about the advisability of her transfer to local resources as he felt there were none available that could meet her needs. He continued to express concerns up to her eventual transfer to Resource C.

3.6.6 Given the nature of Ms L's challenging behaviour, finding a resource for her would have been difficult. For a population the size of local authority A one would expect fewer than a dozen people with her level of challenging behaviour as displayed at Unit X. Providing a specialist service and maintaining the expertise required would be very difficult. Such services require a large pool of experienced and trained staff, with regular input from a multidisciplinary team and are inevitably expensive. Challenging behaviour requiring such input is refractory and long term management and not short term treatment is usually required. Staff often experience "burnout", particularly in circumstances where improvements are small and infrequent and consistency of management is crucial.

3.6.7 Services provided for people with learning disabilities, in particular those with additional complex needs such as challenging behaviour, must be sustainable and provide a quality of care and treatment for a long period of time. The Mental Welfare Commission has found, in its recent visits to all Assessment and Treatment services for people with learning disabilities, that there are many people in these services who now require long term care and support, not assessment and treatment. They are however unable to be discharged because there are no suitable resources available with the skills and expertise to provide appropriate care and support. This results in people who do require assessment and treatment being unable to access the service and run the risk of being placed in inappropriate settings such as general psychiatric wards or referred to specialist facilities elsewhere, often in England.

3.6.8 Following her departure from Unit X, Ms L returned to a local resource where her behaviour was such that she was unable to remain there and had to be transferred to an alternative. She is now awaiting a place in a specialist resource in the North of England. This demonstrates a lack of suitable resources in Scotland.

4. Summary of key findings

4.1 Although unit X has a process for risk assessment for physical interventions, we found no evidence that the staff used this is a constructive, ongoing way to manage the risks that Ms L's behaviour posed to herself and others.

4.2 The large volume of documentation available to us regarding Ms L provided scant evidence of a systematic approach to management of challenging behaviour.

4.3 Unit X's policy on clinical observation is significantly inconsistent with best practice guidance in Scotland. Apparent high levels of observation may have given a false impression of the availability of members of staff to prevent harm to Ms L and others.

4.4 When adverse incidents occurred, there was usually a report on a standard form. However, the quality of these reports was variable and we could find no evidence that they resulted in any reconsideration in how Ms L's care was managed. Our impression was that reports of this type were not collected, analysed and reported in order to improve risk management in the unit.

4.5 Ms L was subject to frequent, predictable episodes of physical restraint to prevent injury to herself and others. While we accept that restraint was needed, we consider that she was significantly deprived of her liberty as a result. In our opinion, she should have been detained under mental health legislation. Deprivation of liberty did not take place in accordance with procedures prescribed by law and was therefore, in our opinion, in breach of human rights legislation.

4.6 There were gaps in communication between unit X and others. Ms L's relatives were not always informed of significant events and ongoing communication with the local authority responsible for Ms L was patchy. The Care Commission has already made legal requirements as a result of the lack of information to relatives.

4.7 There is a group of people with learning disability who present ongoing challenges to carers. The nature and complexity of challenging behaviours that people like Ms L display require skilful assessment and management. We are not convinced that national policy takes account of the special needs of people like Ms L.

4.8 Although we have some criticisms of aspects of Ms L's care, we found that staff made strenuous efforts to do their best for her and much of her care accorded with principles of intervention for adults who lack capacity.

5. Recommendations

Recommendations to Unit X

5.1 Unit X must reassess its processes for identifying and managing clinical risk. This should address training in risk assessment and management, multi-professional input to risk assessment and improvements to documentation on interventions to reduce risk.

5.2 Unit X must review policies on observation and ensure that they comply with national guidelines.

5.3 Unit X should conduct a full examination of its governance of adverse incident reporting. This should address thresholds for incident reporting, examination of patterns and trends, feedback to staff and procedures for implementing action needed to reduce risk locally and across the organisation. Documentation on reporting of incidents may need to be amended as a result.

5.4 Unit X should, from time to time, audit completion of incident reports to ensure that appropriate information is captured and shared with the Care Commission and the Mental Welfare Commission.

5.5 Unit X must review their policy on restraint with regard to the status of patients where care plans include the regular or planned use of physical restraint or other measures which may lead to a deprivation of liberty.

Recommendation to Unit X, Local Authority A and Health Board A

5.6 Local authority A, NHS Board A and Unit X should ensure that there is appropriate and ongoing input at all case conferences and planning meetings for people who are placed out of area. There should always be a representative from the local authority who is carrying care management responsibilities for the case. This recommendation is also applicable to all local authorities and NHS Boards who place people out of area.

Recommendation to the Care Commission

5.7 We note that the Care Commission had issued previous enforcement notices in 2006 to Unit X which addresses 4 of our 5 recommendations. The Care Commission should continue to review the service in respect of these recommendations

Recommendation to the Scottish Government

5.8 In continuing to implement “The Same as You?” the Scottish Government should review the need for regional or national planning to support people with learning disability whose needs for care and support are not presently being met on a local basis.