mentalwelfare commission for scotland

dignity & rights ethical tre respect ca & equality

INVESTIGATION ON

The care and treatment of Mr S

Contents

Our aim

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

Why we do this

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

Who we are

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

Our values

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

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

What we do

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

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

Introduction

The Mental Welfare Commission for Scotland has a general safeguarding role for individuals with mental illness, learning disability and related conditions. We have the authority to investigate under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003 if there may have been deficiency of care and treatment.

Mr S had been diagnosed with a mild learning disability early in his life. Until he was 29 years old he lived in hospital. He was discharged in 1992 to a supported tenancy.

He first came to the attention of the criminal justice system in 2009 when he accrued several charges for public disturbances.

Over a one-year period, Mr S was reported to the police on around 130 occasions because of his behaviour at a local supermarket. He was reported to be annoying customers and staff, shouting and swearing. Latterly, he was reported to have been touching women in sexually inappropriate ways.

Mr S was remanded to prison in June 2011. At the time he had been supported in the community by health and social care services. In July 2011 the sheriff presiding over Mr S's case contacted the Commission to relay his concerns that Mr S was again being remanded to prison instead of being admitted to hospital. He was clear that, in his view, prison was inappropriate.

Following the contact from the sheriff, the Commission took immediate action to bring this matter to the attention of the local authority and NHS Board.

As a result, Mr S was remanded to hospital at the earliest possible opportunity in order that he could receive necessary care and treatment. This resulted in good care and rehabilitation. He was given appropriate community accommodation in a different area and, at the time of writing this report, has a good quality of life and has not reoffended.

We were particularly concerned to hear that the risk that he would offend was well known but that services could not agree on how to prevent this. This left Mr S and others at significant risk. We considered it highly inappropriate that he was sent to prison, even for a short period. After we were satisfied that Mr S was receiving appropriate care and treatment, we were informed that NHS and local authority services would review the circumstances that had led to this inappropriate situation.

This report is a combination of the findings and recommendations of the internal review and the views of the Mental Welfare Commission on this distressing case.

Methodology

We received a reflective review of the care and treatment of Mr S in March 2012. The NHS Board and local authority submitted a final report to us in October 2012.

When we received the final report, we met relevant staff from the NHS Board and the local authority. The meeting examined events prior to Mr S's imprisonment, discussed the recommendations from the internal review and reflected on wider learning encompassing how the situation could have been more appropriately handled to Mr S's benefit.

We are grateful to the practitioners and managers from the NHS Board and local authority for working with us to produce this report. We are confident that the services have learned from this case.

Our purpose in publishing this report is to draw attention to the possibility that, across Scotland, individuals with learning disability may be imprisoned inappropriately when they need care and treatment to prevent them from committing offences.

Background information

Mr S is a 49-year-old man diagnosed with a learning disability. Most of his early life was spent in institutional care. At age 29 he moved out to live in a community setting, supported by health and social care services. He had been noted throughout his life to present some challenging behaviours but had no contact with forensic services or the justice system until November 2009.

Since moving to the community Mr S had a longstanding friendship with a female co-resident with whom he spent most of his free time. It is noted that he and his friend spent some recreational time with staff members from their local supermarket. Following his friend's death in July 2008, Mr S's relationships with staff at the store changed.

His behaviour deteriorated following these important life events and he was presenting problems within his accommodation and the local community. These behaviour changes resulted in several arrests in 2009 and his eventual imprisonment in 2011.

Throughout this time of difficulty staff supported him, and the police interacted with him on the basis of mild learning disability. While his level of learning disability was questioned, it was not properly reviewed until he came into contact with forensic services following his arrest in January 2011.

His level of disability was reviewed by psychology and speech and language therapy services in April/May 2011 and reassessed as moderate/severe. This would have had a significant impact on his ability to understand what was happening and to understand why his behaviour was causing so many problems.

Chronology of events

The NHS Board and local authority provided a timeline of events from January 2008 to August 2011. This detailed interaction between agencies, support provided to Mr S by health and social care services and the life events which impacted on his behaviours. It also detailed his contact with the police and court appearances, including forensic service contact.

This is summarised as follows.

January to December 2009

Mr S's medication was increased in January as there was an increase in his anxiety and preoccupation with his physical health issues. This appeared to be beneficial. In the first half of the year, Mr S had enjoyed a holiday to Spain. However, his anxiety and physical health preoccupations increased as a visit to his brother, at his request, was being considered.

He was seen regularly by the specialty doctor[1] but was not seen by the consultant psychiatrist until September 2009. He had begun to go out at night to the local supermarket and police and support workers had been involved in removing him from the store. The local authority held a community care review in October but did not address Mr S going out at night.

In November his practice of going out at night to the supermarket increased. A home visit was carried out by healthcare staff and his medication increased to help alleviate anxiety and disturbed sleep. At this point Mr S was regularly being returned home from the supermarket by police, who subsequently made an adult protection referral.

The local authority held a vulnerable adults case discussion in December, including the police. An action plan was then put in place to support Mr S and involved advising local businesses on how to interact more appropriately and consistently with Mr S.

January to December 2010

Police made another adult protection referral in February as there had been no change to Mr S's behaviour since the previous referral in November 2009. An adult protection case discussion was held in March and a decision to assess his capacity taken. Following assessment he was deemed to lack capacity to make decisions about medication, welfare or finances. There does not seem to have been any further action taken regarding this information at that time.

In the meantime, his visits to the supermarket at night continued and in May police threatened to detain him in a secure location. Care staff asked for a psychiatrist to review him. Mr S was seen by the health care co-ordinator but no change to his management was proposed.

At a further adult protection case conference held on 1 June, which the specialty doctor could not attend, the expectation was placed on Mr S that he would stay home at night. Mr S apparently cancelled his psychiatry appointment in June but attended his next out-patient appointment in July. There was noted to be no change in Mr S visiting the supermarket at night, despite being barred from the store due to his inappropriate behaviour toward some staff members. His medication was increased. Mr S agreed to changes in his care plan in July.

[1] A specialty doctor is neither a consultant nor a trainee: he/she will have had four years' postgraduate training, two of which must be in a relevant specialty and will work under the supervision of a consultant. The amount of supervision will vary according to the experience of the specialty doctor.

Until December he managed to comply with changes and had no police contact. However, on 6 December police notified the local authority that Mr S had been arrested and charged with breach of the peace and assault. It was recorded that extensive discussions among all agencies had shown that he "is well aware of his actions, can manipulate people and, in layman's terms, is not as innocent as he appears". He was seen by a psychiatrist, his medication increased and he was referred to the forensic practitioner.

January to December 2011

Mr S was arrested on 4 January and charged with breach of the peace. He was held overnight in prison. He appeared in court on 5 January.

Throughout January there were interagency meetings involving the local authority, health board and the police. Disagreements between NHS and local authority services were highlighted but no action was taken to move these forward.

A forensic practitioner saw Mr S during January and queried the level of his learning disability. Mr S had further court appearances due to breaching bail conditions. Health practitioners clearly stated the view that Mr S was not fit to plead in court but did not require hospital admission.

Towards the end of February his court appearance was again postponed due to lack of reports. A multidisciplinary meeting at the end of February made a referral to speech and language therapy and to psychology, but did not produce any further solutions to Mr S's situation. In the meantime an interim guardianship order was granted to the local authority on 7 March.

In early March, Mr S was noted to display behaviour problems and be refusing medication. A forensic psychiatry report at the end of March highlighted differences of opinion between NHS and local authority services. It recommended a hospital admission and also queried the level of Mr S's learning disability.

At his court appearance on 29 March, the sheriff agreed that Mr S should be admitted to hospital and set a date in April for an examination of the facts. At the beginning of April a welfare guardianship order was granted for three years.

In mid April the forensic practitioner highlighted his belief that Mr S was less able than he appeared. It was agreed to establish a multidisciplinary core group of senior staff, including the Consultant Psychiatrist (who had not been at previous meetings), from all agencies involved with Mr S. On 18 April the court acquitted him on the grounds that he could not understand what he had done wrong.

Mr S went directly to the supermarket on discharge from court. The case was, however, continued to allow the local authority to put plans in place. Care provision was increased for Mr S, but with little change to his actions.

Clinical psychology and speech and language therapy confirmed Mr S had a learning disability of a moderate to severe level. Recommendations regarding managing Mr S in light of the new information about his level of ability and comprehension were made by psychiatry to the core group in early May.

Planning meetings were held in June and the sheriff was informed of the support plan for Mr S in early June.

On 28 June the police requested the presence of an appropriate adult as Mr S was to be charged with indecent assault. In court the case was continued to allow the sheriff to contact NHS services regarding an admission decision. Mr S was subsequently remanded to prison. The sheriff contacted the Mental Welfare Commission to raise concerns about Mr S's situation.

As a result the Commission immediately raised concerns with the NHS Board and local authority officers. A new consultant psychiatrist was allocated the case and examinations and reports produced.

Based on information from the reports, the sheriff placed Mr S on a treatment order and he was admitted to hospital on 14 July. Planning meetings followed thereafter and he was discharged to supported accommodation in a different area.

Findings from the internal review

We agreed with the conclusions of the internal review. It identified the following problems within and between services attempting to provide Mr S with care and treatment:

1) **Deficiencies in robust assessment, planning and review meant that Mr S ended up inappropriately in the criminal justice system.**

   Opportunities to intervene were not taken due to lack of agreement between key agencies. There was an assumption that staff who knew Mr S well were familiar with his capabilities and knew how to assist him.

   Looking back, it was clear that this was not true. His needs were not properly met and risks were not properly understood.

2) **The services missed a number of opportunities to intervene over a significant period of time.**

   While it was good that staff knew Mr S and each other well, this led to responsibilities being blurred. They minimised the risk. This was especially evident in December 2010 and January 2011. Information from the police and a request from the Sheriff led to an adult protection case conference on 5 January.

   Agencies disagreed on short-to medium-term plans for Mr S (local authority staff thought he should be in hospital but NHS staff did not agree). This ultimately led to his imprisonment.

3) **There was poor interagency working to resolve the disagreement over his care. This included a failure to escalate concerns within the NHS and local authority.**

   There was an inability to find a compromise within the multiagency team. There was also a lack of awareness of a need to escalate concerns and a lack of process for doing so.

   Of particular concern to the local authority was that the Chief Social Work Officer, named as welfare guardian (but with functions delegated to social work staff) was unaware of the situation.

4) **Management of the care within the NHS was largely left to a specialty doctor (not a consultant psychiatrist) who was left to make major decisions about interagency working.**

   The review highlighted a lack of supervision for the specialty doctor and a need for stronger direction and leadership from social work managers to resolve disagreements.

5) **Agencies had separate risk management plans. There was a failure to implement a robust interagency risk management plan.**

   There were failures in communication and follow-up of recommendations from multiagency meetings. There was lack of clarity over what individual or agency was allocated the task of implementing decisions and recommendations from meetings.

The conclusions and recommendations of the internal review

The review team identified that escalating problems with Mr S's care and treatment began in September 2008. These problems appeared to be closely linked to the death of his longstanding friend in July 2008. Good person-centred practice was found on an individual basis from frontline staff and links between services were positive and ongoing. However, the coordination of care was not as rigorous as it could have been. This resulted in a failure to take an overview of Mr S's increasing level of need. This meant that individual good practice did not have the impact that it might otherwise have had.

Mr S seemed to consider many support staff and other professionals in his life to be friends. This may have caused confusion for him when it came to the use of authority to address behaviours which were or were not acceptable.

Some staff blurred professional boundaries. They thought they could help on the basis of their good relationship with Mr S but this approach did not work. The fact that Mr S viewed care workers as friends may have minimised staff's views of the risks from his behaviours.

The recommendations

Assessment and planning:

- To issue guidance to clinical staff that ensures regular ongoing assessment of patient/client capacity and level of functioning and to be attentive to the use of appropriate terminology, particularly where diagnosis is required.
- To review current multiagency risk management planning across social and healthcare settings and ensure training in risk assessment and management takes place regularly.
- To review the leadership and coordination provided by senior officers within the health and social care teams involved in the care and treatment of Mr S.
- To ensure staff are aware of the need for early escalation of serious disagreements in inter-agency care planning, particularly where it impacts or will significantly impact on service user outcome.

Communication

- To evidence the use of medical supervision of junior doctors within mental health and learning disability services.
- To review the need for additional guidance on requirements for chairing and recording adult protection case discussions and conferences and implementing their decisions.
- To further develop the use of the supervision tool within the locality and then across the social work service.
- To clarify the types, remits and membership of inter-agency meetings regarding support planning, serious risk and public protection and to review governance regarding how decisions are implemented. These should be simplified and coordinated.

Legislation

- To provide written guidance for social work staff which makes clear the role and responsibilities of the Chief Social Work Officer as welfare guardian for all local authority guardianship cases.
- To review the need for further training on the appropriate application of incapacity, adult protection and mental health legislation for relevant staff.

Discussion among Commission, NHS and local authority managers and practitioners

We met to discuss the internal review. We all agreed that the services had learned from this case. Both agencies had changed practice to address the failings identified in the review.

Everyone acknowledged that, throughout the contact with Mr S, frontline staff had worked well with him. However, we also agreed there had been a clear feeling that knowing Mr S very well may have led to false assumptions about his abilities and actions.

There was a recognition that historical assessments were perhaps not robust and should have been reviewed and reassessed. An assessment from a practitioner not previously involved with Mr S would have ensured a more objective view.

There was recognition of the benefits of having a full and clear historical and current risk assessment to give a whole picture. While acknowledging that everyone wanted the best for Mr S, practitioners did not step back and examine the "whole picture", giving due consideration to past and present circumstances that would show a need for reassessment. This also needed to take account of wider society and possible stigma attached to Mr S as a result of his behaviour.

Changes to practice in this area

We were pleased to hear that many practices have improved as a result of Mr S's case.

- Adult protection procedures now ensure that all individuals have current and up-to-date assessments.
- NHS supervision practices for specialty doctors have improved in order to identify difficult issues at an earlier stage.
- The local authority has a new escalation policy and process in place and all staff have been made aware of this.
- A joint approach to risk assessment across services is in place.
- There is now a clear expectation that issues around restraint and possible deprivation of liberty will be discussed quickly at higher levels.
- Locality planning groups are identified as the place for raising difficult cases for health and social work practitioners and managers. The group has been exploring how to progress situations when there is an impasse.
- Local authority managers are in discussions with the police about highlighting vulnerable people and families to ensure better joined-up working between agencies.
- There are intentions to examine fully historical and current issues when behaviour changes arise.

Conclusion and recommendations

Mr S had been supported by health and social care services for most of his life in institutional and community care settings. He has a moderate to severe learning disability. His lack of understanding of the inappropriateness of his behaviour led to him being charged with indecent assault.

Services supporting him failed to recognise that he did not understand the importance of what they were saying and failed to properly reassess him when he initially presented with behaviour that was out of character. Nobody checked whether he actually understood that what he was doing was wrong or that he understood why he should not go to the supermarket.

This was compounded by a rigid adherence to hospital admission criteria which, although understandable when having to manage a limited resource, took no account of the need to be flexible on occasions. Staff supporting Mr S directly were doing their best with the information they had to hand but did not ask for help from senior colleagues when they could not achieve the outcome they thought necessary.

The Commission recognises the efforts made to improve interagency working in general and in particular in moving forward in supporting Mr S. We are pleased to note the changes to supporting staff through robust supervision.

We were concerned that agencies, although stuck in their approach to offering appropriate intervention and support to Mr S, took no steps to rectify this situation. We would encourage the use of mediation as early as possible when an impasse to agreed solutions is recognised.

While local services have addressed many of the deficiencies that led to Mr S being inappropriately sent to prison, we consider that there are wider lessons to be learned across all NHS and local authority services. These are:

1) **NHS and local authority services should ensure that they have robust arrangements in place to manage and resolve interagency disagreements.**

2) **NHS and social work managers must ensure that there are appropriate supervision arrangements for staff. This must include processes for identifying and raising concerns about individual cases.**

3) **It needs to be recognised that individuals with learning disability who have long-term care and support needs will change over time. Care plan reviews should include reassessment of intellectual and adaptive ability when people present with a change in behaviour.**

Finally, as Mr S now has a criminal record that could have been avoided, the Mental Welfare Commission recommends that the NHS Board and the local authority involved in supporting and caring for Mr S make a formal apology to him.


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