MENTAL WELFARE COMMISSION
FOR SCOTLAND

REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF MR J

SEPTEMBER 2002

CONTENTS

1.1 Brief Background

1.1.1 Mr J was born on 18.08.26 in India. He speaks Punjabi and moved to Pakistan in 1947. He worked in Pakistan as a farm labourer and received little or no formal education. He was married, but his wife died in the 1970s. They had four children.

1.1.2 The family moved to live in England in the 1950s and they resided with Mr J's brother and extended family. During 1993 he moved to Scotland to live with his son. Although Mr J had had contact with the psychiatric services before, in 1989, it was following this move that Mr J's difficult behaviour again came to the attention of Health and Social Services.

1.1.3 Mr J's first psychiatric admission was to Hospital 1 on 25 January 1989. His next contact with the hospital was on 7 December 1993. His admission was because of his wanderings and aggressive behaviour. He was transferred to Hospital 2 on 4 February 1994 and then for a short time to a residential home for older people on 8 June 1994. He was returned to Hospital 2 on 9 September 1994 when the residential home placement broke down. He was then readmitted to Hospital 2 and remained a patient there until his discharge on 21 February 2001.

1.1.4 On 9 August 2000 the Mental Welfare Commission for Scotland carried out a hospital visit to Hospital 2. A Medical Officer from the Commission interviewed Mr J. This interview was carried out with the assistance of Mrs X from the local authority Interpreting Service. During the interview Mr J described a "head injury" he had suffered many years ago and was not sure why he was in hospital. The Medical Officer identified several areas of concern regarding Mr J's care and corresponded with his Responsible Medical Officer (Dr D).

The concerns raised with the RMO were as follows:

(1) Mr J's diagnosis

(2) Whether a formal assessment of his mental health state had been carried out

(3) Communication issues

(4) Cultural needs

(5) Care planning/assessment

(6) Institutionalisation

1.1.5 The Commission made initial enquiries with the RMO and others about these matters. After consideration of the information gathered it was decided at the February 2001 meeting of the Commission to undertake a formal Inquiry

under the Commission's Deficiency in Care and Treatment Inquiry procedures.

1.1.6 Following the Commission's decision to institute an Inquiry, Mr J was discharged from Hospital 2 into the care of his brother in London on 21 February 2001.

1.2 Terms of Reference

1.2.1 At a meeting on 5 February 2001 of the Full Commission it was decided to set up a Deficiency in Care Inquiry into the care and treatment of Mr J under Section 3(2) of the Mental Health (Scotland) Act 1984.

1.2.2 The Commission gave the Inquiry Team the remit to enquire into the care and treatment of Mr J from the time of his admission to Hospital 2 on 4 February 1994 to his discharge on 21 February 2001.

1.2.3 The Inquiry was directed to address itself, amongst other relevant issues, to the following questions:

(1) Did Mr J receive adequate assessment, care and treatment?

(2) Was adequate use of translating services made by medical and social work staff to facilitate appropriate assessment, care planning and regular reviews?

(3) Were adequate resources made available for Mr J to provide an appropriate quality of life in hospital and to prepare him for possible discharge?

1.3 Inquiry Team

Reverend Canon Joe Morrow
Commissioner (Part-time), Mental Welfare Commission
Chair of the Inquiry

Professor Juliet Cheetham
Social Work Commissioner, Mental Welfare Commission

Dr Shainool Jiwa
Commissioner (Part-time), Mental Welfare Commission

Mr Jamie Malcolm
Nurse Commissioner, Mental Welfare Commission

Dr Madeline Osborn
Medical Commissioner, Mental Welfare Commission

Assisted by the Enquiries and Investigations Unit in the persons of Mrs Yvonne Osman, Complaints Officer; Mr John Burns, Enquiries and Investigations Officer; and Ms Gail McKenzie, Enquiries and Investigations Administrator.

1.4 Methods undertaken by the Inquiry

1.4.1 The Inquiry's investigation began with the assembling and perusal of the medical, nursing and social work notes. Further written materials such as protocols and guidance notes were also reviewed.

1.4.2 Mr J and members of his family were interviewed by two members of the Inquiry Team.

1.4.3 The list of people interviewed who were involved in the care of Mr J is given at 1.5. These interviews took place in various places including Hospital 2 and the Commission's offices. All those approached by the Inquiry Team co-operated fully and provided a substantial amount of information. Notes were taken at the interviews. A tape recorder was used and a note of the interview was sent to the persons concerned to be corrected for factual accuracy.

1.4.4 It was made clear to all those interviewed that the Inquiry would be reporting to the relevant bodies according to the terms of the Mental Health (Scotland) Act 1984.

1.5 List of Persons Interviewed.
(Those who had some direct responsibility for Mr J are marked with *. The posts indicated are those they held at that time).

1.5.1 Medical Staff
*Dr A (Consultant Psychiatrist, Hospital 2)
*Dr B (Clinical Assistant, Hospital 2)
*Dr C (Senior Registrar, Hospital 2)
*Dr D (Consultant Psychiatrist, Hospital 2)
*Dr E (Locum Consultant Psychiatrist, Hospital 2)
Dr F (Clinical Director, Hospital 2)

1.5.2 Nursing Staff
*Ms H (Registered Mental Nurse, Ward B, Hospital 2)
*Mr I (Registered Mental Nurse, Ward B, Hospital 2)
*Ms K (Primary Nurse for Mr J, Ward B, Hospital 2)
*Mr L (Acting Ward Manager, Ward B, Hospital 2)
*Ms M (Lead Clinician for Old Age Psychiatry, Hospital 2)

1.5.3 Social Work Staff
*Ms N (Mental Health Officer and Care Manager)
Mr O (Senior Social Worker, Hospital 2)
*Mr P (Senior Social Worker, Hospital 2)
Mr Q (Health Social Work Manager, Hospital 2)
Mr R (Manager, Older People's Services, Local Authority 2 Social Work Dept)

1.5.4 Family
Mr J's son
Mr J's brother
Mr J's sister-in-law
Mr J's niece

1.6 Acknowledgement

The Inquiry Team would like to thank all those who participated in the Inquiry for their co-operation, both in the interviews by the Mental Welfare Commission and through the provision of reports and case file material as requested.

SECTION 2: STATEMENT OF FACT

2.1 Contact with Hospital 1

2.1.1 Mr J first had contact with Hospital 1 on 25 January 1989 when he was admitted following a referral by his GP. He received a diagnosis of epilepsy and reference was made to social problems with a recommendation that he be referred to the social work department. He appears to have been assessed by a psychiatrist who recorded that Mr J was *"alert and well oriented with no evidence of any delusions or hallucinations, no evidence of depression, memory fair"*.

2.1.2 Mr J was admitted again to Hospital 1 on 7 December 1993. He was referred to the Psycho-geriatric unit (Ward A) by his general practitioner and was admitted under the consultant care of Dr G. He presented at this time as being forgetful, wandering and aggressive at times. The Hospital 1 medical notes recorded that, on admission, Mr J was unable to give a history as he spoke Punjabi *"patient not able to give history (speaks Punjabi)*". The history was given by Mr J's son, who indicated that his father had always been aggressive and unpredictable, and would wander off without telling anyone.

2.1.3 Mr J settled into Ward A Hospital 1 and an additional history was taken by Dr G on 13 December 1993 which was recorded in the medical notes. Mr J's son acted as interpreter on this occasion. He stated that his father would attempt to return to England where he had lived with his brother. His father's whereabouts were unknown for two to three nights. It was also reported that Mr J had seizures and when he was returned to his son he was weak and dishevelled. It was indicated that the police had returned Mr J home on four or five occasions. It was further reported that his seizures were regular but decreasing in frequency. They initially occurred daily but, in recent years, had been occurring much less frequently. He had seizures every three weeks at the time of interview. It was noted that he could be aggressive, wandering, and forgetful and that he laughed to himself. There was a further interview on 16 December 1993, in which his son acted as interpreter.

2.1.4 Following what appeared to be a grand mal seizure, Mr J was seen by a Consultant Neurologist, who suggested he have an electroencephalograph (EEG) and a Computerised Axial Tomographic (CT) scan of his brain. Dr G requested these investigations. The EEG was carried out during Mr J's admission to Hospital 1 but he was transferred to Hospital 2 before the CT scan could be done. On the Consultant Neurologist's advice, Mr J was prescribed an anticonvulsant drug, Phenytoin Sodium.

2.1.5 A Community Care Assessment was carried out on 31 December 1993 while Mr J was still in Hospital 1. Ms N, Mental Health Officer and Care Manager, completed this with the assistance of Mrs Y, an interpreter from the local authority Interpreting Service. The assessment gives Mr J's history from his original settlement in England in the 1950s to the time of interview when he was living with his son and daughter-in-law in Scotland. Mr J is reported to

have displayed problematic behaviour for a number of years. He was said to wander and be unable to deal with his own affairs. In the assessment he is reported by his son to have had a head injury and that the problematic behaviour appeared to stem from that point. The assessment records that in 1993 Mr J was reported to require considerable help with self-care and that his son and daughter-in-law would find it difficult to continue to look after him. They believed he should be cared for in a home close to his family so that they could have regular contact with him.

2.1.6 One direct assessment of Mr J's mental state was carried out using an independent interpreter during his stay on Ward A Hospital 1 . This occurred on 26 January 1994, using an interpreter from the local authority Interpreting Service. The interview was conducted by Dr G. The medical case-notes recorded that the interpreter said " *When questioned about hallucinations said no voices at all. Talks to himself when upset. Also laughs to himself. Talks to parents, brother and sisters and wife, unhappy conversations, unpleasant memories. Normal within the culture for people in unhappy circumstances. Had to be quite firm with Mr J to prevent him from digressing from the point. No evidence of psychosis, but has become forgetful and is of limited intelligence and education"* . The medical notes record that nursing staff made reference to his aggressive behaviour on two occasions at this time (28 January 1994 and 3 February 1994).

2.1.7 On 3 February 1994 a brief entry in the medical notes indicated that Mr J became disturbed and threatened to leave the hospital. At this stage he was detained under Section 25 of the Mental Health (Scotland) Act 1984 and his detention was subsequently extended under Section 26 on 6 February 1994. There was little information in the medical notes on the basis for continuing detention.

Transfer to Ward B, Hospital 2.

2.1.8 On 4 February 1994 Mr J's care was discussed with Dr A at Hospital 2, as a result of which Mr J was transferred to Ward B there the same day. Dr A took over consultant responsibility. In a letter dated 8 February 1994, Dr G wrote to him with a comprehensive account of Mr J's mental and physical assessment during his admission to Hospital 1. She indicated that a referral for CT scanning had been made and that an interpreter was willing to accompany Mr J to the appointment. There is no record of this letter in the Hospital 2 case-notes.

2.1.9 A note was made upon admission to Hospital 2 that Mr J had *'language difficulties'*. However, no attempt appears to have been made by medical staff to use an interpreter to speak with Mr J about his admission or indeed to conduct a mental health assessment. In the first nursing care plan, reference is made to Mr J being found to have difficulties in communication. The nursing records at Hospital 2 note the fact that Mr J spoke little English. The first care plan refers to difficulties in communication: *"Poor due to language barrier…….unable to speak English – can only use 2 to 3 words, broken English"*. In the same care plan, reference was made to contacting the

interpreter on call if communication became difficult. It was noted that he required a vegetarian diet *"because of his religious beliefs"*.

2.1.10 On admission to Ward B comments were recorded by a Trainee Psychiatrist in relation to Mr J's sleeping habits, self care and language difficulties. Reference was also made to his having a history of aggressiveness, possible cognitive impairment and epilepsy. This was the extent of any mental health assessment that was recorded in the medical notes.

2.1.11 Mr J was detained under Section 26 of the Mental Health (Scotland) Act 1984 two days after admission to Hospital 2. There was no indication of a diagnosis on the Section 26 form or in the case-notes.

2.1.12 Mr J was given an appointment by the CT Scanning Department to attend for a scan on 16 February 1994. He did not attend the appointment. There is a record in the Hospital 1 case-notes that Dr G notified Dr A about this non attendance; there is no record of this notification in the Hospital 2 notes, and the CT scan was not carried out. The Hospital 2 notes contain no record of the findings of the EEG examination carried out at Hospital 1 until a brief note written on 2 November 2000. Mr J's prescription of anticonvulsant medication was continued.

2.1.13 A Social Circumstances Report was prepared by Ms N on 25 February 1994. Once again this was carried out with the assistance of Mrs Y. In addition to the background history in the Community Care Assessment carried out in December 1993 several other matters are noted. Mr J stated that he had never been admitted to a psychiatric hospital and that his only period of hospitalisation was following an attack on him that caused severe head injuries. Mr J did not know why he had been transferred to Hospital 2 and was unaware that he was formally detained. One or two outbursts of aggressive behaviour whilst in Hospital 2 were thought to be due to the language barrier. The report refers to Dr C, Psychiatrist, stating that Mr J could be paranoid at times although he was unsure if this related to his inability to communicate because of language difficulties rather than a recognised mental disorder. This comment was also recorded in the nursing notes. There is no evidence that this issue was ever addressed. On having his detention explained to him Mr J agreed to remain in hospital on a voluntary basis and stated that he understood the need to take medication. Ms N concluded that 'given the difficulties that have been discussed previously surrounding Mr J's inability to both speak and understand English the writer has reservations on the necessity to detain this patient'. The Inquiry noted that in the Social Circumstances Report the writer refers to Dr A as Mr J's Responsible Medical Officer.

2.1.14 The Section 26 was allowed to expire on 6 March 1994. There was no record in the medical notes of any further medical assessment in the 22 days following the assessment made on 4 February 1994 until a note about his physical health on 26 February 1994.

2.1.15 It is recorded in the nursing notes on 26 May 1994 that Dr C adjudged Mr J not to be schizophrenic but to have a paranoid aspect to his personality due to his

inability to fully understand English. This information was also contained in the February 1994 Social Circumstance Report relating to Mr J.

2.1.16 On 27 February 1994 Mr J was started on a course of 'depot' injections of Fluclopenthixol Decanoate 200mg every two weeks. It was unclear for how long this prescription continued. There was no entry in the medical notes regarding this treatment or its effects on Mr J. No information on the effects of the treatment was explained to Mr J nor was there any record of his consent being sought. In an interview with Dr C on 24 July 2001 with regard to consent he stated that "*Dr A asked me to start Mr J on a depot neuroleptic (Clopixol). He told me to do this on the telephone. I think his decision was possibly based on a report that he received from the charge nurse that Mr J had become more agitated, more aggressive and withdrawn. Dr A got this information directly from the charge nurse. I do not recall if Dr A ever saw Mr J at the start of this medication. To my knowledge Dr A and myself never saw Mr J together"*. Dr A, who was the Consultant, said at interview: "*It was mostly Dr C who discussed consent issues and I was not involved. I was not involved in the discussion of consent to any of his treatments as he was already on all treatments at the time I took over his care"*.

Transfer to a residential home on 8 June 1994.

2.1.17 Mr J was transferred to a residential home which was managed at the time by Local Authority 1. Ms N continued to pay heed to Mr J's cultural needs. She organised three visits a week for him to go to the local Mosque social centre. She also arranged for Mr J to have an appropriate and varied diet which included the provision of hallal meat. Mrs Y, the interpreter, volunteered her time to visit Mr J at the residential home a few times and shared some Indian recipes with the chef. She also brought in a few items for Mr J's room to make it more homely for him.

2.1.18 At this time Mr J's day-to-day medical care was allocated to Dr C who, we have been told by the Trust, was then employed as an Associate Specialist. It was unclear from the medical notes whether Mr J had been discharged from psychiatric services at the time of his transfer. Mr J continued to be treated with 200mg of Flupenthixol every two weeks.

Second Admission to Hospital 2

2.1.19 Mr J became difficult to manage in the residential home because of his aggressive behaviour. He was referred back to Dr A and it was decided that he be re-admitted to Hospital 2 under Dr A's care. This took place on 9 September 1994.

2.1.20 When Mr J was readmitted to Hospital 2 Ms N, through an internal note (20.09.94) to Mr P, Senior Social Worker at the hospital, drew attention to Mr J's dietary and social needs and asked the hospital Social Work Department "*to monitor Mr J's case and attempt to ensure that his dietary and social needs were being met as these areas were severely lacking during his last admission*". The transfer summary note from the residential home to Hospital

2 also referred to these needs and gave key contacts and telephone numbers. Ms N was advised to contact the dietician and Dr A about these matters. Throughout Mr J's second stay in Hospital 2 he had no contact with the Social Work Department. On Mr J's return to Hospital 2 from the residential home on 9 September 1994 the nursing notes referred to an accompanying letter reporting that he attended the local Mosque 3 times a week and was given meals in accordance with his religious dietary restrictions. The transfer note from the hospital to the residential home included key names and contact details of those involved with Mr J's social, dietary and cultural needs.

2.1.21 From the date of his re-admission on 9 September 1994 until 12 January 1996 there were no entries in Mr J's medical notes. **This is a period of sixteen months**.

2.1.22 The nursing record entry on 12 September 1994 to Hospital 2 indicates that Mr J was prescribed Clopixol 200mgs every 2 weeks by Dr B.

2.1.23 We were told by the Trust that Dr E, who was employed as a Locum Consultant, assumed responsibility for Mr J's care between February and November 1998; in this he was supported by Dr C as an Associate Specialist. Dr C was appointed as a Locum Consultant in November 1995 and then became wholly responsible for Mr J's care until Dr D took over as consultant in 1999. Dr E told the Inquiry Team that he was not aware that he had been responsible for Mr J's ward during his employment with the Trust.

2.1.24 The Inquiry had difficulty ascertaining Mr J's diagnosis. On 20 April 1998 a diagnosis of schizoaffective disorder was recorded on a pro-forma case summary. This was completed by Dr B, who was the GP who was employed as a Clinical Assistant to provide GP services to the Ward. However no evidence was available in the medical notes as to how the diagnosis was reached. There was no evidence of a diagnosis being made by the Consultant in charge of Mr J's care or someone with a psychiatric background, nor was there a record of the relationship between the diagnosis and his ongoing treatment.

2.1.25 It appears Mr J had been treated for four years prior to the diagnosis of schizoaffective disorder without any record of a formal diagnosis being recorded.

2.1.26 From the date Mr J was started on Fluclopenthixol to the first recorded diagnosis there were no recordings in the medical case-notes of diagnostically reliable signs or symptoms of mental illness.

2.1.27 There was no entry in the medical notes from the 20 April 1998 until 3 January 1999. **This is a gap of almost nine months**.

2.1.28 Between 12 September 1994 and 10 August 2000 the medical notes make no reference to Mr J's mental state and give no indication that any further psychiatric assessment was being carried out on him apart from Dr B's pro-

forma diagnosis (see paragraph 2.1.24). There was no indication of his response to care and treatment.

2.1.29 There were two occasions when the nursing notes referred to Mr J's having an aggressive outburst (17 May 1996 and 13 August 1996). This is in contrast to his previous settled behaviour. There is no record of these incidents being investigated or of his mental state being assessed. The nursing notes suggest that these outbursts may be a direct result of his communication difficulties. There is a later note of 2 December 1997 indicating that Mr J became verbally and physically aggressive towards nursing staff for no apparent reason. He was *"reprimanded re same and apologised for his behaviour"*.

2.1.30 Mr J's care was transferred to Dr D (Consultant Psychiatrist) in or around June 1999, though this is not recorded in the medical or nursing notes. The first reference to this transfer of care was contained in a letter Dr D wrote to the Mental Welfare Commission in response to the Commission's visit on 9 August 2000.

2.1.31 A Medical Officer from the Mental Welfare Commission interviewed Mr J during that visit. This interview was carried out as part of the Commission's policy of interviewing patients who do not have English as a first language. This interview took place with the assistance of an interpreter from the local authority Interpreting Service.

2.1.32 The Medical Officer's report to the Commission identified a number of issues which were raised with Dr D relating to Mr J's care and treatment, particularly his medication regime. At 23 August 1996 Mr J was being treated with oral anti-psychotic medication (Thioridazine). This drug appeared to have been prescribed since at least 9 September 1994. There was no evidence in the medical notes of the normal monitoring of symptoms and possible side-effects in response to this medication. There was no record of any basis for the prescription of Thioridazine. Mr J's treatment with the anti-psychotic drug Thioridazine was stopped on 20 December 2000. The reasons for this are not recorded in the medical case-notes.

2.1.33 In a letter from Dr D to the Commission dated 28 August 2001 he refers to Mr J's *"long standing schizophrenic illness*".

2.1.34 One unsigned entry in the medical notes dated 18 November 2000 indicated that medical records from Hospital 1 were checked. This appears to be the first recorded attempt to review his notes. The hospital notes recorded EEG changes which showed degenerative changes. There is no recorded evidence that a connection between Mr J's epilepsy and psychotic symptoms was considered. When Dr D was interviewed on 12 June 2001 he indicated to the Inquiry that he understood that there could be a link between epilepsy and psychosis, but there was no evidence that he had taken any steps to ascertain the possible interplay in Mr J's case. The Hospital 1 notes also record the possibility of cognitive impairment but again there was no recorded evidence of any systematic attempt to assess or monitor this further.

2.1.35 The biochemistry report dated 30 August 1996 stated that Dr C's diagnosis of Mr J's condition was one of dementia.

2.1.36 The Inquiry found that during the care of Mr J four diagnoses were recorded in his medical notes: one of epilepsy (4 February 1994); one of dementia (30 August 1996); one of schizoaffective disorder (Dr B's pro forma case summary on 20 April 1998); and one of chronic schizophrenia (Dr B's pro-forma diagnosis on 20 July 2000). Also in a letter dated 9 August 2000 from Dr D to the Commission he refers to Mr J having 'organic psychosyndrome'. In addition, records indicate that at that time the possibility he had no psychiatric illness was considered.

Social and cultural needs

2.1.37 During the period of Mr J's first admission to Hospital 2 there is reference in the nursing notes to contact with an interpreter and visits to the local Mosque. On one occasion nursing staff contacted Mrs Y (interpreter) when Mr J's mood appeared low. Reference is made to a visit by the Community Relations Officer and the voluntary visiting service taking Mr J for a run in a car. However, such references are sparse during this second admission. There are numerous clear recordings in the nursing notes that Mr J took part in institutional recreational activities (bus outings, a fish supper and a trip to the pantomime) There was, however, no record of an assessment of his individual needs in this area. There was an absence of recorded planning with regard to recreational activities and social and cultural needs.

Physical health needs

2.1.38 There are several references to reviews by Dr B of Mr J's physical health needs in the medical notes. It is clear that throughout his stay in hospital his respiratory function gave cause for concern from time to time. There is no mention in the medical records that Mr J ever received a comprehensive respiratory assessment. For example, there was no record of any microbiological examination of his sputum or chest x-rays or any other relevant examinations. However, in a letter to the Commission dated 9 October 2000, Dr D stated that the reason he did not agree to Mr J going to stay with his brother was "*because he had repeated chest infections with wheezing and breathlessness"*. This becomes particularly relevant in view of the fact that his brother and nephew reported to the Commission that on discharge from hospital he was coughing up blood in his sputum.

2.1.39 On admission on 9 September 1994 the nursing assessment was that Mr J had deteriorating eyesight. The nursing notes record "*His sight appears poor, query cataracts"*. On 13 April 1995 he visited the optician and was diagnosed as being blind in his right eye and partially sighted in the left eye. He was prescribed glasses. As noted above a reference was made to his visual difficulties on his admission on 9 September 1994 indicating an apparent 7 month gap until he was assessed by an optician. There is no further record of any assessment of his eyesight in the medical or nursing notes. On 30 January 2001 he was referred by Dr B to Hospital 1 who said that Mr J had mature

cataracts in both eyes. He was due to be assessed on 23 February 2001. The medical staff made no reference to this condition on his discharge on 21 February and no referral was made to a specialist in London. There was no indication from the medical notes that his poor eyesight had been taken into account in assessing his behaviour, literacy and mental state.

2.1.40 Mr J injured his hand on the 7 January 1997. This possibly occurred during a seizure. There is no record of the injury being investigated in relation to the seizure nor was the use of an interpreter sought in clarifying the matter. Mr J's brother reported that Mr J had told him that he had been *"pinned to the floor and attacked"* and that another time someone had badly injured his finger.

2.1.41 Although a diagnosis of epilepsy was mentioned in the medical case-file on his transfer to Hospital 2, there is no record in the nursing or medical case-notes of any attempt to monitor the nature and frequency of Mr J's seizures until a further EEG was carried out after the Commission visit in October 2000. There are no other recorded investigations of his epilepsy.

2.1.42 The Social Circumstances Report indicated that Mr J had reported having suffered a head injury after an attack. In the interview with the Commission's Medical Officer, he again referred to being in hospital because he had "*hurt his head"*. There is no evidence in the medical or nursing records that this was explored further.

2.1.43 At interview Mr J's brother and nephew expressed concern about his physical condition on discharge and were worried that his physical care had not been good in hospital. Mr J's brother said that Mr J's fingernails were badly overgrown and his skin was dry and scaly. Mr J's son did not have concerns about his father's care.

2.1.44 In a letter dated 28 August 2000 to the Commission, Dr D stated that "*In view of the long-standing schizophrenic illness, in association with epilepsy, Mr J is going to be a long-stay care patient in hospital"*. In a further letter to the Commission dated 9 October 2000, Dr D further stated that he "*could not agree to Mr J staying with his brother because of Mr J's repeated chest infections which would need medical attention"*. However, on 21 February 2001, Mr J was discharged into the care of his family without further recorded review of these matters.

The Discharge

2.1.45 There were numerous recordings of Mr J's brother and his family requesting that he be moved into their care or nearer to them. This occurred as recorded in the nursing notes on ten occasions. (5 October 1997, 2 February 1998, 24 April 1998, 18 February 1999, 16 October 1999, 18 February 2000, 11 June 2000, 27 December 2000, 18 February 2001 and 21 February 2001). The response from the nursing staff was to advise the family to make contact with the medical staff. It was not recorded anywhere that nursing staff raised the family's concerns with medical staff.

2.1.46 Mr J's son was interviewed by the enquiry team on 25 May 2001 and Mr J's brother was interviewed on 2 May 2001. The brother and his family said that they wanted to care for Mr J at home. The family, including Mr J's son, confirmed that the discharge took place on the morning of the 21 February 2001, when they arrived at the hospital with a van, and took Mr J to England. The family was given little or no support relating to the care of Mr J after his discharge. There was little evidence of support or information given to the family concerning Mr J's condition**.** The discharge letter gave a variety of psychiatric diagnoses and indicated that Mr J suffered from chronic obstructive airway disease. Mr J was discharged to his brother's care in London on 21 February 2001. There was no referral to the psychiatric services in London but a letter was prepared for the local General Practitioner. Dr D made a discharge note dated 21 February 2001 in the case records saying that Mr J's brother, son and nephew visited that morning wishing to take him to London. In the medical notes reference is also made to Mr J's brother wishing to take him but his son not thinking this wise. Dr D noted that "*it will be better for him to be in London for religious and family reasons. He seemed to be happy to go to London."*

2.1.47 There is no reference to social work or other agencies for the purpose of discussing or arranging Mr J's discharge. However, Dr D stated in a letter to the Commission dated 9 October 2000 that he had "*tried to contact Mr Y, social worker, who acted as liaison, but the contact number we have is unobtainable".* At no time was there a social worker called Mr Y involved with Mr J. However, there was an interpreter, referred to previously, called Mrs Y.

2.1.48 There is no record of any attempt to ascertain the level of Mr J's consent to his discharge.

2.1.49 The nursing notes are silent on Mr J's discharge. The nursing staff were not involved in the process until the morning of 21 February 2001 when the family arrived on the ward to meet with Dr D. At interview the family indicated that they had spoken with Dr D in the days prior to their attending the hospital that morning. Mr J's nephew believed that it had been made clear to Dr D that the family wished Mr J to be discharged to their care in London before they attended on the 21 February. The discharge was completed in the space of the morning and Mr J placed in the care of his family. At interview the nursing staff remarked on the suddenness of the discharge and the lack of planning involved.

2.1.50 Very soon after his arrival in London Mr J's family found it difficult to care for him and requested help from the local Social Services Department, and his niece was told to obtain background information from Hospital 2. A Social Worker at Hospital 2 therefore prepared a report. His social work report to the Social Services Department in London (21.03.01) states that "*the ward staff on duty on the day of Mr J's discharge said that [Mr J] was visibly upset and emotional but due to communication issues and family involvement it was difficult for them to ascertain whether this was due to distress or relief/joy at*

the prospect of being reunited with his family". There is no record of any attempt to discuss with Mr J plans for his discharge on 21 February 2001, based on information obtained from Dr D and the ward charge nurse. In his conclusions the Social Worker states

"(a) while in hospital it was clear that there were some difficulties in communicating effectively with [Mr J] and attempts were made, via an interpreter, to accurately establish his views and wishes.

(b) at the point of discharge it remained unclear as to the diagnosis of mental health difficulties.

(c) Mr J was discharged following a request from his family and although he appeared pleased with this move there may have been allowed greater opportunity to clarify the issue".

SECTION 3: COMMENTS AND OBSERVATIONS

3.1 Social Work

3.1.1 Social work has a key contribution to make to the assessment of patients who need care in the community and of those who are subject to detention under the Mental Health (Scotland) Act 1984. Social workers should also contribute to the multidisciplinary review of patients' care and to discharge planning. This includes helping relatives to consider options for the care of a family member when they have concerns about existing arrangements. Carers may also request a social work assessment of their own needs.

The Assessment of Mr J's Needs:

3.1.2 The assessment carried out in December 1993 by Ms N with the assistance of Mrs Y as interpreter (see paragraph 2.1.5) was full and informative. It indicates that Mr J was likely to need 24 hour residential care when he left hospital and that this care should include appropriate emotional and social support and recreational activities.

3.1.3 The Social Circumstances Report prepared by Ms N two months later provided some useful additional information about Mr J's mental health and also raised questions about the need for Mr J's detention and about his lack of awareness that he had been detained. This report drew attention to a possible relationship between Mr J's occasional disturbed and aggressive behaviour and his inability to speak or understand English. When Mr J moved to the residential home Ms N ensured that staff there were fully informed about his background and needs, including cultural needs for which special arrangements were made (see paragraph 2.1.17).

3.1.4 While Mr J was at the residential home there were monthly assessments of his needs and progress there which involved his key worker, the manager of the residential home, Mrs Y (interpreter), Ms N and Mr J. These assessments and the implications for Mr J's care were carefully recorded.

3.1.5 Very regrettably little of this useful information appears to have been placed in Mr J's records when he was admitted to Hospital 2 on 9 September 1994. Although there are records that some of it was sent by the manager of the residential home and by Ms N, there is no Social Circumstances Report in his medical notes. Up until Mr J's discharge from hospital the hospital social work file contained only the Social Circumstances Report from February 1993 and two handwritten notes (2 August and 5 September 1994). One referred to a call from Dr A asking which social worker had been working with Mr J. The other recorded a call from Ms N advising the Social Work Department of Mr J's dietary needs and arrangements for his attendance at the local Mosque. A letter from Ms N (20 September 1994) to Mr P, the Senior Social Worker at Hospital 2, referred to the residential home care plan and asked the hospital social work department "to monitor Mr J's case and attempt to ensure that his dietary and social needs are being met". A file note then records a conversation Ms N had with the hospital social worker to clarify her

expectations and notes that Ms N was advised to contact hospital "admin" and the dietician about her concerns. No further action was taken by the Social Work Department. We were told by Mr P that, when Mr J was admitted to Hospital 2, it would have been assumed that once Ms N had provided information about Mr J's cultural needs to his consultant and to ward staff they would be responsible for ensuring the relevant arrangements were made. Mr J did not see a social worker at any point during his hospital stay of nearly six and a half years at Hospital 2.

3.1.6 The last entries in the social work file are responses in March 2001 to English Social Services Department's request for information about Mr J, who had been very quickly referred for help there by his family after his discharge from hospital.

Reviews of Mr J's Treatment:

3.1.7 We have already noted that there were very few reviews of Mr J's care and treatment. None of these involved social workers. This was not unusual for patients in long stay wards because hospital social workers did not (and still do not) provide a regular social work presence on long stay wards, although responses would be made to requests for social work help for individual patients.

3.1.8 This invisibility of social workers does not encourage nursing staff to refer continuing care patients to social workers. More than one nurse told us that, because they knew their patients so well, they expected to meet their social needs themselves. Nurses also saw Mr J's consultant as the person whom relatives should approach regarding their wish to arrange his discharge. We have recorded in paragraph 2.1.45 that such requests were frequent. Given these repeated requests nurses might reasonably have concluded that family members had either not met Dr D or that their concerns about Mr J's future care had not been allayed. However, there is no evidence that either Dr D or nurses involved with Mr J saw social workers as having any role in assessment or planning for discharge.

Social Work Services in Hospital 2:

3.1.9 These are provided by Local Authority 2 and the services are located on the hospital site. This is now a relatively uncommon arrangement in Scotland with many departments providing hospital social work services from area teams. Hospital based services should ease both communication with and accessibility for patients, families and staff.

3.1.10 The Social Work Services Design for Hospitals 2 and 3 for 2000 sets out the Social Work Department's objectives, one of which is to assist people in their discharge and return to the community. This Design also describes the full range of services on offer. These include arrangements for new patients in acute wards, whom ward staff believe might be helped by receiving a social work interview within three days of admission. A duty service is also available for all patients with immediate problems. There are dedicated staff

to provide co-ordinated assessment, care planning and discharge preparation for people on the discharge programme; and the Social Work Department will also provide community care assessments, care plans and care co-ordination for individuals leaving hospital who have serious social care needs, in accordance with the joint agency discharge protocols. A comprehensive discharge planning service will be provided to assist service users and hospital staff in discharge planning. This includes liaison with community based resources and agencies. The Service Design also underlines the importance of multidisciplinary working and, to this end, a social worker will represent the Department at each "designated ward" thereby providing advice, information and consultation at multidisciplinary ward meetings. There is a leaflet for patients which describes these services and how they can be accessed. We were told this Design was sent to Consultants before it was finalised.

3.1.11 The organisation of these social work services, as set out in the Service Design (June 2000) may well contribute to this sporadic contribution by social workers to the care of continuing care patients. While the Design describes a comprehensive range of services which includes assistance with discharge planning there is no specific reference to continuing care patients although we were told that the intention of the Design was that they should also be able to receive the services described. We were also told that no social workers have any designated responsibility for continuing care wards; their intervention there is at the request of the patient or his or her relatives or hospital staff. As we have indicated above, the nurses we interviewed did not perceive the need for social work help for their patients. There appears therefore to be a vicious circle: the absence of social workers from long stay wards means that staff from other disciplines are not alerted to the possible need for social work contribution to the care of patients; and the ensuing lack of requests for social work help for continuing care patients does not encourage busy social workers to develop this area of work.

3.1.12 We were told that the current arrangement for social work services for continuing care patients has not changed significantly since Mr J was admitted to Hospital 2, although social workers have assisted with specific discharge programmes. We were also told that in 1993 there were more patients in Hospital 2 than at present so social work resources were too limited to allow other than exceptional work with long stay patients. Even though the staffing situation had improved when the Service Design was issued in 2000 we were informed that the establishment of six caseworkers for Hospitals 2, 3 and 1 was not always complete because of resignations and sick leave.

3.1.13 We think it is unsatisfactory there is no social work attachment or presence on long stay wards. Mr J's case shows that this absence can mean both relatives and patients do not receive all the help they need if hospital staff are not alert to the help social workers can give. Mr J's case is not an isolated example: **the Commission is aware of other patients in continuing care wards in other hospitals in Scotland who have been disadvantaged because of the virtual absence of social workers from these settings**.

3.1.14 While we respect doctors' and nurses' intentions to do as much as possible for their patients we think they should refer them to social workers when questions of alternative care are being considered. We strongly agree therefore with the advice and directives of the various guidance and protocols referred to later. There are also many other matters which may need social work attention. Admission to a continuing care ward can be distressing for both patients and families. Plans may need to be made for contact between them to be sustained. There can also be financial and property difficulties. Social workers should offer advice and guidance in these circumstances.

3.1.15 We think that senior social work and hospital staff should review together, with their respective managements, the best arrangements for ensuring continuing care patients and their relatives are properly informed about social work resources in Hospital 2 and referred for social work help in appropriate circumstances. Doctors and nurses who specialise in work with continuing care patients should be fully informed about the responsibilities and contribution of social work to their care. Given the relatively few long stay wards and the low turnover of patients in them it may well be appropriate for a social worker to meet all continuing care patients on admission, and their relatives, to clarify whether social work help may be needed.

3.2 Health Care

The assessment of Mr J's mental health needs

3.2.1 From Mr J's first contact with Hospital 2 on 4 February 1994 the medical and nursing assessment of his needs appears to be rudimentary. There was no occupational therapy assessment. We were told that there was no occupational therapy service in long-stay wards. Only one mental state assessment was carried out using an independent interpreter. Apart from the admission note prepared by the Trainee Psychiatrist on 4 February there is no other substantial discussion of his mental state or of his diagnosis, with treatment and care appearing to have continued without a clear diagnosis having been determined. It is notable that he received depot neuroleptic medication from April 1994 for an unspecified period of probably some years with no recorded review of this treatment and its effect on his mental state.

3.2.2 From the symptoms and behaviour described in the notes, Mr J could have been suffering from a number of psychiatric disorders including depression, abnormal grief reaction, a psychotic illness or temporal lobe epilepsy. In addition there are suggestions that he might have some intellectual disability and there had been a possibility of head injury in the past. The medical case-notes contained no discussion of the various diagnostic possibilities in Mr J's case and do not describe any attempts to investigate them.

3.2.3 In the absence of adequate mental state examinations inferences about Mr J's mental functioning were made from his behaviour. In our view, these inferences were made carelessly. There is no evidence that any attempt was made to understand how his behaviour might have been affected by his unusual circumstances. For example, his visual impairment, linguistic isolation, cultural values and epilepsy do not appear to have been taken into account in understanding isolative or aggressive behaviour.

3.2.4 Mr J's behaviour prior to admission i.e. his aggression, wandering and possible perceptual disturbances were discussed with his family. However, there is no record that depressive signs, evidence of intellectual impairment, manifestations of his epilepsy, the quality of his relationship with his wife and his reaction to her death were ever discussed with his family or information sought from them.

3.2.5 Whilst in Hospital 1 he was seen by a Neurologist and further neurological investigations were set in train by Dr G. However, these were not followed up following his transfer to Hospital 2. Although there is a reference in the Hospital 2 nursing care plan to recording any seizure activity in the nursing notes, and there is a record of seizures taking place, his epilepsy was not adequately investigated, nor the relationship between his epilepsy and his behaviour assessed. There is no record of an EEG being carried out until 17 October 2000 (after the Commission had raised Mr J's case with the then RMO, Dr D) and there is no record of any referral to neurology services.

3.2.6 There is no record of any assessment of mood, thought content or the form of his thinking. Perceptual disturbances were enquired about during the interview with the interpreter but other possible psychotic symptoms were not. While nursing care plans throughout Mr J's admission refer to his social isolation and link this to language difficulties, there appears to have been no consideration that this tendency to isolate himself could have been connected to his mental state or seizure activity. The reference in the Social Circumstance Report to Mr J having sustained a head injury following an attack was never followed up.

3.2.7 It is striking that there is nothing in the nursing notes that appears to connect changes in Mr J's behaviour with his mental state. An example of this is the entry on 2 December 1997 *"After breakfast ....[Mr J] became verbally and physically aggressive towards nursing staff for no apparent reason. Reprimanded re same and he apologised for his behaviour."* There was no recorded follow up to this or any other references to changes in his behaviour and apparently no discussion or review over time of how this behaviour might relate to his mental state or treatment.

3.2.8 Though information obtained from his family included reports of forgetfulness there are no records of any formal or informal assessment of Mr J's cognitive ability, or that consideration was given to an assessment by a clinical psychologist.

Reviews of Mr J's care and treatment in hospital

3.2.9 We were told that there was a system of case reviews on Wednesday of each week when the medical staff attended the Ward and discussed selected patients. This review involved the doctor and nursing staff on duty. Although staff referred to this system at interview there appeared to be no written policy or procedures in operation to ensure that all patients were reviewed regularly with their consultant and named nurse in attendance. There is nothing in the notes to indicate that Mr J ever received a case review involving medical and nursing staff from his re-admission to Hospital 2 on 9 September 1994 until his discharge on 21 February 2001. At interview none of the medical or nursing staff could throw any light on why Mr J had not received an annual review throughout his 6½ years in Hospital 2. No staff were aware of any written Trust policy on the frequency or form of annual reviews. The lack of any review of Mr J's care is not in accordance with the guidance on continuing NHS care given by the Management Executive in NHS MEL (1996)22, *NHS Responsibility for Continuing Health Care.*

3.2.10 The Mental Welfare Commission had raised concerns in 1999 with the Trust about the infrequency of case reviews of patients in continuing care wards at Hospital 2, as had another external review.

Mr J's consent to treatment

3.2.11 While it appears that Mr J accepted depot medication it was clear to the Inquiry Team from the case-notes and from interview with the medical staff

involved in his care that there had been no consideration given to Mr J's consent to treatment.

Medical and nursing records

3.2.12 The nursing notes consisted of basic care plans and a narrative record of Mr J's care. On his first admission to Hospital 2 the nursing care plan identified communication difficulties and social isolation, epilepsy and personal hygiene with the interventions appearing recorded as having been followed up. However, the Inquiry team noted that while the problems identified were significant the interventions were somewhat limited and apparently not recorded. It was notable that the interventions in relation to Mr J's "communication difficulties" included speaking slowly and clearly to him. The reference to using an interpreter referred to in the first care plan was lost when the care plan was rewritten on 19 January 1995. This is discussed further in Section 3.4.4 and 3.4.5 .

3.2.13 There was very limited information about Mr J's life and social circumstances in the nursing records. There was no reference to his family situation or to communication with the family. It is hard to see how an appropriate plan of care and effective assessment of a patient's need for continuing care in hospital can be determined without this essential information. Also, the Inquiry team believe that it is not possible to provide individualised care for a person if the staff providing the care do not know that individual's personal history and the events that led to their admission to hospital.

Mr J's physical health needs

3.2.14 The problem of Mr J's deteriorating eyesight was identified around the time of his re-admission to Hospital 2 on 9 September 1994. According to the notes it was not until 13 April 1995 that the nursing notes indicate that Mr J saw an optician, who found him to be blind in his right eye and partially sighted in the other. There is no reference to any examination of his eyesight in the medical case file, apart from a note of "corneal opacity in one eye" recorded in 1998. There is no evidence to suggest that the impairment in Mr J's sight was taken into account in trying to understand and assess his behaviour.

3.2.15 Throughout Mr J's admission his respiratory function gave cause for concern from time to time. There is no indication in the medical or nursing records that he ever had a comprehensive respiratory assessment. There is no record of any microbiological examination of his sputum, or chest X-rays or other relevant investigations. The family reported to us that at the time of his discharge he was coughing up blood. Shortly after discharge he was diagnosed as having cancer of the lung.

Communication between medical and nursing staff and Mr J's relatives

3.2.16 During Mr J's second admission to hospital his relatives made several approaches to nursing staff to discuss his discharge. It appears from the notes that on each occasion the family were advised to contact medical staff with no

offer of any assistance by ward staff to communicate the family's request or to raise the matter with the relevant doctor on their behalf. The guidance given in *NHS Responsibility for Continuing Health Care* (NHS MEL(1996)22 stresses that patients and their families and carers must be kept fully (underlining original) informed about how procedures for hospital assessment and discharge will work and that they should receive the relevant information they require to make informed decisions about continuing care. This information should be presented in writing and/or other formats appropriate to their needs and be in clear concise terms with personal explanations being given on request. The Inquiry team saw or heard no evidence that there was any attempt by staff to proactively provide information to Mr J's family about his care, plans for the future and the options available.

Mr J's life in hospital

3.2.17 From his readmission to Hospital 2 on 9 September 1994 nothing in the case-notes or from interviews with staff dispels an impression of Mr J living an institutional life of limited activity with a poverty of social interaction. Efforts were made by staff, within the limited resources available, to involve Mr J in recreational outings including bus runs and going out for fish and chips and he did go on brief holidays from Ward B on two occasions. However, there is no reference anywhere to any kind of assessment of his social and recreational needs. The Inquiry Team was left with the impression that Mr J had simply been "slotted in" to the limited range of institutional social activities available in the Hospital with little recognition having been given to his personal needs.

3.2.18 The Inquiry Team was told that there would not normally be an occupational therapy assessment of a patient in Mr J's situation and, in fact, that it would be very unusual. No-one would receive such an assessment unless specifically requested.

3.2.19 The events around Mr J's discharge poignantly illustrated the limits of his life in hospital. While waiting for staff to pack his belongings he continued with his "job" in the Ward, that of washing the medicine cups while the medication trolley was taken around by nursing staff. It appeared from the nursing records that this activity was likely to have been the major event of his usual day in hospital.

3.2.20 The Inquiry Team formed the view that Mr J was being institutionalised as a long stay patient. Apparently no thought was given to what assessments and activities might have helped him in living outwith the stark environment of a long stay ward in Hospital 2, where he lived for 6½ years.

3.3 Plans for Mr J's Discharge:

3.3.1 Guidance on discharge planning is clearly set out in NHS MEL(1996)22 *NHS Responsibility for Continuing Health Care.* The guidance and directives in this letter are also reflected in the Trust's discharge protocols and the Social Work Service Design for Hospital 2 (June 2000).

3.3.2 The NHS MEL(1996)22, issued on 6 March 1996, was addressed, inter alia, to all General Managers of Health Boards, Chief Executives of NHS Trusts and Directors of Social Work. This circular sets out policies to promote effective care in the community and includes a substantial section on discharge planning. For example, paragraphs 15, 16 and 17 state that "in all cases of discharge from NHS long stay care social work staff … should be involved at the outset. Hospitals and social work staff should work together to ensure the most effective integration between social work assessments and care management procedures and hospital discharge arrangements. … Decisions about whether to discharge patients from NHS care and on how their continuing care needs might best be met should be taken following an appropriate multidisciplinary assessment of the patient's health, social care and housing needs in consultation with a patient's relatives/carers. … The multidisciplinary assessment involving patient and families/carers/advocate must be co-ordinated between key professional staff from health and social work". Paragraph 25 then sets out arrangements to ensure that patients and relatives are <u>fully</u> (underlining original) informed through clear written information, about procedures for hospital assessment and discharge.

3.3.3 The Trust's Discharge Protocols in operation when Mr J was in Hospital 2 in part reflect the directions in the MEL (1996)22, although we were told by Mr R, Manager Older People's Services (letter 26 September 2001), that there were no protocols for the discharge of long stay patients "primarily because such situations are usually part of a hospital discharge programme and separate agreements are drawn up for hospital and ward closures and discharges resulting therein. Notwithstanding this the principles and practice contained within (the protocols) would be applicable to assessment and care management arrangements for all people being discharged from hospital who were in need of social work service". Mr R also wrote that discharge protocol documents "would be available to all social work frontline staff and should certainly be familiar to staff working in hospital settings". Mr R was not able to comment on the Board's and Trust's arrangements for circulating this information to their staff.

3.3.4 The Trust's Mental Health/Learning Disabilities Division *Discharge Protocol 1997* sets out agreed guidelines for clinicians, and states, inter alia, … "That no-one should be discharged without at least 24 hours notice … That prior to discharge there will be a multidisciplinary review which should include all disciplines involved in the individual's care as well as appropriate community staff … The client will be involved in the review and where appropriate the carer … That it is the consultant's responsibility to enter into consultation with the multidisciplinary team and that the named nurse (or deputy) will contact appropriate members of the multidisciplinary team about the impending

discharge. … There should be clearly delineated and understandable lines of authority and accountability for the actioning of the discharge plan… There should be documentation available from all professions involved in the discharge process … The named nurse will be responsible for co-ordinating the client's discharge and will recognise the importance of collaboration with clients and/or relatives in the discharge process (this should be documented) … The named nurse would also be responsible for ensuring that all necessary plans have been made and a discharge plan will be completed for each patient … Prior to discharge home circumstances where appropriate will be checked provided the client has given consent."

3.3.5 The Discharge Protocol does not refer specifically to either acute or continuing care patients but its procedures would appear appropriate to both groups; as Mr R indicates the principles and practices in the following protocols would also be relevant to all patients being discharged.

3.3.6 The local NHS and Local Authority Joint Planning Agreement for Discharge of Patients in Acute Phase of Hospital Care (undated) refers particularly to older people and reiterates in more discursive form and with more procedural detail the directives and advice set out above. This agreement was revised in a further draft in June 2000 which includes flowcharts of procedures to be followed.

3.3.7 The Inquiry Team was also given an undated copy of a short paper which refers to Hospital 2. It is entitled *Procedure for Discharge Planning for Individuals in Rehabilitation and Long Term Wards*. This clearly sets out eight steps to be followed once an individual is considered ready for discharge. This includes the appointment of a care co-ordinator (likely to be a social worker) to develop a comprehensive care plan. There must also be a planning meeting with clients' relatives and key professionals and a detailed timetable of tasks to be completed before discharge takes place.

3.3.8 There is no evidence from our interviews with those responsible for Mr J's care that they were influenced by any of these discharge protocols and procedures and it is clear that their directions and guidance were not followed in Mr J's discharge arrangements. This meant that an elderly person who had been in hospital or residential care for more than eight years was discharged to the care of his family without Dr D or any other responsible person having full knowledge of the care that would be available for him either from his family or local health and social services. There had also been no full consultation with Mr J's family about his likely needs and how these might be met.

3.3.9 We greatly respect Mr J's relatives' wish to support and care for him and their persistent efforts to achieve this objective. We think their wishes should have been fully considered when they were first expressed. Before Mr J was discharged there should also have been full exploration, with the assistance of the relevant English Social Services Department, of the care that would be available for Mr J from local agencies and his relatives. Some care should have been taken to explore the individual responsibilities of different family members and their willingness to fulfil these obligations. Account should

have been taken of the longstanding and quite complex difficulties some of Mr J's relatives had had in caring for him before he first came into hospital and of the understandable disagreements between family members about the best care arrangements for him. It would also have been appropriate to consider with Mr J's family his possible increased dependency after an 8 year stay in hospital.

3.3.10 We believe the rushed and unplanned arrangements for Mr J's discharge are a further and serious example of the deficiency in the care he received.

3.3.11 From our interviews with social work managers and hospital based social work staff we learnt that all were very surprised there had been no requests from medical and nursing staff for a social worker to contribute to planning for Mr J's discharge. Although we were told that all patients who are included in a hospital discharge programme have an allocated social worker, it is not clear whether social workers are usually involved, or expect to be involved, in discharge planning for all other long stay patients. Mr O, now senior social worker at Hospital 2, told us there had been less than a dozen invitations to social workers to join discharge planning for continuing care patients but he was not aware of how many such patients had been discharged in that period.

3.3.12 Mr R, Manager of Older People's Services, told us that social workers will not always be involved in the discharge arrangements for long stay patients "if they had informal support". He also said he thought that patients who are to be discharged should only be referred for social work help with their consent. In short, it would appear that the directives and guidance of MEL(1996)22 were not being routinely followed in Hospital 2.

3.4 Cultural and Other Needs

Language Needs

3.4.1 At Mr J's admission to Hospital 1 in 1989, a psychiatric diagnosis was made. However, there is no record in the medical notes of the fact that Mr J did not speak English, nor is there any recorded attempt to determine what language(s) he did speak. Upon his first psychiatric admission to the same hospital, almost five years later at the end of 1993, the medical notes record that the "*patient was not able to give history (speaks Punjabi)*". His son was called upon twice to provide the background to his father's mental health problems. It is inappropriate to use a family member as the sole source of information and it undermines the opportunity for the patient to give his own views.

3.4.2 Over a year later on 17 January 1994, Mr J had his first medical interview through an interpreter from the local authority Interpreting Service. The medical case-notes recorded that the interpreter said, "*Talks to himself when upset. Also laughs to himself. Talks to parents, brother and sisters and wife, unhappy conversations, unpleasant memories. Normal within the culture for people in unhappy circumstances. Had to be quite firm with Mr J to prevent him from digressing from the point.*" Interpreting in the mental health sector requires awareness and training about mental health issues. When this is not the case, a patient's communication and behaviour can be misunderstood and untested assumptions made about the cultural context.

3.4.3 On 3 February 1994, the medical notes record that Mr J was detained under Section 25 of the Mental Health (Scotland) Act 1984. The medical notes are silent on how this information was conveyed to him and what attempt had been made to ensure that he had understood the reasons for his detention. Detention under the Act requires that the patient understands why she/he is being detained. The fact that this was not conveyed to Mr J in a manner that he understood is clear. Not surprisingly, more than six years later, when the Medical Officer from the Mental Welfare Commission spoke with Mr J, he was still unclear as to why he was in a mental health hospital.

3.4.4 In the first nursing care plan on Mr J at Hospital 2 on 4 February 1994 there is reference to difficulties in communication with him. "*Poor due to language barrier, unable to speak English – can only use 2 to 3 words, broken English".* In the same care plan, reference was made to contacting the interpreter on call if communication became difficult. However, in the four months that Mr J was in hospital, there was no record of an interpreter being called in to communicate with him about any matters concerning his care and treatment including his consent to treatment.

3.4.5 Upon Mr J's readmission to Hospital 2 on 9 September 1994 until his discharge 6½ years later on 21 February 2001, there is no record in the medical or nursing notes of any attempts to communicate with Mr J through an interpreter. This is so despite the fact that on two occasions – 17 May and 13 August 1996 - the nursing notes indicate that Mr J's aggressive outbursts

were a result of his communication difficulties and were in contrast to his previously settled behaviour.

3.4.6 It was not the case that, because some of the health staff were of Asian origin, they could communicate effectively with Mr J in his own language. For example, Mr J spoke Punjabi and understood Urdu. Dr A told us he spoke Hindi, and also some Punjabi. Dr B could understand and speak Punjabi, but not well. Dr C told us he could understand a little Punjabi, but communicated with Mr J in Urdu and Hindi. Finally, Dr D understood Hindi but could not communicate in either Punjabi or Urdu. Although some of these doctors could have some limited communication with Mr J, interpreters were clearly needed to be able to communicate fully. Health and Social Work Staff should not assume that because staff and patients come from what appear similar ethnic minority groups, that they will necessarily speak a common language.

3.4.7 The attention paid by the medical and nursing staff to Mr J's communication and cultural needs stand in stark contrast to the proactive approaches by the Mental Health Officer and Care Manager, Ms N. Through the services of Mrs Y, an interpreter from the local authority Interpreting Services, Ms N undertook a thorough Community Care Assessment on 31 December 1993 and prepared a Social Circumstances Report on Mr J in which she took note of a number of his cultural needs, including the need for Mr J to socialise with people who shared his cultural heritage and spoke his language – Punjabi.

3.4.8 Ms N continued to pay heed to Mr J's cultural needs whilst he was at the residential home from 8 June to 9 September 1994 and undertook practical measures to fulfil those needs. She arranged for him to visit the local Mosque social centre three times a week; she also arranged for Mr J to have an appropriate and varied diet, which included the provision of hallal meat. Mrs Y, the interpreter, volunteered her time to visit Mr J at the residential home a few times and shared some Indian recipes with the chef, which other residents seem to have enjoyed as well. She also brought in a few items for Mr J's room to make it more homely for him. Mrs Y's work, which was outside her professional requirements, was in our view praiseworthy. Ms N's work was a good example of how a white professional can contribute to the positive acknowledgement and reinforcement of the culture of someone from a non-white minority ethnic group.

3.4.9 Alert to the fact that Mr J's cultural needs had been neglected during his first admission to Hospital 2, upon his readmission on 9 September 1994 Ms N asked the hospital Social Work Department "*to monitor Mr J's case and attempt to ensure that his dietary and social needs were being met as these areas were severely lacking during his last admission".* Additionally, to ensure the continuity of the culturally sensitive service provision, she passed on all the relevant information to the hospital Social Work Department. However, upon readmission to Hospital 2, despite Ms N's sterling efforts, the provision of culturally sensitive services for Mr J fell apart. They were not to be revived for the rest of his years in hospital.

Dietary Needs

3.4.10 There was a lack of attention to his dietary needs in addition to his language needs. There is no mention in the Hospital 1 records of his dietary needs, and the solitary mention at Hospital 2 on 4 February 1994 records the false assumption that Mr J required a vegetarian diet "*because of his religious beliefs*". It is saddening to note that despite the appropriate and effective dietary measures introduced by Ms N and Mrs Y at the residential home, matters slipped to their old ways at Hospital 2, the result being that Mr J was probably denied a relatively straightforward, inexpensive measure that could have added to the quality of his life in the hospital. In short, Mr J was absorbed into the cultural life of the ward which included Halloween parties, fish and chips, pantomime and trips to Butlins without any apparent assessment of how appropriate these were for him.

3.4.11 In addition to Mr J's obvious language, social and dietary needs, the other significant aspect of his care that was unattended to concerns his family. Despite numerous attempts by Mr J's brother and his family requesting that they would like Mr J transferred near to where they lived in England so that they could be closer to him and, therefore, more involved in his care, there is no evidence to suggest that the hospital staff made any efforts in this regard. Moreover, no recorded attempts were made to understand the family dynamics or, indeed to appreciate the family's anxieties about the care that Mr J was receiving in hospital.

3.4.12 The hospitalisation of Mr J was particularly distressing for his brother who considered it his duty to look after his sibling and he expressed deep guilt about the fact that his brother had to be in a hospital hundreds of miles away from him.

3.4.13 The family seem to have finally taken matters into their own hands and turned up in a van at Hospital 2 on 21 February 2001, seeking the discharge of Mr J. A hasty discharge was arranged without any attempt to seek Mr J's views on it, the poignancy of which is markedly evident in the following quote : "*on the day of Mr J's discharge [Mr J] was visibly upset and emotional but due to communication issues and family involvement it was difficult to ascertain whether this was due to distress or relief and joy at the prospect of being reunited with his family"*. It is ironic, even at this stage, that the staff after 6½ years did not appear to know Mr J's feelings about his leaving hospital.

SECTION 4: FINDINGS

The Inquiry Team found that in the 6 ½ years Mr J had been in hospital, there was no evidence that he had received adequate assessment, a clear diagnosis or appropriate care. He was given drug treatment without a clear diagnostic basis. His physical needs were not adequately addressed. His communication, cultural and social needs were neglected and he lived a limited institutional life, with little attention being paid to his individual needs. The manner of his discharge was disgraceful. The Inquiry's detailed findings are as follows:

4.1 Did Mr J receive adequate assessment, care and treatment?

4.1.1 Comprehensive social work assessments of Mr J's needs were made before his first admission to hospital and when he was detained. Appropriate use of interpreters was made to assist with these assessments.

4.1.2 During both Mr J's stay in the residential home and at the time of his second admission to Hospital 2, those involved in his care made careful plans to try to meet his dietary, social and cultural needs. None of these plans were taken up by social work, medical or nursing staff at Hospital 2, despite all the relevant information pertaining to Mr J's dietary, social and cultural needs being communicated to the hospital Social Work Department. Consequently, the quality of care that Mr J received in relation to these needs during his years at Hospital 2 was extremely poor.

4.1.3 Much of the information about Mr J's background and needs in the assessments made by Ms N, and about interpreting and other resources for cultural and social activities, did not reach Mr J's medical file. Only the social work file contained a copy of the Social Circumstances Report.

4.1.4 After Mr J's second admission to Hospital 2, no social work help was requested or offered during his stay there of six years and five months. Mr J's family had to seek help from their local Social Services Department soon after his discharge.

4.1.5 There was extremely limited information about Mr J's personal history and social circumstances in the medical case-notes, and none in the nursing records and care plans.

4.1.6 The care and treatment given by the Consultant Psychiatrists responsible for Mr J fell well below what the Commission believes to be acceptable standards.

4.1.7 From medical and nursing records, there is no evidence that medical and nursing staff considered making a social work referral to assess Mr J's social and family circumstances following his second admission to Hospital 2.

4.1.8 There are no records of an adequate assessment being made of Mr J's mental state. In Hospital 1, one mental state examination was carried out by a psychiatrist with the help of an independent interpreter. No further mental state assessments, using an interpreter, were carried out following his transfer

to Hospital 2. The relationship between his visual impairment and his behaviour and mental state does not appear to have been considered. Equally, the relationship between the communication difficulties and Mr J's visual impairment and his behaviour or mental state was not addressed.

4.1.9 There was no evidence that Mr J had an adequate cognitive assessment in spite of a history of head injury and possible memory impairment.

4.1.10 There was no recorded ongoing assessment of Mr J's visual disability. This is unacceptable.

4.1.11 There is no evidence that Mr J's respiratory function was adequately investigated, despite his recurring respiratory difficulties throughout his admission to hospital. Very shortly after his discharge from Hospital 2, it was established that he was suffering from carcinoma of the lung.

4.1.12 There is no evidence that Mr J's epilepsy was adequately investigated during his admissions to Hospital 2, though appropriate investigations had been set in train at Hospital 1. The relationship between his epilepsy and possible mental disorder was not assessed.

4.1.13 From medical and nursing records, it does not appear to have ever been established that Mr J had a mental disorder. There was no evidence that consideration had been given to a differential diagnosis in his case. He was treated with depot neuroleptic medication for several years, without a diagnostic basis for this treatment being established.

4.1.14 Despite being treated with neuroleptic drugs for several years, there was no record to suggest that medical and nursing staff considered whether Mr J gave informed consent to treatment or had the capacity to do so. It is hard to see how this could be done without the use of an appropriate interpreter.

4.1.15 There is no record that Mr J's mental state or treatment was reviewed by the psychiatrist responsible for his care between the time of his second admission to Hospital 2 on 9 September 1994, until his discharge on 21 February 2001.

4.1.16 During his admission to Hospital 2 the medical notes contained no comprehensive treatment plan which covered his pharmacological, psychological and social aspects of treatment.

4.1.17 There was an informal arrangement to review the care and progress of patients on Ward B, in which Mr J stayed. However, during the 6 years 5 months of his stay in Hospital 2 he was never selected by medical and nursing staff for a review of his care. [1]

4.1.18 Following Mr J's second admission to Hospital 2, there was no evidence of any further review of whether his needs were best met by continuing care in hospital, or whether he could be cared for in an alternative setting.

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[1] MEL(1996)22

4.1.19 A basic nursing care plan was drawn up following Mr J's second admission to Hospital 2 in September 1994. The care plan was rewritten on two occasions but there were no changes until a visit by the Commission's representative in August 2000 when it was revised. However there is no other record that the nursing plan and subsequent nursing interventions were adequately monitored and assessed during this admission.

4.1.20 While some activities were arranged for Mr J, from the limited resources available in Hospital 2, there was no record that an individual assessment of his recreational and activity needs had ever been made.

4.1.21 His family were offered no consistent or appropriate advice and support in relation to Mr J's care.

4.2 Was adequate use of translating services made by medical and social work staff to facilitate appropriate assessment, care planning and regular reviews?

4.2.1 Most of the health professionals within Hospital 2 caring for Mr J failed to recognise the importance of using appropriate interpretation services in assessing his mental and physical health and social care needs and providing appropriate treatment and care.

4.2.2 Mr J's limited ability to speak English was seen as a deficiency in his communication rather than a problem shared between him and those caring for him.

4.2.3 On the few occasions when formal communication was attempted there was inappropriate use of family interpretation. During his second admission to Hospital 2 on the occasion when an interpreter was used, based on the records available to the Inquiry, the service was inappropriate in two ways:

(i) the interpreter did not appear to be aware of the requirement for an accurate interpreting service, which is crucial in the process of a mental health assessment;

(ii) the interpreter introduced his own views, attitudes and value judgements in the interpreting process.

However, during the first admission to Hospital 2 the professional interpreter demonstrated an example of good practice.

4.2.4 Mr J was detained on 3 February 1994. Section 110 of the Mental Health (Scotland) Act 1984 requires that hospital managers ensure the person being detained understands to the best of their ability their rights and the implications of their detention under the Act. There is no record this was done in Mr J's case.

4.3 Were adequate resources made available for Mr J to provide an appropriate quality of life in hospital and to prepare him for possible discharge?

4.3.1 There is no evidence that either Dr D or the nursing staff at Hospital 2 tried to secure a social work contribution to the process of planning Mr J's discharge.

4.3.2 In planning his discharge, the guidance and directives given by the Management Executive of the NHS in MEL(1996)22, *NHS Responsibility for Continuing Health Care* and in Section 27 of the Trust's discharge protocol were almost entirely ignored.

4.3.3 There are no social workers attached to long stay wards in Hospital 2 and the hospital's Social Work Services Design does not specify the contribution that social work should make to the care and treatment of long stay patients.

4.3.4 There were no records of any communication between nursing and medical staff about the requests made by Mr J's brother and his family to take Mr J home.

4.3.5 No independent attempts were made to ascertain Mr J's views during the discharge process or involve him in discharge planning.

4.3.6 There was no evidence that any consideration was given to advocacy or befriending services in Mr J's case.

4.3.7 After his admission to Hospital 2, no effort was made to identify his cultural or social needs. There were no accurately informed attempts made to address these.

SECTION 5: RECOMMENDATIONS

5.1 Health and Social Work

5.1.1 The Trust and Local Authority 2 Social Work Departments must ensure that Social Circumstances Reports are readily accessible in medical files; and all recent social work assessments should be kept in social work files.

5.1.2 The Trust and Social Work Department should develop a joint policy to ensure that continuing care wards have an allocated social worker who participates in all annual reviews of patients.

5.1.3 The Trust and Social Work Department should give clear information about hospital social work services to continuing care patients, their families and medical and nursing staff.

5.1.4 The Trust and Social Work Department should revise their current discharge protocols to include procedures to be followed in the case of continuing care patients. They should ensure all staff are aware of the Scottish Executive protocols and follow them. MEL (1996)22 must also be followed. There must be clear recording of all actions taken.

5.1.5 The Trust and Social Work Department must have access to trained, independent interpreters and have a clear protocol for their use in assessing patients whose communication skills are limited because of either their ethnic background or other factors. There must be policies for staff training in this area.

5.1.6 The Trust and Social Work Department must ensure that the patient's care is discussed with and explained to him/her in a way that he or she can understand. This applies particularly to discharge planning.

5.1.7 The Trust and Social Work Department should ensure that all staff establish the patient's family's views about his or her care; these should be recorded. This applies particularly to discharge planning.

5.1.8 The Trust and Social Work Department should offer an apology to Mr J and his family for the deficiencies in the care he received during his stay in Hospital 2 between 4 February 1994 and 21 February 2001.

5.2 Health

5.2.1 The Trust should ensure that at least a preliminary diagnosis is recorded before patients receive substantive medical treatment.

5.2.2 The Trust should ensure that patients to be transferred from one hospital to another are accompanied by copies of all case-notes and correspondence.

5.2.3 The Trust should ensure that all continuing care patients have their treatment, progress and needs systematically reviewed and recorded at least once a year.

5.2.4 The Trust must develop a clear protocol for assessing the psychiatric, physical, dietary, language and cultural needs of all patients from minority ethnic backgrounds.

5.2.5 The Trust must ensure that the competence of their consultants is thoroughly appraised. It must arrange appropriate further training or other remedial action where necessary.

5.2.6 The Trust must ensure that patients with capacity to make treatment decisions are not treated without informed consent. Capacity should be assessed and recorded and regularly reviewed in all patients. Appropriate interpretation services must be used when necessary.

5.2.7 The Trust must ensure that sensory impairment in all continuing care patients is addressed and regularly reviewed. The Trust must ensure that all staff are trained to recognise the relationship between sensory impairment, mental disorder and subsequent behaviour.

5.2.8 The Trust must ensure that all continuing care patients have their needs for therapeutic and recreational activities regularly reviewed and recorded and appropriate activities are available and patients are helped to engage with them.

5.2.9 The Trust must ensure that a comprehensive nursing assessment and care plan is established for all patients in continuing care wards. The Trust must ensure that nursing care plans and consequent nursing interventions are regularly reviewed. The Trust must also ensure that every patient has an overall multidisciplinary care plan which addresses their pharmacological, psychological and care needs.

5.2.10 The Trust must ensure that their responsibilities under Section 110 of the Mental Health (Scotland) Act 1984 are met in the care of all patients, and particularly those whose first language is not English.

5.2.11 In addition to the need to provide interpretation services for patients whose first language is not English, the Trust must ensure that such patients have the opportunity to talk to an appropriate person in their own language on a social or therapeutic basis. It must ensure that the provision of advocacy or befriending services is considered in all cases of patients whose first language is not English.

5.3 Social Work

5.3.1 The Social Work Department should make an assessment of each continuing care patient's need for social work services. This assessment will require a review of the patient's background and life history.

5.4 The Scottish Executive

5.4.1 The Scottish Executive should be requested to issue up to date guidance to all Trusts and Social Work Departments on the use of interpreters within mental health services.

5.4.2 The Scottish Executive should be requested to issue up to date guidance on the use of advocacy and befriending services to people with mental health problems from minority ethnic background within mental health services.

SECTION 6: REFERENCES AND BIBLIOGRAPHY

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