Scottish Parliament Region: North East Scotland

Case 200900775: Tayside NHS Board

Summary of Investigation

Category

Health: Hospitals; psychiatry; clinical treatment; diagnosis

Overview

The complainant (Mrs C) complained about the transfer of her son (Mr A) to the Intensive Psychiatric Care Unit (the IPCU) at Carseview Centre (the Centre), Ninewells Hospital (Hospital 1), Dundee, on 8 January 2008. Mr A had been transferred from the Forensic Unit (the Unit), Murray Royal Hospital, Perth, where he was being treated under a Compulsory Treatment Order (CTO). She also complained that, on 16 January 2008, Mr A was granted a period of escorted leave within the vicinity of the Centre, from where he was able to abscond.

Mrs C complained that when Mr A returned to the IPCU that same evening, he was not provided with adequate physical care and treatment. Mr A died in the early hours of 17 January 2008.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Tayside NHS Board (the Board)'s decision making processes to transfer Mr A from the Unit to the IPCU at Hospital 1 were unclear (*upheld*);

(b) the decision taken to allow escorted leave from the IPCU was inappropriate for Mr A on 16 January 2008 (*upheld*); and

(c) Mr A's physical care and treatment was inadequate on his return to the IPCU from a period of unescorted leave on 16 January 2008 (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) urgently review their procedures for the transfer of patients under a CTO to ensure that non urgent transfers are properly categorised and dealt with as such; and that decisions are properly recorded;	16 March 2011

(ii)	ensure that, where there is a statutory right of appeal against the decision to transfer, the appropriate persons are formally notified of that right;	18 April 2011
(iii)	ensure that every consideration is given for the named person to have the opportunity to provide their views formally and for these views to be recorded and considered as part of the decision making process;	18 April 2011
(iv)	ensure that decisions taken about the level of leave allowed during any episode of care and the level of escorts are explained and understood by the patient and their relatives (where appropriate) and a full record is made of these;	18 April 2011
(v)	consider the introduction of a locally based alert system within the vicinity, which would enable staff to draw attention to potential incidents sooner than the time taken to return to the ward;	18 April 2011
(vi)	review the escort arrangement at the IPCU for accompanied time out, to ensure that the arrangement is clinically appropriate in terms of the risk assessment for the patient;	18 April 2011
(vii)	provide training to ensure the adequate medical examination, nursing observation and assessment of vital signs within the IPCU, when managing a patient recently having consumed an illicit substance;	18 April 2011
(viii)	ensure that there is appropriate consideration for review of the procedure or protocol for referring a patient to the local Accident and Emergency department for further consideration of physical care and treatment when they admit to having consumed illicit substances;	18 April 2011
(ix)	remind staff of their professional responsibilities towards the care and treatment of a patient received into their care with or without prior advice provided by other professional disciplines;	16 March 2011

(x)	conduct an audit to ensure full compliance of the use of assessment tools and measures and completion of monitoring charts and vital signs monitoring charts;	18 April 2011
(xi)	ensure that this report is shared with all staff involved in Mr A's care when he returned to the IPCU on 16 January 2008, so that they can learn from the findings of this report; and	16 March 2011
(xii)	provide an apology to Mrs C for the failures identified in this report.	16 March 2011

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The complainant, Mrs C, complained about the decision to transfer her son (Mr A) to the Intensive Psychiatric Care Unit (the IPCU) within Carseview Centre (the Centre) in Ninewells Hospital (Hospital 1) on 8 January 2008, where he was under the care of a Consultant Psychiatrist (Consultant 1). Mrs C also complained about the level of care and treatment provided to Mr A after he had transferred to the IPCU. Mr A had been transferred from the Forensic Unit (the Unit) at Murray Royal Hospital (Hospital 2), where he had been under the care of a Consultant Forensic Psychiatrist (Consultant 2).

2. Mr A had been in Hospital 2 since 31 July 2007, following a transfer from HMP Barlinnie following a deterioration in his mental health. This had taken place under a transfer directive in accordance with the terms of Section 217 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act). Mr A's custodial sentence expired in September 2007, at which time an application for a Compulsory Treatment Order (CTO) was made by Tayside NHS Board (the Board) and granted by a mental health tribunal.

3. Soon after Mr A's arrival in the Unit Mrs C lodged a complaint with the Board, dated 3 September 2007, raising her concern about the proposal to transfer Mr A from Hospital 2 to Hospital 1. She considered that such a transfer would be detrimental to Mr A's health and long-term recovery. In particular, she considered that as Hospital 1 was close to his home environment, there would be increased access to people and situations in which Mr A may have access to illicit substances. Mrs C also raised concerns about Mr A’s previous admissions to the IPCU at Hospital 1, including that he had absconded whilst under observation.

4. Mrs C's complaint was responded to on 24 October 2007. The Board advised Mrs C that Mr A did not require the same level of restriction the Unit in Hospital 2 offered to him in respect of his presenting mental health and that since his admission he had maintained steady improvement. They confirmed that it was the view of Consultant 2 that Mr A would not continue to require the level of security provided by the Unit on a permanent basis.

5. Subsequently, Mr A was transferred to the IPCU in Hospital 1 on 8 January 2008. Following this, during a period of escorted leave from the

IPCU on 16 January 2008, Mr A absconded. He returned to the IPCU later that evening, where he died in the early hours of 17 January 2008.

6. Mrs C complained to the Board on 30 January 2008. She referred to her original complaint of 3 September 2007 and she also complained about events leading up to Mr A's death on 17 January 2008. She complained, in particular, that her son had died due to the negligence of staff in the Centre, in allowing him to abscond twice while he was held in a secure unit. The Board acknowledged the complaint on 31 January 2008. They confirmed that they were investigating the issues Mrs C had raised and that she would be advised of the outcome.

7. A response from the Board was issued on 5 March 2008. They advised that it was the opinion of the responsible medical officer in the Unit (Consultant 2), and the multi-disciplinary team, that Mr A had evidenced an improvement in his condition to an extent whereby he no longer required the level of security offered within the Unit. This was in accordance with the principles embedded within the Act whereby each individual must be offered the least restrictive option in regard to their care and placement. The Board continued that Mr A had enjoyed accompanied time out from the Unit with no attempts to abscond. With regard to Mr A absconding twice from the Centre, they advised that the first recorded occasion was during an admission in 2006, prior to his detention at HMP Barlinnie, when he failed to return to the IPCU from planned unaccompanied time out. The second occasion had been on 16 January 2008.

8. They concluded that, having examined the medical and nursing notes, they could find no evidence that Mr A should not have been transferred to the IPCU; that nursing staff facilitated, by any omission of care, his absconding from the Centre on two separate occasions; or that the nursing team were remiss or neglectful in their professional duties in any way which could have contributed to Mr A’s death.

9. A further complaint was raised with the Board on 28 March 2008 by solicitors acting on behalf of Mrs C and Mr A’s stepfather. The solicitors asked how Mr A had absconded from the Centre during a period of planned/ accompanied time out on 16 January 2008. They also asked for confirmation of his condition when he returned to the Centre later that evening and details of the clinical investigations and treatment provided. The Board responded on

19 May 2008. They advised that at approximately 16:30 on 16 January 2008 Mr A requested that a member of staff escort him to the vending area of the Centre for a cup of coffee. A Nursing Assistant (the Assistant) had done so. Mr A was described as settled and not agitated in any way. Mr A had a cigarette just outside the building on the patio area. He had then gone to the toilet. Following this, Mr A had obtained a coffee and taken it with the Assistant to the patio area. When he was finished the Assistant had asked if he was ready to return to the IPCU. The Assistant had then turned away to open the door and, as he turned back holding the door open, Mr A was running down the path headed for a wooded area. The weather was cold and dark and the Assistant had felt he would have been at risk had he followed, as it was outwith the security of the Centre and he had no colleagues to help him if he had caught Mr A. The Assistant had therefore returned to the Centre to report Mr A missing.

10. With regard to Mr A's condition on return and the subsequent clinical investigations and treatment, the Board said that when Mr A returned his gait was unsteady. Mr A had been taken to his bedroom and he was asked if he had consumed anything. He had replied 'a few nips'. He was breathalysed and the results came back negative. He was searched but no illicit substances or alcohol were found. The duty doctor (Doctor 1) had examined him and nurses were advised to observe Mr A's respiration rate and keep him hydrated. It was noted in the medical documentation that Mr A had admitted to medical and nursing staff to taking a £10 bag of heroin. Nursing staff observed Mr A as per Doctor 1's instruction at 21:00, 22:00, 22:15 and 23:00. They observed that Mr A was lying on his bed at this point (23:00) and he was asked to get ready for bed. A nurse recalled that his breathing was normal and that he responded to her request. The Board advised that although not all checks were documented, staff clearly recalled making them. On a regular check at 23:45, Mr A was found not to be breathing and cardiopulmonary resuscitation (CPR) was carried out in line with local procedures. Mr A was pronounced dead at 00:15.

11. The post-mortem result gave the cause of death as the adverse effects of heroin. Mr A was found to have secreted a condom of heroin within his back passage, which had leaked.

12. Mrs C brought her accumulated complaints to my office on 26 May 2009.

Investigation

13. My complaints staff made a number enquires to the Board and interviewed Board staff involved in this case. In addition, advice has been obtained from a nursing adviser to the Ombudsman with extensive experience in psychiatric nursing (Adviser 1), the Ombudsman's medical adviser (Adviser 2) and a consultant in psychiatric care (Adviser 3).

14. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

15. The complaints investigated are that:

(a) the Board's decision making processes to transfer Mr A from the Unit to the IPCU at Hospital 1 were unclear;

(b) the decision taken to allow escorted leave from the IPCU was inappropriate for Mr A on 16 January 2008; and

(c) Mr A's physical care and treatment was inadequate on his return to the IPCU from a period of unescorted leave on 16 January 2008.

Relevant Legislation

16. The Act applies to individuals with a 'mental disorder'. This term is used to cover mental health problems, personality disorders and learning disabilities. The Act is based on a set of guiding principles. As a general rule, anyone who takes any action under the Act has to take account of the principles (the Milan Principles – see Annex 4). There are ten principles. In particular, principles 6 and 7 state:

> '6 Respect for carers: those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice and have their views and needs taken into account.
>
> 7 Least restrictive alternative: service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.'

17. The Act allows for people to be placed on different kinds of compulsory order according to their particular circumstances. There are three main kinds of

compulsory powers: emergency detention; short-term detention; and CTO, which has to be approved by a mental health tribunal (the tribunal).

18. Section 124 of the Act sets out the procedures which apply where a person subject to a CTO requires to be transferred from one hospital to another. The transfer under this section can occur only where the managers of the receiving hospital consent to the transfer. In normal circumstances, under section 124, notice of the proposed transfer of at least seven days requires to be given by the managers of the transferring hospital to the patient, the patient's named person and to the patient's primary carer. However, seven days notice need not be given if the patient consents to the transfer or if the patient requires to be transferred urgently. The Code of Practice which accompanies the Act states an urgent transfer would be 'where there are strong clinical reasons for doing so' (volume 2, chapter 9). It goes on to state that in both these circumstances the managers of the transferring hospital still need to notify the patient, the patient's named person and the patient's primary carer as soon as possible before the transfer takes place or, if this is not feasible, then as soon as possible after the transfer has taken place. In all cases, best practice is to ensure that as much advance notice is given as possible.

19. The Act makes provision for an appeal to be made to the tribunal by either the patient or the patient's named person either where notice has been given of the proposed transfer or where the transfer has already taken place. In this regard, the Code of Practice states:

> 'It will be important for all members of the patient's multi-disciplinary team to make sure that the patient and the patient's named person are fully aware that they have a right to appeal against a transfer. It would also be best practice for them to ensure that they provide the patient and the named person with information and assistance to enable them to exercise their rights, should they wish to do so.'

(a) The Board's decision making processes to transfer Mr A between the Unit and the IPCU at Hospital 1 were unclear

20. Mrs C complained that Mr A's transfer to the IPCU had not been appropriate and the reasons for the transfer were unclear at the time.

21. During Mr A's admission in Hospital 2, the clinical record indicated that Mr A was assessed regularly and managed in line with an agreed multi-disciplinary care plan. Very soon after his admission, Mr A discussed the

possibility of being able to move to a mental health in-patient setting closer to his home and the multi-disciplinary team began to explore that, as a result of their observation of Mr A's continued mental health improvement.

22. Consultant 2 wrote to Consultant 1 on 8 August 2007. She advised that she understood that Consultant 1 was keen to look after Mr A in the longer term and advised that Mr A had been started on anti-psychotic medication which was beginning to take effect. She indicated she would be happy to discuss Mr A's future management with her to ensure a smooth transition of care. Consultant 1 replied on 13 August 2007. She stated that Mr A had been under her care from March until May 2006 but that subsequent to this he was difficult to engage, continued to abuse drugs and there was a possibility of non compliance with medication. Consultant 1 said that Mr A was admitted again to Hospital 1 on 12 July 2006 but discharged himself against medical advice on 17 July 2006. Given this background, Consultant 1 felt it would be helpful in the initial stages to have formal arrangements in place in order to transfer Mr A to the IPCU for further care when he was ready.

23. On 29 August 2007 solicitors acting on Mr A's behalf wrote to Consultant 2 advising that he was keen to move to the Centre at Hospital 1; that he was finding the regime in Hospital 2 difficult to cope with; and had not had any visitors.

24. Mr A was seen by Consultant 1 on 5 September 2007 and a CTO for Mr A was granted at a mental health tribunal hearing on 21 September 2007. He was also granted accompanied time out within Hospital 2 grounds, given his overall improvement.

25. On 25 October 2007 a Care Programme Approach (CPA) meeting was held, when it was agreed that transfer to the IPCU was appropriate. Consultant 1 had not been able to attend the meeting due to annual leave and had submitted her apologies. Although it is not clear from the nursing records, both the Board and Mrs C have confirmed that Mrs C was in attendance. Consultant 2 was on sick leave and the CPA was attended by her specialist registrar. The nursing records note that it was agreed the specialist registrar would contact Consultant 1 to discuss possible transfer details.

26. Following this, Consultant 1 wrote to the specialist registrar on 8 November 2007. She confirmed that she had reviewed Mr A in

September 2007. She advised that at that time he remained acutely unwell and had only been reduced from constant observation levels to general observation levels. She advised that on discussion with Consultant 2 at that time it had been considered that Mr A was appropriately placed within the Unit and that Consultant 1 would be asked to review him with a view to transfer to the Centre if he continued to make progress. Consultant 1 advised she had met Mrs C that day at the Centre and Mrs C had expressed concerns regarding Mr A moving to the Centre. Consultant 1 had informed her that she would be reviewing Mr A before such a transfer would be arranged and that Mrs C would be included in the discussions regarding the next stage of Mr A's care.

27. Consultant 1 wrote again to Consultant 2 on 27 November 2007. She advised that she had visited Mr A at the Unit on 19 November 2007 for the purposes of reviewing him in relation to his fitness to transfer. She confirmed it was apparent that he had made considerable progress and that his mental state had stabilised further. She advised that Mrs C had been visiting Mr A on that day and she had spoken with her. Mrs C had again strongly expressed her desire for Mr A not to be transferred to the Centre. Consultant 1 recommended that, given Mrs C's strong concerns regarding the transfer, it would not be to anyone's advantage if the named carer was totally opposed to the care plan proposed. She therefore recommended that consideration be given to an initial transfer to General Adult Psychiatry within Hospital 2.

28. However, on 5 December 2007 Consultant 2 wrote to Consultant 1 advising that Mr A remained keen to return to his accommodation in his home town and was close to a stage where he would be appropriately managed in the community under a CTO. She confirmed her opinion that Mr A was now at a stage where he was ready to have some rehabilitation and discharge planning in his home area. Mr A was subsequently transferred to the IPCU on 8 January 2008. A transfer letter from a doctor in the Unit to the IPCU was sent on the same day. The letter thanked the IPCU for accepting Mr A and provided details of his custodial sentence which had ended on 21 September 2007, at which time the CTO had been granted. It provided details of his medical history and enclosed a copy of his vignette (summary of past medical and social history), family tree and line diagram (time line of clinical events).

29. Prior to this transfer, it was noted in the nursing records that on 24 December 2007 Mr A was observed to be attempting to surreptitiously hand money to a fellow patient. When challenged, he had denied it but later claimed

he was handing over money for cigarettes. Consultant 2 had been informed and this, together with a conversation Mr A had had with Mrs C the previous day about absconding during his time out on Christmas Day, led to a joint decision being taken by Consultant 2 and the charge nurse to rescind Mr A's (home) pass from hospital for Christmas Day. There was no mention of this in the transfer letter.

30. In response to my complaints reviewer's enquiries, the Board confirmed that there was agreement that Mr A was suitable for transfer to the IPCU under the least restrictive principles of the Act. It was known that Mrs C was unhappy with Mr A's possible return to the Centre in light of his potential access to his former social contacts but Mr A himself continued to express a desire to return to his home area.

31. The Board continued that there were pressures on the Unit but that was not the sole reason for Mr A's return. However, the Board acknowledged that this issue did influence the timing of his return in early January 2008. From the documents provided to my complaints reviewers and the interviews held with Board staff, it was clear that the demand for beds in the Unit was high at the particular time Mr A was transferred and there was a patient requiring transfer to the secure setting offered by the Unit but the Unit was unable to admit him because of bed pressure.

32. At interview with one of my complaints reviewers, Consultant 2 said that, in view of Mr A's improved mental health and mindful of his requests, the potential for his transfer had to be considered. Allied to this, Consultant 2 confirmed that a bed was required within the Unit for a patient who was the subject of a court transfer.[1] Taking this into account, along with Mr A's presenting mental health state and in light of his request to be transferred, Consultant 2 made the decision that it should be Mr A who was considered for the transfer.

33. At interview, and in a written submission, Consultant 1 indicated that there had been very little discussion and agreement in relation to this transfer in the period immediately preceding it. Consultant 1 said she had not agreed with the transfer but felt she had no option but to accept Mr A into her care. Her

[1] When responding on the draft report, the Board advised that a bed was required within the Unit for a patient who required to be admitted from HMP Perth, where he was a remand prisoner.

understanding was that there was a bed management requirement within the Unit and Mr A was considered as appropriate for transfer to the IPCU to resolve that issue. She said she had not been happy with the transfer and knew that Mrs C was very unhappy. Consultant 1 asserted that her view had been that she did not consider Mr A to be well enough to be transferred. She advised that the information relating to Mr A's (home) pass for Christmas Day being rescinded had not been communicated to herself or nursing staff on the ICPU, nor had Mrs C's formal complaint of 7 September 2007. These two matters demonstrated that Mr A should have remained in the Unit.

34. Consultant 1 explained that, prior to the transfer taking place, she had asked for the clinical view of a Rehabilitation Consultant (Consultant 3) within the Board to consider whether there was a possibility of alternative settings for Mr A to receive care and treatment. At interview with my complaints reviewer, Consultant 3 recalled a brief conversation with Consultant 1 about the care and treatment of Mr A. He had not met Mr A but based on the information provided to him, there was not scope for Mr A to be treated immediately within the rehabilitative service he provided as he did not consider the rehabilitation service he provided could offer the right therapeutic environment for a patient such as Mr A.

35. Apart from the letters between Consultant 1 and Consultant 2, in which they both offer suggestions for Mr A's placement, and the transfer letter of 8 January 2008 there is no other contemporaneous record of the decision taken to accept Mr A into the ICPU. However, a Transfer Certificate (Transfer to Other Hospital Within Scotland) (the Certificate) was completed.

36. Responsibility for completing the Certificate rested with the managers of the transferring hospital. In terms of reasons for the transfer, the Certificate stated that Mr A no longer required to be in the Unit and was being transferred back to a hospital in his own home area. It also confirmed that Mr A had consented to the transfer. Under Part 2 - Notification to Patient - the manager was asked to complete Sections A or B as appropriate. Section A requested confirmation of notification at least seven days in advance of the proposed transfer and was not completed. Section B, which required confirmation that it had been necessary to transfer the patient urgently with less than seven days notice being given, was not completed (shaded), however, in the box requiring reasons for an urgent transfer the following was entered:

'Both [Mr A] and [Mrs C] (who is his named person) were aware that he would be transferred back to [the Centre] when a bed became available. This has become an urgent transfer due to urgent pressure on the forensic in-patient services and a bed becoming available in Dundee.'

37. It was also confirmed that as soon as practicable on or, as the case may be, after the transfer, notification was given to Mr A and Mrs C. The Certificate confirmed that they were both notified on 8 January 2008. The Board have advised Mrs C was contacted by telephone.

38. With regard to notification, the Board advised that it was clear Mr A consented to the transfer and the notification requirement was met. In terms of notifying Mrs C, as the patient's named carer, the Board commented that it was clear from the nursing records that Mrs C had been previously informed of the intention to transfer Mr A, although no date had been set at the time. However, they confirmed that it was not clear that Mrs C had been informed of her right to appeal the transfer. The Board went on to say that, with regard to notifications, the Act did not specify or make clear who should make notifications about the right of appeal or the procedures.

39. The Board advised that for the purposes of the Act, where it refers to hospital managers it is referring to the Health Board and health body responsible for the hospital. In this instance, the Board were the responsible managers for both the transferring and receiving hospitals.

Advice received

40. Adviser 1 has said he noted that Mr A had been assessed as fit for transfer and was keen to be transferred from the Unit within Hospital 2 to the IPCU within Hospital 1. Consultant 1 had reviewed Mr A in relation to his fitness for transfer and found him to have stabilised and to be amenable to treatment.

41. Adviser 1 considered that the final decision, being taken hurriedly in order to make use of the available bed, reduced the opportunities for Mrs C to fully express, in a formal setting, her concerns about the transfer. Adviser 1 would have preferred to see robust evidence of full consultation and involvement of all stakeholders in the final decision, including Mrs C and Consultant 1. It was the case that a CPA meeting was held on 25 October 2007, although it was noted

that Consultant 1 submitted her apologies ahead of the scheduled meeting and as a result the IPCU was not represented at the meeting.

42. Adviser 1 continued that a CPA meeting is in keeping with the principle of respect for carers. In this regard, although Mrs C's views regarding Mr A's possible transfer were well known, Adviser 1 considered Mrs C did not have the opportunity to formally voice them after the CPA meeting held on 25 October 2007 and within a setting where all the stakeholders were present at the same time. Therefore, it was Adviser 1's view that Mrs C did not have the opportunity to be fully apprised of the rationale underpinning the decision subsequently taken.

43. Adviser 1 noted that Mr A had been found to be trying to obtain illicit drugs from other residents during the period up to Christmas 2007 and noted that this was not recorded in the transfer letter. However, he considered Mr A was mentally stable and he was 'stable enough for transfer to go ahead'. Adviser 1 confirmed that this was a transfer to a locked clinical setting commensurate with Mr A's clinical needs at that time and was part of the broader plan to re-integrate Mr A back into his local community.

44. Whilst Adviser 1 could find no formal agreement by Consultant 1 to the transfer, he had no fundamental disagreement with the decision taken in respect of Mr A's transfer. Thereafter, Mr A's care and treatment was provided within that setting.

45. Adviser 3 confirmed that it was reasonable on clinical and legal grounds to transfer Mr A from the Unit to the IPCU on 8 January 2008. However, he noted there was no clear documented statement from Consultant 1 agreeing to accept Mr A into her care, which he said was regrettable.

(a) Conclusion

46. The advice I have received and accept is that the decision that Mr A was fit to transfer from the Unit to the IPCU was reasonable, based on his presenting symptoms and taking into account the relevant legislation. Nevertheless, I have serious concerns about the Board's actions leading up to that transfer. While technically the Board, as managers of the receiving hospital, agreed to the transfer, I am critical that they did not obtain the formal written agreement of the consultant into whose care Mr A was being transferred (Consultant 1) prior to the transfer.

47. It is also clear that Mrs C had deep concerns about Mr A's transfer. While she had the opportunity to express these informally to Consultant 1 and at the CPA meeting in October 2007, this was some time prior to his actual transfer and she was not afforded the opportunity to formally voice them again. It is also clear that what prompted the urgent transfer of Mr A on 8 January 2008 was the pressure on beds at the Unit and there was no clinical reason for the transfer to be deemed urgent. This does not accord with the Code of Practice, which states that where it is necessary to transfer a patient urgently this should be for clinical reasons. I do not consider the pressure of beds to justify, on clinical grounds, an urgent transfer and I regard such practice as unacceptable.

48. As regards notification of the transfer, the Board have stated that as Mr A consented to the transfer the notification requirement was met. It is clear from the documentation on file that Mr A was keen to be transferred. Nevertheless, the Code of Practice makes it clear that where the patient consents to the transfer the patient and/or his named person (in this case Mrs C) should be notified before or as soon as possible after the transfer. While the Board have said that Mrs C was aware of the intention to transfer Mr A, I would have expected formal written notification to be given. Moreover, the Board have also been unable to provide me with confirmation that Mrs C was advised of her right of appeal to a tribunal. In response, they have argued that the Act does not stipulate whose responsibility this is, however, I do not find this reasonable nor does it accord with the Code of Practice. In all the circumstances, I uphold the complaint and make the following recommendations.

(a) Recommendations

49.	I recommend that the Board:	*Completion date*
(i)	urgently review their procedures for the transfer of patients under a CTO to ensure that non urgent transfers are properly categorised and dealt with as such; and that decisions are properly recorded;	16 March 2011
(ii)	ensure that, where there is a statutory right of appeal against the decision to transfer, the appropriate persons are formally notified of that right; and	18 April 2011
(iii)	ensure that every consideration is given for the named person to have the opportunity to provide	18 April 2011

their views formally and for these views to be recorded and considered as part of the decision making process.

(b) The decision taken to allow escorted leave from the IPCU was inappropriate for Mr A on 16 January 2008

50. Mrs C complained that Mr A had been able to leave the Centre as a result of negligence on the part of the staff on duty on 16 January 2008.

51. The Board said the decision for Mr A to have accompanied time out from the IPCU was supported by confirmation in Mr A's nursing progress notes. The Board indicated that the nurse in charge on 16 January 2008 was complying with approved accompanied time out arrangements. The accompanied time out would only have been rescinded if there had been a change in Mr A’s presentation and an agreed management care plan authorised by the responsible medical officer (in this case, Consultant 1). The Board indicated the accompanied time out was agreed through the appropriate processes, as there had been no change in Mr A's mental health condition or any cause for concern. If there had been a requirement for a registered nurse or more than one nurse to conduct the escort, this would have been identified in a care plan in advance. There was no requirement indicated for this in Mr A's assessment. The accompanied time out of the IPCU had been limited to the confines of the Centre itself and the garden area. Mr A was not being accompanied out of the Centre.

52. In a written response Consultant 1 advised that following Mr A's transfer, he was clinically reviewed on 9, 10 and 14 January 2008 by the multi-disciplinary team. A routine urine analysis was carried out on 14 January 2008, which proved to be negative of any illicit substances. He appeared well and was granted time-limited escorted time out within the boundaries of the Centre. This was in line with the treatment plan which had been in place in the Unit and the information provided in the documentation accompanying the Certificate. Consultant 1 said that decisions with regard to ward passes were made at weekly multi-disciplinary team meetings. Prior to transfer, Consultant 1 said she had been informed that Mr A had been on accompanied time out in the grounds of Hospital 2 with trips into the nearby town with no problems in the previous three months. However, she stated that this was not in fact an accurate description of his status regarding passes. She advised that critical information regarding the suspension of his pass for 24 December 2007 and the

information that no further passes outwith Hospital 2 were arranged from 18 December 2007 should have been conveyed in the transfer letter of 8 January 2008.

53. The Board have also advised that when a patient is transferred it is normal practice for escorting nurses to take the case files along with the patient when they are being transferred. They have no reason to believe that this did not happen in this case but could not provide absolute evidence. When commenting on the draft report, Consultant 1 stated that the Unit medical records did not come with Mr A on his transfer to IPCU.

54. The medical notes recorded a multi-disciplinary/agency risk assessment and management plan as being completed on 8 January 2008. It identified the primary risk as the use of illicit substances, causing Mr A's mental health to deteriorate, and the secondary risk was absconding. The risk assessment confirmed Mr A was to be confined to the ward until he was reviewed by Consultant 1. It also noted the multi-disciplinary care plan review date '11/1/08-weekly'.

55. It was noted in the nursing records on 10 January 2008 that there had been a 'Dr Meeting'; that Mrs C remained concerned about Mr A obtaining illicit drugs; that Mr A had been seen by Consultant 1; and that from 10 January 2008 Mr A was allowed out of the locked ward at the IPCU in the company of staff. It was noted that on 11 January nursing staff spoke to Consultant 1 that a patient was intending to bring illicit drugs to the ward for Mr A and that Mr A had offered the patient £70 to buy illicit drugs. This had been denied by Mr A. On 14 January 2008 it was noted in the nursing records 'from meeting' that Consultant 1 had counselled Mr A regarding recent drug transactions with fellow patients. It was noted that Mr A denied this. On 15 January there was a similar entry in the nursing records about another incident of Mr A asking a patient to obtain illicit drugs for him.

56. There were completed nursing care plans dated 8, 11 and 16 January 2008, where it is noted that Mr A would be reviewed on 18 January 2008. There was also an IPCU weekly meeting summary dated 13 January 2008 which was completed by nursing staff. It recorded that Mr A had settled into the IPCU; had no management problems; had a few visitors; and that there was no evidence of negative/positive symptoms. There was no other record in the medical or nursing notes of the multi-disciplinary review

meetings referred to at paragraph 52; however, Consultant 1 provided my complaints reviewer with a copy of a progress note signed by her and a GP trainee. The note was dated 14 January 2008 and recorded Mr A's progress that week. It noted that Mr A had requested a fellow patient to obtain drugs for him; had given a patient on the ward £70 and persuaded him to abscond with a list of different types of illicit drugs to buy. This information had been received from the other patient and it was noted Mr A denied it. It was also noted that Consultant 1 had discussed with Mr A the use of drugs on the IPCU and explained that any such activities would quickly result in Mr A being returned to the Unit.

57. The nursing record for 16 January 2008 stated that Mr A 'requested a member of staff take him to the vending area for a cup of coffee'. The records described the incident of Mr A absconding without warning after finishing a coffee and the nursing assistant returning to the IPCU to inform nursing staff (after he had initially checked to see if Mr A had gone around the building to the front of the Centre and was in view). This was also described by nursing staff when my complaints reviewer interviewed them on 17 February 2010 with Adviser 1.

58. The Board confirmed that Hospital 1's procedures were followed by the nursing staff when Mr A absconded. This being that the nursing staff discharged their responsibilities at that particular time by advising relevant personnel and external agencies, as well as Mrs C, of Mr A's absconding. Mr A returned to the IPCU of his own volition later that day.

59. The Board has said that as a result of Mrs C's complaint the escorted time out and risk assessment had been subject to the normal service reviews and had resulted in the implementation of the Integrated Care Pathway (a particular care planning arrangement) supporting processes and documentation. They added that since the implementation of the Act, there had been clear guidance for staff in the process of escorting patients and instructions that staff should not pursue in chase, nor should they restrain patients.

Advice received

60. Adviser 1 advised that modern mental health care is based upon the measured and positive management of risk. It is about reducing the likelihood of risk events occurring; not about risk elimination. The latter approach leads to defensive, risk averse practices which can inhibit recovery. He was of the view

that the decision for Mr A to be able to leave the IPCU was an appropriate one, based on a multi-disciplinary discussion and a positive management of risk for Mr A's ongoing care.

61. Adviser 3 agreed it was reasonable to allow Mr A to have brief escorted periods away from the IPCU from 10 January 2008 but that it would be appropriate to consider a policy of double escorts and an alarm system.

(b) Conclusion

62. It is clear that every consideration must be given to care provision being provided within the least restrictive environment, based on the measured and positive management of risk. I am satisfied, from the documentary evidence, that Mr A was adequately assessed on 8 January 2008 when he was transferred to the IPCU. A post transfer risk assessment was made and the risks recorded. The action plan noted that he should be confined to the IPCU until reviewed by Consultant 1. This was in line with Mr A's clinical presentation and an assessment of prevailing risks and vulnerabilities at the time.

63. It is clear from the nursing record that Consultant 1 reviewed Mr A as being able to leave IPCU on accompanied time out from 10 January 2008. While I note Consultant 1's concern that information in relation to the suspension of Mr A's pass for Christmas Day was not referred to in the transfer letter, this information was available from Mr A's medical and nursing records which the Board have confirmed would normally transfer with the patient. While Consultant 1 has stated that the medical records were not transferred with Mr A, I would have expected Consultant 1 to have ensured that Mr A's full medical and nursing records were available prior to taking such a decision.

64. Nevertheless, I am concerned that the decision to allow Mr A accompanied time out passes from the locked ward is not documented in the medical records and referred to only in the nursing records. I am particularly concerned because it was recognised that Mr A absconding was a risk. There is no documentation detailing the clinical rationale for the decision on 10 January 2008 to allow him escorted time out from the locked ward environment nor is the escort arrangement itself documented. Given the references in the nursing records to Mr A attempting to obtain illicit drugs and persuading a patient to abscond to obtain these for him from 10 January 2008 onwards, I am also critical that there was no apparent reconsideration of the

decision to allow Mr A time out passes. On balance, given these failings, I have decided to uphold the complaint.

65. I make the following recommendations to the Board.

(b) Recommendations

66. I recommend that the Board:	*Completion date*
(i) ensure that decisions taken about the level of leave allowed during any episode of care and the level of escorts are explained and understood by the patient and their relatives (where appropriate) and a full record is made of these;	18 April 2011
(ii) consider the introduction of a locally based alert system within the vicinity, which would enable staff to draw attention to potential incidents sooner than the time taken to return to the ward; and	18 April 2011
(iii) review the escort arrangement at the IPCU for accompanied time out, to ensure that the arrangement is clinically appropriate in terms of the risk assessment for the patient.	18 April 2011

(c) Mr A's physical care and treatment was inadequate on his return to the IPCU from a period of unescorted leave on 16 January 2008

67. Mrs C complained that Mr A was not treated appropriately when he returned to the IPCU after absconding from escorted leave on 16 January 2008.

68. The nursing notes indicated that Mr A returned at 19:55 in a taxi, from which he was helped to one of the IPCU's fire doors by the taxi driver. It was noted that once in the IPCU Mr A admitted to taking a £10 bag of heroin. The duty doctor (Doctor 1) was asked to examine Mr A at 20:30. Mr A was searched by nursing staff but nothing illicit was found on him. Nursing staff contacted the appropriate staff to inform them of Mr A's return and also contacted the police and Mrs C. The nursing notes recorded that Doctor 1 was present on the ward and was asked to talk to Mr A to ensure he was alright.

69. Doctor 1 recorded in the medical notes that Mr A had absconded earlier in the evening, that he had returned to the IPCU of his own accord and that he had admitted to taking a £10 bag of heroin. The following clinical features were documented by Doctor 1: pallor; constricted pin point pupils; dizziness and poor

balance; heart rate more than 100 beats per minute; slow respiratory rate - around 12 breaths per minute; nausea (it was recorded that Mr A vomited during the examination); thirst; clammy skin and hands tremoring; puffy. There was no documentation of the Glasgow Coma Scale (a measurement used to assess conscious level), blood pressure or oxygen saturation of the blood. Doctor 1's clinical impression was 'heroin use'. Doctor 1 noted 'observe and rest' and that nursing staff should monitor respiration and keep hydrated. It was noted that she advised nursing staff to call her if they had concerns.

70. In response to my complaints reviewer's enquiries, Consultant 1 advised that she had been informed of Mr A's return to the IPCU and that Doctor 1 was in attendance. Consultant 1 was not on call but had been contacted by Doctor 1, who had informed her that she was carrying out a physical and mental health assessment of Mr A. Consultant 1 said that she instructed Doctor 1 that if she had any concerns regarding Mr A's health he should be sent to the Accident and Emergency department and that a drug screen should be carried out as soon as possible. There was no record of this discussion with Doctor 1 in the medical or nursing records. The nursing notes recorded that Consultant 1 had been contacted; that she had advised that Mr A be confined to the ward; and that a drug screen should be carried out the following day. It is not clear from the nursing notes who had contacted Consultant 1. The medical records recorded that Consultant 1 was contacted in the early hours of 17 January 2008 to advise of Mr A's death.

71. One of my complaints reviewers interviewed Doctor 1 by telephone. She advised my complaints reviewer that she saw Mr A in his room, having been informed by nursing staff of his return to the IPCU and being asked to review him as he appeared unwell. Her recollection of her examination of Mr A and subsequent events are based on a statement she prepared dated 31 January 2008, a copy of which she has provided to this office.

72. She advised that Mr A had been fully conscious and alert but had signs of taking heroin. His Glasgow Coma Scale was 15/15 and he had pin point pupils. He had admitted to her that he had taken a £10 bag of heroin and that, prior to that, he had last taken drugs seven months previously. Given his conscious level and state of alertness she had not considered that he required to be admitted to Accident and Emergency or be given an antidote, as he appeared to be coming round from the effects of heroin and was fully conscious. She had not taken Mr A's oxygen saturation and was unsure whether the IPCU had had

appropriate equipment for this. (It was noted in a post incident meeting held on 17 January 2008 that consideration should be provided to the IPCU purchasing a pulse oximeter for oxygen saturation.) She confirmed she had not taken Mr A's blood pressure. As she was examining Mr A in his room and not the treatment room, she did not have blood pressure equipment but as he appeared to be coming round from the effects of the heroin she did not consider it was necessary to do this. She had requested nursing staff to keep him hydrated and observe him. She gave no instructions as to the interval of observations but expected them to be hourly. (In Doctor 1's written statement, dated 31 January 2008, it was noted that she asked nurses to observe Mr A on an hourly basis.) Doctor 1 advised my complaints reviewer that, with hindsight, she should have requested 30-minute observations. Her expectations were that nursing staff would call in on Mr A and make conversation with him to ensure that he was conscious. She stated that she had not contacted Consultant 1 when she examined Mr A and, if she had felt it necessary, she would have contacted the out-of-hours duty consultant at home. She stated that she had only contacted Consultant 1 after Mr A had been pronounced dead, in the early hours of 17 January 2008. In response to the draft report, Doctor 1 advised that she recalled that a conversation had taken place between herself and Consultant 1 at the time of Mr A's examination. She recalled the nursing staff making a courtesy call to Consultant 1 to inform her of Mr A's return. She had been called out to speak to Consultant 1 on the phone. Consultant 1 had reminded her that she could send Mr A up to Accident and Emergency if concerned and Doctor 1 had informed her that she would speak to the Specialist Registrar on call if she had any other queries, as she knew Consultant 1 was not on call that night. Doctor 1 confirmed that this telephone encounter was not recorded by herself in the medical notes.

73. It was noted in the nursing records that the nursing staff night shift had given Mr A jugs of juice and water; and also that nursing staff checked Mr A at 21:00 and he was asleep. The notes recorded that nursing staff 'will continue to monitor mental state, behaviour and physical presentation during course of shift'.

74. The next entry noted that at approximately 23:45 the staff nurse had been summoned by his colleague to Mr A's bedroom where Mr A was found not to be breathing. The nurses' personal alarm system was immediately activated and CPR was commenced. It was noted that a medical emergency (crash) team was contacted immediately; that Doctor 1 was called and attended; and that

CPR was carried out until Mr A was pronounced dead at 00:15 on 17 January 2008. Doctor 1 recorded in the medical notes that her impression was that Mr A had suffered 'resp [respiratory] arrest from asphyxia of aspirating own vomit'.

75. In response to my complaints reviewer's enquiries, the Board have advised that, although there was no record in the nursing notes, nursing staff were interviewed following Mr A's death and indicated they carried out visual observations at intervals during the evening and, specifically, at 22:00, 22:15 and 23:00.

76. The nursing staff on the ward were interviewed by my complaints reviewer. They confirmed that the decision was taken to observe Mr A rather than transfer him to Accident and Emergency. He had been assessed as coming round from the clinical effects of a possible illicit substance or possible alcohol. They had been requested to observe Mr A and encourage him to drink, which they had done.

Advice received

77. Adviser 2 reviewed the care of Mr A from 19:55 on 16 January 2008 until his death at 00:15 on 17 January 2008. He commented that Doctor 1 was a relatively junior doctor and not a specialist trainee in psychiatry. That, in itself, was not extraordinary in the out-of-hours cover of many different types of in-patient units but it was important, as he would not expect all doctors of this grade to have sufficient experience to manage a patient without taking advice from a more senior colleague. Consultant 1 had stated that she gave advice to Doctor 1 at the time but there was no contemporaneous record of that advice and the advice, as described by Consultant 1, was broad and non-specific. Consultant 1 said she had advised Doctor 1 to transfer the patient to Accident and Emergency if she 'had any concerns' about Mr A. That advice would have been enhanced if she had instructed on specific criteria which would constitute concern, or specific criteria which might indicate the need to administer naloxone (an antidote), oxygen or to take any other specific steps.

78. Adviser 2 went on to say that while Doctor 1 undertook an assessment detailed enough to correctly diagnose features of heroin use, her assessment would have been improved by measurement of oxygen saturation and blood pressure and an attempt to establish how the heroin had been taken. The implication of her advice to nursing staff to 'monitor respiration' was that she

considered it was possible Mr A could deteriorate and that such monitoring would detect deterioration before it became potentially life threatening. However, her advice would have been improved had she given clearer instructions on what specific observations were required; how frequently they were to be undertaken; and what changes would indicate the need for nurses to call for further medical review. If Doctor 1, in giving such advice to nurses, found that the IPCU could not undertake the monitoring she believed necessary then a discussion should have taken place about the need for transfer. Adviser 2 noted that Doctor 1's specific written advice ('monitor respiration') did not appear to have been followed by nursing staff, in that there were no recordings and no statement to say that such recordings were made in the nursing notes. He agreed with Adviser 1 that the nursing checks were insufficiently structured, frequent or specific to allow the chance of detecting significant clinical deterioration of Mr A before it actually occurred. As such, the clinical care Mr A received following his return to the IPCU fell below a standard that could reasonably be expected.

79. Adviser 2 concluded that while it could not be said with absolute certainty that better assessment, monitoring and observation of the patient and, in particular, recording of respiratory rate, would have prevented Mr A's sudden death, in his opinion it would have been highly likely to have done so.

80. Adviser 1 commented that the care and treatment provided after Mr A's return to the IPCU by nursing staff was lacking. At the very least he would have expected temperature, pulse, respirations, blood pressure, fluid intake and conscious level to have been monitored and charted regularly – perhaps every 15 to 30 minutes as a minimum, particularly where there was knowledge of a period free of any illicit drug use. He noted comments made by staff that on his return from being away from the IPCU that afternoon, Mr A was 'under the influence of something'.

81. However, Adviser 1 also noted that there was a brief period when Mr A returned to the IPCU when staff could have considered him to be of reduced risk from any adverse effects of any illicit substance he may have obtained and consumed whilst out of the IPCU. He appeared to staff to be 'coming round' and was able to engage in conversation when the night shift came on duty.

82. Nevertheless, Adviser 1 noted:

'Although the records indicate that staff checked on [Mr A] and gave him a jug of juice and a jug of water, neither the checks nor his fluid intake seem to have been formally charted. In fact the checks narratively recorded in the nursing notes at 21:00 and 23:45 seem to be erratically timed and infrequent under the circumstances.'

83. Adviser 1 added that he would expect to have seen reference to a full assessment carried out by the nursing staff taking over Mr A's care into the evening and night shift. This was not the case and no further assessment of care within the nursing team appears to have been undertaken. He noted that in terms of the Nursing and Midwifery Council Code of Professional Conduct nurses were responsible for their acts and omissions regardless of advice received from other professionals.

84. He advised:

'The night shift [at interview on 17 February 2010] were clear that they had carried out everything that was asked of them by Doctor 1. I do not believe this to be the case. Giving him a jug of juice to drink does not constitute hydrating him – this would require regular communication and prompts to drink the juice and the charting of his intake, neither of which took place. Doctor 1's instructions were to monitor his breathing – looking into his room at him lying on the bed to see if he was still breathing does not constitute effective monitoring. I would have expected his respirations to be charted at regular intervals, minimum every 30 minutes. The instruction to observe should mean more than looking in on someone every hour. Given that [Mr A] was under the influence of an illicit substance(s) I would have expected his vital signs, level of consciousness and response to stimuli (such as voice/touch/mild pain) to be charted and recorded – minimum every 30 minutes initially. Failure to do so meant that the staff wrongly assumed [Mr A] to be sleeping when he was in fact slipping into a state of unconsciousness.'

(c) Conclusion

85. When Mr A returned to the IPCU on 16 January 2008, it is clear that Doctor 1's assessment could have been more thorough and her instructions to nursing staff more explicit. While Doctor 1 now recalls a conversation between herself and Consultant 1 taking place, it is clear that Consultant 1 was not the on call consultant and the discussion was brief. The advice I have received is that Doctor 1 was a junior doctor, who may have lacked the experience

necessary to manage a patient presenting with Mr A's symptoms, and she should have requested the support of a more senior colleague.

86. I am critical that Doctor 1 did not make a fuller assessment by taking Mr A's blood pressure and oxygen saturation. If the IPCU did not have the facilities for this then consideration should have been given to transferring Mr A to Accident and Emergency at that time. I am also critical of the failure to give more specific instructions regarding the frequency of observations.

87. Nevertheless, regardless of the lack of specificity by Doctor 1, I am left in no doubt that there was a complete failure by nursing staff to undertake even the most basic of observations of Mr A in terms of the taking and charting of respirations, vital signs, level of consciousness and vital stimuli. This is the most critical of a number of failings I have identified in relation to Mr A's care and treatment when he returned to the IPCU.

88. In all the circumstances, I uphold this head of complaint. I believe it is imperative that the Board and all those involved in Mr A's care that night consider carefully the failures identified to ensure that a similar situation does not recur.

89. I make the following recommendations.

(c) Recommendations

90. I recommend that the Board:	*Completion date*
(i) provide training to ensure the adequate medical examination, nursing observation and assessment of vital signs within the IPCU, when managing a patient recently having consumed an illicit substance;	18 April 2011
(ii) ensure that there is appropriate consideration for review of the procedure or protocol for referring a patient to the local Accident & Emergency Department for further consideration of physical care and treatment when they admit to having consumed illicit substances;	18 April 2011
(iii) remind staff of their professional responsibilities towards the care and treatment of a patient	16 March 2011

	received into their care with or without prior advice provided by other professional disciplines;	
(iv)	conduct an audit to ensure full compliance of the use of assessment tools and measures and completion of monitoring charts and vital signs monitoring charts;	18 April 2011
(v)	ensure that this report is shared with all staff involved in Mr A's care when he returned to the IPCU on 16 January 2008, so that they can learn from the findings of this report; and	16 March 2011
(vi)	provide an apology to Mrs C for the failures identified in this report.	16 March 2011

General recommendation

91.	I recommend that the Board:	*Completion date*
(i)	provide an apology to Mrs C for the failures identified in this report.	16 March 2011

92. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The complainant's son
The IPCU	Intensive Psychiatric Care Unit, Carseview Centre
The Centre	Carseview Centre, Dundee
Hospital 1	Ninewells Hospital, Dundee
Consultant 1	Consultant in charge of Mr A's care at Carseview Centre
The Unit	Forensic Unit, Murray Royal Hospital
Hospital 2	Murray Royal Hospital, Perth
Consultant 2	Consultant in charge of Mr A's care at Murray Royal hospital
The Act	Mental Health (Care and treatment) (Scotland) Act 2003
CTO	Compulsory Treatment Order
The Board	Tayside NHS Board
The Assistant	A nursing assistant
Adviser 1	The Ombudsman's clinical nursing adviser in mental health
Adviser 2	The Ombudsman's clinical medical adviser in mental health

Adviser 3	A consultant in psychiatric care
Doctor 1	Junior doctor within the IPCU
Consultant 3	Rehabilitation consultant within the Board
The Certificate	Transfer Certificate

Annex 2

Glossary of terms

Asphyxia	A lack of oxygen to the brain
Aspirating	To withdraw fluid or air from a cavity
Cardiopulmonary resuscitation (CPR)	Emergency resuscitation procedure
Rehabilitation	Treatments designed to facilitate a process of recovery
Transfer Certificate	Transfer to Other Hospital Within Scotland

Annex 3

List of legislation and policies considered

Mental Health (Care and Treatment) (Scotland) Act 2003

NHS Tayside Patient Observation Policy

NHS Tayside search procedure in the event of a patient going missing from Carseview Centre

Nursing and Midwifery Council's Code: Standard of conduct, performance and ethics for nurses and midwives

Annex 4

Milan Principles

Non-discrimination: People with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.
Equality: All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation language, religion or national, ethnic or social origin.
Respect for diversity: Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
Informal care: Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.
Participation: Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.
Respect for carers: Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
Least restrictive alternative: Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe, effective care, taking account where appropriate of the safety of others.
Child welfare: The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.
Reciprocity: Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
Benefit: Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.