Significant Case Review

Undertaken on behalf of Glasgow APC

On Mrs Ellen Ash

Content

1. INTRODUCTION

1.1 Background

On 19 August 2013, Mr Jeffrey Ash pled guilty to willful fire raising and culpable homicide of his mother, Mrs Ellen Ash, aged 83.

On 19 September 2013, Jeffrey Ash was sentenced to 3 years and 4 months in prison.

In his summing up the judge noted “for some time before her death you (Jeffrey Ash) had shouldered most of the increasingly onerous burden of caring for her in the family home where you both lived.”

The judge also recognised that by March 2013 Mrs Ash had become virtually impossible to care for, but that however difficult the circumstances, Jeffrey Ash had no right to take it upon himself to end his mother's life. Instead, the judge concluded Jeffrey Ash should have insisted on additional support for her.

Mrs Ash came to the attention of Social Work Services when she was admitted to hospital in March 2011. She had a diagnosis of Alzheimer’s, which was exacerbated by frequent urinary tract infections. She also had high blood pressure.

Her son Jeffrey Ash went to live with her following this hospital admission and a home care support package was arranged. There were several subsequent hospital admissions and discharges and, on each occasion, Mr Ash insisted he was coping well and willing to care for his mother. Indeed prior to the final hospital admission Mr Ash reduced his mother’s personal care package from two visits per day to one visit per day.

A number of professional workers accepted these reassurances at face value despite there being signals to the contrary.

1.2 Summary of Findings from Initial Case Review

The Initial Case Review findings are based on a Critical Incident Review conducted by Susan Orr, Head of Children and Families, Policy and Planning, Social Work Services.

The initial review highlighted significant issues and lessons that needed to be learned.

The Initial Review also found that there was no reason or specific evidence to suggest that Mr Ash would harm his mother or that he posed a particular threat to her. However, it was also found that there was a lack of professional

challenge throughout the case history and a lack of rigour in evaluating information presented to practitioners and managers.

Having considered these findings, Glasgow Adult Protection Committee decided to commission a Significant Case Review.

A Significant Case Review is intended to discover whether lessons can be learned about the way Adult Protection systems work together. This usually involves situations where vulnerable adults have been part of adult protection or social care systems and have experienced significant harm.

1.3 Methodology

The review team adopted a multi-agency; systems based approach to understanding professional practice and identifying underlying factors that affected this case. We also considered factors that might also influence practice more generally.

The aim of this review is to look at how the adult support and protection system functioned on this occasion and how findings and lessons from this case might bring about change and practice improvements.

The process involved the collection and analysis of data from a number of sources including case files and conversations with key participants and members of staff. Findings from this analysis were written up, shared and checked with key professionals.

1.4 Remit and Process

The systems approach requires the review team to look at how professionals experienced events at the time they were working with the vulnerable adult and with other agency workers. This open mind approach encourages the team to uncover any significant and wider learning. Accordingly, formal terms of reference were not drawn up but we did agree to focus on events that happened within a time line from 24 March 2011 to 21 March 2013.

An interagency Significant Review Panel was established to oversee the work of the review team and to act as a point of reference and support for key issues.

1.5 Review Team

Colin Anderson, Independent Chair
Officer of Glasgow City Council
Officer of NHS Greater Glasgow and Clyde

1.6 Data Sources

The Critical Incident Review prepared by Susan Orr was extremely helpful in informing and directing the more in depth and analytical work of the SCR team.

The review team had conversations with key professionals involved with the case, using this process to help formulate and validate findings.

Chronologies were provided by all relevant agencies and this helped the team establish a time line for key events and identify key episodes requiring more in depth analysis.

The following is a synopsis of relevant key events from a joint chronology comprising case notes from NHS Greater Glasgow & Clyde, Glasgow Social Work Services and Cordia.

According to NHS case notes, Mrs Ash was an inpatient at Stobhill General Hospital from 04 March until 28 May 2010 when she was referred to the Older People Mental Health Service (OPMH). She had a diagnosis of Alzheimer's, which was exacerbated by frequent urinary tract infections.

She was assessed by the Acute Mental Health Liaison Team and on her discharge was transferred to a community clinic based at the OPMH team.

On 14 July 2010 a Consultant in Old Age Psychiatry wrote back to Mrs Ash's GP saying her son had cancelled an outpatient review due to his mother's poor mobility.

On 21 July 2010 the GP requested a follow up visit by OPMH service stating they felt the patient to be "a little vulnerable" but the Community Mental Health Team having discussed the case, suggested referral to Social Work Department would be appropriate, and referred this back to GP for action on the 30th July. On the 9 August 2010 the GP again refers the patient back to OPMH stating the patient is now "quite vulnerable".

The first Social Work record in relation to Mrs Ash is dated 29/03/2011 when it is recorded that she was admitted to hospital (third admission) under compulsory measures i.e. section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003. An emergency detention certificate under this legislation can last up to 72 hours however, the remainder of Mrs Ash's hospital admission was informal. Records show that compulsory measures were required at admission stage because Mrs Ash was refusing fluids and dietary intake and was incapable of making decisions with regard to her medical treatment. On admission a Section 47 certificate under the Adults with Incapacity (Scotland) Act 2000 was completed.

Social Work records state her son was not coping with her care needs and was requesting long term care. The record also reflects that her son worked away from home a lot.

Mrs Ash was described in hospital case notes as "unkempt on admission, confused, constantly wandering and verbally aggressive". She is also described as doubly incontinent. Acute NHS notes describe her as having chronic confusion with frequent bruising on her legs from banging in to furniture at home.

It is also recorded that her son works away from home a lot and is "keen to have her in 24 hour care".

At this time the SW Hospital team requests a Specialist Multi-Disciplinary Assessment Tool (SMAT) be completed by ward. On 8 April 2011 Social Work request a psychiatric assessment. Mrs Ash was seen on the 12 April 2011, outcome of this intervention was refer to Social Work, to query if a Power of Attorney (POA) was in place and liaise further with her son. Hospital notes on 19 April 2011 reflect the SMAT as being completed, with a Social Care Worker completing an assessment on 21 April 2011.

It was also recorded that no Power of Attorney had been identified and that Mr Ash had stated he could no longer cope with his mother at home. There was no consideration of a carer's assessment at this stage.

The option of a care home is pursued and, having been assessed by a Care Home it was felt that her needs would be best met in a specialist dementia unit. Discussions with staff at this time indicate that Mrs Ash would pace up and down the ward .Hospital notes on 08 June 2011 record a "decision" that she requires a specialist Dementia Nursing Home.

Social Work notes reflect that on 26 May 2011 a 13 ZA meeting of the Social Work (Scotland) Act 1968, chaired by a Social Work Team Leader, took place. There was no Advocacy Worker representing Mrs Ash at this meeting. There is a medical and Social Work recommendation that she should not return home, but should receive dementia specific residential care. Mr Ash is present and is clear that his mother would oppose a move into residential care. The recommendation is that that the hospital doctor would again raise the issue of full time care with Mrs Ash, but there is no record of this discussion having taken place. Subsequent interviews with Social Work staff highlighted that they did however, challenge Mr Ash over his ability to care full time for his mother.

In June 2011 Mr Ash visited nursing homes appropriate to the needs of his mother but on 6 July 2011 Mr Ash advised Social Work that he wished to take his mother home. At the time, Social Work records state that he (Mr Ash) "appears to have unrealistic views about his mother's level of needs".

On 8 July 2011 a discharge planning meeting is held and Mr Ash is advised that his mother is refusing assistance with personal care; is refusing to wash

and change her clothing; cannot cook for herself; be left alone at home or go outdoors alone. Mr Ash states he is not yet ready to place his mother in a care home, has a full understanding of her needs and would move in to live with his mother.

Mrs Ash is discharged home on 13 July 2011 with home care support package of two visits per day for personal care plus a shopping service, and is referred to a community support team, which provides specialist input to individuals with dementia.

Subsequent discussions with this team indicate the referral was logged and Mrs Ash placed on a waiting list. The referral had not been progressed at the time of her death, some20 months later, and the team advised that if the referral had been marked "urgent" it would have been prioritised.

Although a transfer summary was written by the hospital based Social Care Worker, it is not clear where the case was transferred to and there was no further recording on a Social Work system until 11 August 2011, when Mr Ash reduced the care package because his mother "did not require as much support".

There is no record of this being followed up or the reason for the service reduction being verified through an assessment of risk and needs.

Following Mrs Ash failing to attend a clinic appointment a Community Psychiatric Nurse (CPN) paid a visit to review Mrs Ash and found she was scoring 10/30 (severe impaired range) on the Mini Mental State Examination (MMSE) test.

Mr Ash told the CPN that his mother was reluctant to go out and he was going to contact Social Work regarding a Day Care placement. The CPN also expressed concern for Mrs Ash who had a cough and followed this up with a letter to her GP.

During September and October 2011 a Social Work Occupational Therapy assessment took place and a bath lift was installed. It was noted that Mrs Ash continued to refuse to have a bath but on 16 November 2011 Mr Ash phoned to say that his mother had used the bath lift and the OT closed the case.

Social Work records dated 17 November 2011 state: "Home Care Review was undertaken and it was noted that Mrs Ash had improved". The Home Care Service was reduced to one visit per day. However, Cordia records state that the service reduction to one visit per day did not happen until 13th June 2012. The Home Care Assessor raised the issue of carer support but Mr Ash declined this.

It is recorded that Mr Ash declined the offer of carer support but added that he would like his mother to attend day care. It is recorded that a referral was to be made however there is no record of the actual referral being made by the Home Care Service. There is a record of a referral made by a Hospital Social

worker during the 3rd hospital admission and it is believed this was the catalyst for the placement offer at day care being made. When interviewed by the SCR team the Home Care Assessor (HCA) stated a placement was offered but Mrs Ash refused to attend.

On 24 December 2011 Mrs Ash was again admitted to hospital with a urinary tract infection, swollen legs, confusion and incontinence. It was recorded that she was having falls and fell while in hospital. She was seen by the Falls Co-ordinator while in hospital.

Mrs Ash was discharged home on 6 January 2012 and the Home Care Service was restarted "at the previous level".

Mrs Ash was again admitted to hospital on 4 February 2012 (30 days since last admission). She was described as difficult to examine, aggressive, hypothermic, showing signs of self-neglect, skin damage, poor personal hygiene, black necrotic heel. It was noted that the heating system at home was broken. It was also noted that Mr Ash wanted to leave the hospital immediately but was persuaded to stay long enough to give an update on his mother's medical history. In his feedback to staff he suggested that his mother's hands had been warm to touch 2 hours previous to admission.

Social Work records reflect a query as to whether an updated assessment was required but there was agreement that ward staff would refer for this if necessary. Initial concerns were raised by ward staff with the hospital duty Social Worker on February 27 2012 regarding home circumstances and son's ability to adequately care for Mrs Ash. An AP1, which is the multiagency referral form for Adult Support and Protection issues was not initiated and submitted to SW until the 28 March, stating that Mr Ash lacked the abilities to provide the care required by his mother. Mrs Ash was discharge home to the care of her son on the 30 March 2012

Acute NHS records on 08 February 2012 note, "Social Work will not intervene at present".

In discussion with ward staff, Mr Ash describes his mother as very independent and able to make her own breakfast but, states he wished an increased package of care and acknowledged his mother had not been attending to her personal care needs. There is no record of the care package being increased. Indeed some 4 months later, the package was reduced to one visit per day at the request of Mr Ash.

Acute notes also reflect that a letter was sent to Scottish Gas regarding the heating system at Mrs Ash's home and a referral was made to Social Work for a more comprehensive discharge plan concerning self-neglect and poor hygiene.

On 27 February 2012 a hospital based Social Worker spoke with Dr 1 who stated a Community Care Assessment was required to determine a future care plan. Dr 1 also added that Mrs Ash had a cognitive impairment and

lacked capacity and the medical view was that a care home placement should be considered. On 28 February 2012, Social Work Services allocated a Social Worker to complete this assessment.

On 07 March Social Work records log a conversation between the Social Worker and charge nurse and consultant who "queried neglect" by Mr Ash and concerns were also expressed re the lack of heating in the home and worries about Mrs Ash's personal hygiene.

It is recorded that Mr Ash subsequently advised he was in the process of getting the heating fixed and would speak to home carers regarding personal hygiene issues.

A Social Work record entry on 13 March 2012 contains a reassurance from Mr Ash that the heating will be fixed "next week" and reference is also made to Mrs Ash visiting a day centre for assessment, although there is no record of this being followed up. This is the second referral for day care but it is not clear from records whether it is linked to the first referral made by the HCA.

On 14 March 2012 hospital records log that Mrs Ash could go home with a full package of care but that she needed to be "flagged up that she could be a vulnerable adult". Community Care Assessment undertaken during this admission recommended that "Mrs Ash's health and wellbeing would be best met within residential dementia care home. This was in contrast to the first assessment completed in 2011 which recommended Nursing Dementia Care.

On 22 March 2012 hospital records log a telephone call from Dr 1 to a hospital Social Worker who, the record states, is unaware of vulnerable adult status and can't take this forward because the Team Leader is on leave. However, there is a follow up call from a Duty Team Leader.

Social Work records on the same date (22 March 2012) state that "although Doctor 1 wants Mrs Ash to be known as a "Vulnerable Adult", they were not making a formal referral under Adult Support and Protection Legislation". An AP1 form is taken to the ward by Social Work staff for ward staff to complete.

On the same day the Team Leader telephones Dr 1 to seek clarification on the term "vulnerable adult". Dr 1 expressed a concern that Mrs Ash might be subject to "neglect". It was also noted in the Carefirst notes that a multi-disciplinary meeting held on the ward that day concluded that "Social Work had not done enough to determine whether home conditions were appropriate and whether Mr Ash was fully willing to act as a carer."

On 23 March 2012 the Social Worker advised Mr Ash that staff had concerns regarding his ability to care for his mother and they wished this to be monitored on her return home.

On 28 March 2012 Social Work records log that they have received the AP1 form in which Mrs Ash is described as "confused and urinary incontinent, unkempt with long dirty fingernails". There is also reference to her being

hypothermic and with a necrotic heel plus black and necrotic skin on her lower right leg.

Under terms of Adult Support and Protection legislation, a duty to enquire was opened on 27 March and undertaken by Hospital Social Work Staff. The inquiry is carried out by Social Worker 3 because Social Worker 2 is on annual leave. This was recorded, considered and closed down by the Team Leader on 30 March 2012. The recommendation of the duty to inquire is that the case should be considered for case management and consideration be given to a guardianship order under Adults with Incapacity legislation. Although the recommendation for case management was passed to the Anniesland community team, there is no record of the guardianship recommendation being passed on or followed up. It is fair to assume that if the duty to inquire had moved to an investigation stage, a full risk assessment would have been carried out and the referral would have had greater priority in terms of allocation at area team level.

Mrs Ash was eventually discharged home on 30 March 2012. Social Work records state that Home Care services are restarted at pre admission level. "Contact will be four times per day" this despite a previous note recording that the package had been reduced.

Cordia records show the following services history:

13 July 2011 – service started – seven days per week. Two calls per day – one call in the morning for assistance with washing and dressing and one at 'tuck time' for the same tasks.

24 December 2011 – service user admitted to hospital.

05 January 2012 – service user discharged from hospital.

06 January 2012 – service re-started – same care plan as before (7 days x 2 calls per day).

04 February 2012 – service user admitted to hospital.

31 March 2012 – service user discharged from hospital and service re-started – same care plan as before (7 days x 2 calls per day).

13 June 2012 – care plan reduced to one call per day (a.m.) for washing/ dressing assistance. Reduction made at request of service user.

02 March 2013 – service user admitted to hospital.

15 March 2013 – service user discharged from hospital and service restarted – same care plan as before (7 days x 1 call per day).

21 March 2013 – service user died.

A subsequent Social Work case note on 30 May 2012 records that "although four visits per day are required for home care, only two are recorded on the system. However, there is no indication of further steps being taken to address or rectify this position. Indeed as previously noted, the care package was reduced to one visit per day some two weeks later.

On 02 April 2012 a case closure summary is recorded on the Social Work system, adding that the referral is closed down and there will be no further contact by the hospital Social Work team. A recommendation is made that the case should be monitored by the Community Social Work team "in order to ensure wellbeing at home" and a letter to Mr Ash on 13 April 2012 advised that "the case is now being transferred to the Anniesland team for care management".

On 02 April a telephone call from a hospital Social Worker to Mr Ash recorded that "his mother is doing well, with no issues with home care".

A CPN visit is recorded on 04 April 2012, when Mrs Ash had a low score 10/30 on a cognitive test. Mrs Ash was home alone during this visit and a follow-up phone call with her son records that "he had no concerns regarding his mother and acknowledged that day care was on offer and that "Pinkston Day Care would be in touch about this". There is no mention of this in Social Work records and no indication that this was followed up. Subsequent investigation by the SCR team determined that a day care placement was offered but Mrs Ash refused to attend. However, Mr Ash spent half a day visiting the day care facility with a view to gaining an insight into the experience of day care and encouraging her future attendance.

OPMH notes on 20 December 2012 record a "six month review" of Mrs Ash and again she scores 10/30 in the MMSE. Mr Ash reported a deterioration in his mother's condition and his method of coping with her repetitive behaviour was to go in to another room. He said he could not persuade his mother to access day care and also said that he would be speaking to a solicitor regarding Power of Attorney.

On 23 December the CPN discussed Mrs Ash with the Consultant in Old Age Psychiatry who decided as there were "no outstanding problems" she should be discharged from the OPMH service to her GP's care.

Mr Ash was advised of this in a copy letter to his GP, which was sent on 16 January 2013. An attempt had been made on the 23 December 2012 to make contact with Mrs Ash's son by phone, to inform him of the decision but no reply to call – therefore a letter was sent to Mrs Ash.

The letter clarified that Mrs Ash was being discharged from the OPMH service and stated "If, however, there is any deterioration in Mrs Ash's mental state in the future please do not hesitate to contact our team".

Social Work records on 25 February 2013 log a telephone conversation

between Mrs Ash's GP and the duty Social Worker in the Anniesland Older People Team. The GP advises that Mrs Ash was physically unwell, had a urine infection, was refusing fluids and required admission to hospital. It is not clear from the notes but it can be assumed that Mrs Ash was refusing to go to hospital because it is noted, "there are no legal powers in place". The duty Mental Health Officer is contacted to consider compulsory measures.

It is not clear from Social Work records how this matter was resolved but on 25 February 2013 Mrs Ash was admitted to hospital for the final time. This admission was completed on an informal basis despite advice being taken from the duty Mental Health Officer and Mental Welfare Commission for Scotland.

Hospital records reflect that Mrs Ash was "more confused than normal" and also recorded that she had previously been considered as a "vulnerable adult". No follow up of this statement is found in the remaining notes pertaining to this admission.

On admission a Section 47 certificate under the Adult with Incapacity (Scotland) Act 2000 was completed.

It is recorded that Mr Ash was not spoken to until 12 March 2013 (some 16 days after admission) when he verified that arrangements were in place to have his mother home. An Occupational Therapy review confirmed that required bathing and toilet aids were already in place.

On 14 March 2013 Mrs Ash was discharged from hospital to the care of her son and the previous level of home care was restarted. There is no record of a comprehensive reassessment of her needs or an assessment of her son's capacity to care for her, nor is there any further consideration of statutory measures. There is no record of any liaison with hospital Social Work services.

On 21st March 2013 Mrs Ash's body was found following the discovery of a fire in her home.

2. FINDINGS IN DETAIL

2.1 Introduction

A Significant Case Review improves our adult support and protection systems through helping us understand what happened and why, in a particular case. However, it is vital that it should also help us move from an individual case focus to look at wider systemic issues. The review should identify both strengths and gaps in professional practice and in support and protection systems.

2.2 An Analytical Overview

This was a complex case involving a range of statutory legislation, regulations and guidance. It also involved complex practice decisions and tensions. In terms of case management, it was necessary to balance a number of fundamental principles including the right to self-determination, the right to support, the right to protection and the right to have a carer's needs and wishes respected, assessed and met.

This Significant Case Review highlights a range of significant issues and learning, both for the practice of individual professionals and for the wider care, support and protection systems.

It must be emphasised that both the Critical Incident Report and Significant Case Review found there was no reason or specific evidence to suggest that Mr Ash would deliberately harm his mother or that he posed a particular threat to her.

However, there were key points in the case when there was a lack of what has been described as professional challenge and too often, there was a lack of appropriate rigour in analysing and evaluating information.

Essentially, workers gave too much weight to what Mr Ash and Mrs Ash were telling them, thereby allowing the right to self-determination to override the right to protection. This has particular relevance to statutory responsibilities under Adult Support and Protection legislation and associated mental health legislation.

There was a fundamental breakdown in the way that systems shared and made information available. Following an initial assessment, electronic and paper systems did not push or flag key risk factors for subsequent hospital admissions, Social Work interventions or care at home support plans.

There were examples of breakdowns in communication between key

agencies involved in the care, support and protection of Mrs Ash. Indeed there were concerning examples of communication breakdowns within individual services and teams.

Perhaps the most vivid example of this was when hospital Social Worker 1 undertook a care assessment of Mrs Ash's needs while hospital Social Worker 2 undertook a "duty to enquire" under terms of the Adult Support and Protection (Scotland) Act 2007. The latter assessment recommended that an application for guardianship under Adults with Incapacity (Scotland) Act 2000 should have been made. This would have had the effect of making a judgment whether Mr Ash was a fit and proper person to hold such a guardianship or whether the Local Authority should intervene on Mrs Ash's behalf.

The SCR team formed the opinion that there was sufficient evidence gathered from the "duty to enquire" to warrant a formal investigation under Adult Support and Protection legislation. However, such is the complexity of legislation and practice in this area of work that there is often more than one option and the final decision should come down to professional judgement based on a comprehensive risk assessment.

The two assessments, despite being completed by the same team, were never cross-referenced and only the recommendation for care management was transferred to the local area team following hospital discharge. Although a personal care at home package was put in place for Mrs Ash, the case was never allocated within the area team and a Care Manager was never appointed.

There is no evidence of a single agency or person taking responsibility for co-ordinating or managing a single shared care plan, inclusive of medical and social care needs and risks. It is particularly concerning that, despite numerous opportunities presenting themselves, there were was no co-ordinated approach to any single agency assessing and owning responsibility for risk factors.

Home Carers were visiting on a twice-daily basis until the service was reduced to one visit per day some nine months before the death of Mrs Ash. It was believed by the hospital Social Work team that, should matters deteriorate or become untenable, this would be picked up and reported back to the care manager by front line carers. Although carers did observe a marked deterioration in Mrs Ash's condition, only one relatively minor event was reported to Social Work Services.

There were a number of signals that Mr Ash was not coping with his mother's needs but at no time was a comprehensive carer's assessment completed under terms of the Community Care and Health (Scotland) Act 2002.

Each hospital visit appeared to be viewed as a single treatment episode and there was an underlying belief that Mrs Ash would continue to make a good

recovery once she was discharged home. Following discharges from hospital, staff reinstated care at home services “at the previous level”. There is evidence to suggest the assumption, by hospital staff, was that the service would be at four times per day when it was only ever twice per day and was reduced to one visit per day by the time of the final hospital discharge. This was despite the outcome of two earlier comprehensive assessments recommending a specialist dementia residential and nursing care options.

Under section 259 of the Mental Health (Care and Treatment) (Scotland) Act 2003, people with Alzheimer’s have a right to access independent advocacy. It would appear that Mrs Ash had no advocacy support during the statutory process to consider her transfer from hospital to a care home. If an independent advocacy service had been involved with Mrs Ash this would have given her as much control as possible over her life and would have provided a challenge and balance to the wishes of her son.

Without the benefit of a single person to coordinate care and with systems responding to the presenting needs of individuals, there is always a risk that referrals and incidents are addressed on a single episodic basis, rather than there being a reflective consideration of the full case history. In the case of Mrs Ash, the cumulative risk impact associated with a number of hospital admissions and discharge assessments was not properly considered.

2.3 Findings in Detail

Finding 1

During the period under review, Mrs Ash had six admissions to hospital. On her first hospital admission (04 March 2010 to 28 May 2010) she had a diagnosis of Alzheimer’s, which was exacerbated by high blood pressure. Mrs Ash was referred to an Acute Liaison Psychiatric Nurse who assessed her on the ward. She was referred to the Older People Mental Health Service (OPMH) community based service following this assessment.

It is worth noting that although the Acute Liaison Nurse service was available on all six admissions there was only one further referral to the service, during her 3rd admission to hospital (23 March – 13 July 2011). In discussion with the nurse in this service she advised that it would not have been uncommon to have received a number of referrals in respect of one individual and that this would provide continuity in terms of monitoring progress.

Mrs Ash’s second admission to hospital was on 7 October 2010. She had been found on the floor of her home, had bruising on both legs and was doubly incontinent. She was discharged home two weeks later and according to medical notes, “with no service package in place and still incontinent of urine. No follow up required. Case closed.”

On the 2 December 2010, a Community Psychiatric Nurse (CPN 1) visited Mrs Ash. Her son was not present. Case notes log that “the house felt cold

and Mrs Ash was unkempt" but no major concerns were raised during the visit and Mrs Ash refused any formal support from Social Services". Mrs Ash was admitted to hospital on the 7 December 2010 with hypothermia, bruising on both legs, and was doubly incontinent.

The next record on 3 February 2011 logs the CPN 2 discussing Mrs Ash with a Consultant Psychiatrist who decided to discharge Mrs Ash from the Post Dementia Diagnostic Service. She was referred to "the nurse led clinic" which involved reviewing individuals on a six monthly basis. We heard from the CPN 2 involved at the time, that it was usual for patients to be discharged from the service if they were not on any specific cognitive enhancing or psychiatric medication and were not presenting difficult or challenging behaviour.

CPN 2 also confirmed that because Mrs Ash refused Social Work services he did not feel it appropriate or necessary to make a formal referral. He also confirmed that on more than one occasion Mrs Ash was home alone when he called. On these occasions Mrs Ash opened the door and allowed him admission without challenge. It was confirmed by the CPN 2 that there was no regular contact or liaison meeting between the OPMH service and Social Work Services.

It is difficult to understand how somebody assessed as lacking capacity to make informed decisions and presenting with such a high level of risk and care needs would be discharged from a dementia support service to a six monthly review team and then be allowed to refuse support from Social Work services and all without further question or challenge.

This episode should have been followed up with more rigour by the CPN 1 and there should have been at his stage, if not earlier, an assessment of the need for statutory intervention under the Adults with Incapacity (Scotland) Act 2000 or Mental Health (Care and Treatment)(Scotland) Act 2003.

Mrs Ash was discharged from the Post Diagnostic Support Service in February 2011 and by March 2011 she was hospitalised in an extreme state of cognitive impairment and with a high level of personal, physical neglect.

On her third hospital admission (23 March 2011), some two years prior to her death, medical notes described Mrs Ash as "doubly incontinent, acute chronic confusion, aggressive behaviour, and refusing treatment". Medical notes record Mr Ash "feeling she (his mother) probably requires long term care as unable to cope with her at home". It is also noted that Mr Ash works away from home a lot. Staff involved in planning Mrs Ash's care at home made no challenge as to how Mr Ash might arrange for 24 hour care, when out at work.

Following this third admission to hospital, there appears to have been a more coordinated approach to an assessment of needs and risks. A Specialist Multi Agency Assessment Tool was completed and forwarded to the Hospital Social Work Team requesting a Community Care Assessment. The outcome of the Community Care Assessment was that Mrs Ash required the services of Specialist Dementia Care Home to meet the assessed level of risk and need.

A meeting was held under the auspices of section13ZA of the Social Work (Scotland) Act 1968. This section allows a local authority, following an assessment of need, to determine if an individual who lacks capacity requires a community care service. In such circumstances the principles of the primary Adults With Incapacity legislation should be applied.

In Mrs Ash's case the meeting was held to consider a move to a specialist residential resource. No advocate represented Mrs Ash, but her son was adamant that his mother would oppose such a move. There was a recommendation that the hospital doctor would again raise the issue with Mrs Ash but there is no record of this discussion having taken place. It was agreed that should Mrs Ash return home, a referral would be made to the relevant community area team for case management and follow up.

Although Mr Ash visited care homes appropriate to the needs of his mother he decided to take Mrs Ash home and move in to look after her. Despite concerns previously expressed that Mr Ash appeared to have unrealistic views about his mother's level of needs, the 13ZA process was halted. Hospital Social Work Team Leader 1 (HSWTL1) told us that she had been robust in challenging Mr Ash's ability to look after his mother and had given him a "reality check" of what would be required.

On 13 July 2011 Mrs Ash was discharged from hospital with a home care package of 7 hours including personal care two times per day, every morning, every teatime, shopping twice a week and bathing once a week.

Mrs Ash was also referred to a Community Support Team that provides additional support for people with a dementia. This team would have picked up on the needs of her carer, Mr Ash. However, because the referral was not marked urgent, it was not prioritised and was not processed prior to her death one year and eight months later.

HSW 1 wrote a transfer summary on CareFirst system but it is not clear from the system where the case was transferred to.

On the occasion of her fifth admission to hospital on 4 February 2012 Mrs Ash was again described in hospital records as aggressive, hypothermic and showing signs of self-neglect, skin damage and poor personal hygiene. The following is described in Social Work records: "her heel was black and necrotic with broken skin on her lower right leg. It was also reported that the heating system in the family home was not working".

It was during the fifth hospital admission, as detailed in finding 2 below, that consideration was given to Mrs Ash's need for protection. During this period an Occupational Therapy (OT) environmental assessment was also conducted. The OT assessment records Home Care visits of "4 times per day to assist with personal care, verbal prompting with medication and meal preparation". However, it was noted that the main OT initial assessment

details Home Care visits as 1 per day. On discussion with both OT staff members involved at this time, they were unclear how this information came to differ within Mrs Ash's OT records.

Hospital Social Worker 2 (HSW2) completed a Community Care Assessment. When interviewed, HSW2 confirmed that the main source of information for the assessment was Mr Ash, although he was reported to be difficult to engage at the beginning of the process. The outcome of the Community Care Assessment was that "Mrs Ash's health and wellbeing needs would be best met in a residential dementia care home".

It was also noted by HSW2 that although Mrs Ash had previously been assessed as "lacking capacity" under terms of section 6 of the Adults with Incapacity (Scotland) Act 2000, no other statutory measures were in place. In particular, it is noted that no Power of Attorney had been identified.

According to HSW2, Mr Ash remained adamant that he wanted to look after his mother and there was a recommendation that home care should be at four times per day and the option of day care should be pursued. HSW 2 made referrals to two day care establishments. It was assumed that Mr Ash would progress these contacts and the Community Social Work team would follow up the outcome on discharge home. This did not happen and Mrs Ash never took up the day care option.

During this hospital admission and as reported in detail at Finding 2, (HSW2) was asked to undertake a "duty to enquire" under Adult Support and Protection legislation. This statutory intervention was in response to a referral from a hospital consultant and was supervised by Hospital Social Work Team Leader 2 (HSWTL 2). The outcome of this process was a recommendation that a Guardianship Order under terms of the Adults with Incapacity (Scotland) Act 2000 should be pursued.

On the basis of this recommendation, HSWTL 2 decided to close down the duty to enquire. An application for guardianship would have involved a Mental Health Officer who would have assessed Mr Ash's capacity to look after and care for his mother. The outcome of such an assessment would have determined whether the Local Authority or Mr Ash should become the guardianship applicant.

Mrs Ash was discharged from hospital on 30 March 2012.

On 2 April 2012, three days following Mrs Ash's discharge from hospital, SW records show that the hospital team closed the case and transferred it to the Anniesland Social Work Team for "care management". The notes also state "it is more beneficial to maintain Mrs Ash's health and wellbeing within a Residential Dementia Care Home". The discharge was processed through the electronic case management system (CareFirst) and HSW1followed this up by writing to the relevant locality Social Work team at Anniesland.

The hospital discharge and case transfer process made minimal mention of the Adult Support and Protection process or that a recommendation that Guardianship should be applied for. Although HSW 1 stated she was aware of the AP 1 process, she was unaware of the outcome. HSWTL 1 was on leave at the time of discharge and it is apparent that HSWTL 2 did not make a connection between the two assessments.

It is clear that the two strands of work, despite being undertaken by the same team, were not cross-referenced. This was a fundamental breakdown in communication and in the support and protection system and reflects poor professional practice at a first line management level.

Standard procedure within the IT recording system is to open up an activity to the receiving team who should then make a decision re allocation. In the case of Mrs Ash this did occur but the activity was "abandoned "in August 2013. Evidently a system was in place for case management but it is not clear how much screening of the file was done prior to it being "abandoned".

At the time of this hospital admission, Mrs Ash had been receiving a home care service for "personal care" i.e. washing and dressing at a level of two visits per day, for a period of six months. Twice daily home care visits should have picked up on such vivid evidence of Mrs Ash's hypothermia and deteriorating personal care and should have passed this on to Social Work and Health agencies.

It is recorded that in discussion with Mr Ash, he acknowledged that his mother had not been attending to her personal care needs. He agreed to discuss this with her carers and also requested an increase in the care package. He also agreed to get the heating fixed. These statements and reassurances from Mr Ash appear to have been taken at face value and without further challenge or rigorous follow up.

HSW2 thought Mrs Ash had been discharged with a home care service of four visits per day but records held by Cordia, the service provider, clearly show that only two visits per day were commissioned.

There was also a follow up phone call to Mr Ash by the hospital SW when he reported that his mother was doing well and there were no issues with home care. This was confirmed by a CPN visit on 4 April 2012 when it was noted that Mrs Ash was at home on her own. A follow up phone call to Mr Ash confirmed that all was well and he was awaiting the offer of Day Care for his mother.

Again Mr Ash's reassurances were accepted at face value and nobody linked this home alone episode to the OT assessment that Mr Ash did not live permanently with his mother.

There is no record of the Day Care "offer" being followed up and it wasn't until 25 February 2013 that a further Social Work intervention was noted. This was

in response to a request for help with a compulsory admission to hospital for sixth and final time.

In the meantime community medical records show that on 20 December 2012, a “six month review” showed Mrs Ash again scoring10/30 on the MME which is on the severe impairment aspect of the test scale. A decision was made to discharge her from the service because her test result had not dropped from the previous test six months ago. Mr Ash reported a deterioration in his mother’s condition. He also said that he could not persuade her to attend Day Care. Mr Ash did say however, that he would be seeking contact with a solicitor to arrange Power of Attorney. Again it is unacceptable that there was no follow up by statutory agencies and that the choice of statutory intervention was left with Mr Ash

There should have been a more robust response by Social Work Services in terms of Adults with Incapacity legislation and consideration of a Guardianship Order.

Again professionals accepted Mr Ash’s assurances and promises of action without challenge or by confirming the position through a comprehensive risk and needs assessment.

On 23 December 2012 the CPN discussed the case with a Consultant Psychiatrist who decided to discharge Mrs Ash from the OPMH service to care of her GP. This was on the basis of Mrs Ash not being on any cognitive enhancer or other psychiatric medication that required monitoring by the service. The record also states that “there were no behavioural problems and her main carer was her son”. It is also noted that Day Care has been offered and she receives daily Home Care.

The CPN logged that an attempt had been made to contact Mrs Ash and her son had been unsuccessful, but the reason for failure to make contact was not followed up. Mrs Ash received a copy of the discharge letter. There is no record of any attempt to discuss this decision with Social Work services.

Given Mrs Ash’s assessed level of functioning and the previously detailed concerns regarding her vulnerability, personal neglect and possible abuse, the decision to discharge Mrs Ash from the OPMH service is difficult to understand. However this decision was compromised by other parts of the system not communicating her needs and risks directly with the OPMH and by that service not making proactive enquiries before closing the case.

This situation was further compounded by the decision of the Hospital Social Work Team to transfer the case without clarity in terms of ownership and case management.

It appears that hospital services closed the case after transferring it but without checking that Mrs Ash’s care plan would be progressed.

There is scant information on Mrs Ash's sixth and final admission to hospital. She had again been assessed under the Adults With Incapacity legislation (section 47) as being incapable of giving consent with regard to her medical treatment and was described as "more confused than normal".

Efforts were made between 27 February 2013 and 12 March 2013 to contact Mr Ash. When the hospital team eventually did make contact they again took his word that he would resume responsibility for caring for his mother. Hospital staff discussed an increase in home care provision with Mr Ash but he declined this.

Mrs Ash was discharged on 14 March 2013 and Home Care was started at the previous level of one visit per day.

Again this admission was dealt with as a single episode and no attempt was made to consider a multi-agency assessment of Mrs Ash's needs and risks. Given the further deterioration in her cognitive functioning, a care package of one visit per day was clearly inadequate.

Mrs Ash's body was found some 7 days later in the family home.

Throughout this case there is significant confusion concerning the level of home care service. HSW 2 thought that Mrs Ash was discharged from hospital with four personal care visits per day, but actually received only two visits. On 11 August 2011 Social Work records show that Mr Ash reduced the package stating his mother had improved and did not require a teatime visit. However, Cordia the care at home service provider's records show that only the shopping element was reduced and this did not affect the two calls per day.

Again on 17 November 2011, following a review and at the request of Mr Ash home care levels were reported to be reduced to one visit per day for personal care. However, Cordia records clearly show that the service was not reduced to one visit per day until 13 June 2012.

Following both the fourth and fifth hospital visits on 24 December 2011 and 4 February 2012, Mrs Ash is discharged and the "previous home care package" was recommenced. It is reasonable to assume that the expectation of hospital staff was for four personal visits per day.

On 30 May 2012 a Social Work services Home Care Assessor (HCA), records that "although four home care visits (per day) are required, only two are reflected on the system. There is no evidence of HCA following up on this discrepancy. Indeed some two weeks later on 13 June 2012, the care package is reduced to one visit per day at the request of Mr Ash.

When interviewed HCA explained that her role was to verify the level of service provided by Cordia against the tasks identified by the care plan. When HCA was reminded of Mrs Ash's assessed needs as recorded on the Carefirst

system she was clear that this should have been dealt with by a Care Manager in the Anniesland Social Work Team.

Mrs Ash's health and care needs were never going to improve. It is difficult to understand how somebody with this level of risk and care needs and assessed as requiring 24-hour specialist dementia care could have their care package reduced. There was no rigorous challenge to Mr Ash's request and neither was the decision based on a comprehensive assessment of risk and needs. The request from Mr Ash should have flagged up a risk warning. The lack of appropriate response reflects a systems failure and poor professional practice.

It would also seem that when home care packages were reintroduced following future hospital admissions the assumption was that it would be at the intensive support level of four visits per day.

It is clear from previous documented evidence that Mrs Ash was unable to attend to her personal care needs. Despite this, Cordia records show that the care at home service was reduced from two visits per day to one visit per day on 13 June 2012, "at the service user's request". Follow up interviews with Cordia confirmed that this was in fact at Mr Ash's request. This is yet another example of inconsistent and even irrational statements from Mr Ash going unchallenged. Again the needs of Mrs Ash are not placed at the centre of a needs and risk assessment.

A note in the hospital Social Work records dated 30 March 2012 states that "Home Care Services are restarted at the level prior to admission. Contact will be four times a day". Previous evidence from case files indicate that home care services had been reduced to two visits per day. This is another example of inconsistencies and confusion in Social Work case notes and indicative of poor care management and coordination.

For clarity, Cordia records show the following patterns of care at home being commissioned and provided:

13 July 2011 – service started – seven days per week. 2 calls per day – one call in the morning for assistance with washing and dressing and one at 'tuck time' for the same tasks.

24 December 2011 – service user admitted to hospital.

05 January 2012 – service user discharged from hospital.

06 January 2012 – service re-started – same care plan as before (7 days x 2 calls per day).

04 February 2012 – service user admitted to hospital.

31 March 2012 – service user discharged from hospital and service re-started – same care plan as before (7 days x 2 calls per day).

13 June 2012 – care plan reduced to one call per day (a.m.) for washing/ dressing assistance. Reduction made at request of service user.

02 March 2013 – service user admitted to hospital.

15 March 2013 – service user discharged from hospital and service restarted – same care plan as before (7 days x 1 call per day).

21 March 2013 – service user died.

This continuing confusion and erroneous assumptions regarding the level of home care service was compounded by the absence of case management and reflects poor professional practice and a fundamental break down in the system to meet the risk and care needs of a vulnerable person.

Finding 1

The Assessment and Care Management Process and the Systems for assessing and meeting the risk and care needs of older people with a diagnosis of Alzheimer's did not take sufficient account of Ellen Ash's need for care, support and protection. This increased her vulnerability.

ISSUES FOR THE ADULT PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

Is this inconsistent and fragmented approach to assessing the needs and risks of a person with a diagnosis of Alzheimer's unique to this case and point in time or was it and is it still prevalent throughout the support and protection system?

Does the Committee agree that a clearly identified lead professional should case manage and coordinate all aspects of risk and care needs for vulnerable people who require support and protection services?

Are quality assurance systems in place to monitor, review and report on support given to people with a diagnosis of Alzheimer's?

Is awareness and practice training in place to ensure that staff have the right knowledge and skills to work with people living with dementia, and is the impact of this training evaluated?

Finding 2

Although it had been previously determined that Mrs Ash was an adult who lacked the capacity to make informed decisions regarding her health and care needs, it was not until the fifth admission to hospital on 04 February 2012 that the question of a statutory intervention in terms of the Adult Support and

Protection (Scotland) Act 2007 (ASP), and other protective legislation, was addressed. Hospital medical staff initiated this.

A hospital record states that “AP1 (the form used to make an ASP referral) paperwork states that there has sometimes been a concern that Mrs Ash’s son lacks the abilities to provide the care required” but the record also notes “Social Work will not intervene at present”.

On 14 March 2012 medical notes again recorded that Mrs Ash “could be a vulnerable adult”. This is followed by a comment on 22 March that “Social Work is not aware of vulnerable adult status and will bring yet more paperwork”.

On 22 March a Social Work record logs that hospital staff are not making a referral under ASP but do have concerns over Mrs Ash’s vulnerability and wish her to be known as a “vulnerable adult”. In response, hospital Social Work services left an AP1 form on the ward for staff to complete. Around the same date Doctor 1 records that she has asked for Social Work to undertake a home visit but then writes“ they don’t do home visits “.

On 22 March Social Work records state “a multi-disciplinary meeting on the ward has a consensus that not enough had been done by Social Work staff to determine if home conditions were appropriate and if Mr Ash was fully willing to act as carer”.

The Hospital Social Work service eventually received an AP1 form on 28 March 2012 but HSW2 had already commenced the duty to enquire process.

The duty to enquire assessment was restricted to hospital records and personnel and did not consult community practitioners such as the General Practitioner and Cordia personnel who were delivering front line care.

It was clear from the assessment that Mrs Ash had a severe cognitive impairment, had suffered from episodes of neglect and was a vulnerable person who lacked capacity to make informed decisions regarding her care and risk needs.

HSW2 also noted that Mr Ash “lacked significant insight in to the needs of his mother”. This and other evidence informed the recommendation for case management and that an application should be made for Guardianship Order under terms of section 57 of the Adults with Incapacity (Scotland) Act 2000.This process would have involved the appointment of a Mental Health Officer and this in turn would have resulted in assessment of whether Mr Ash was a fit person to act as a guardian or whether the Local Authority should assume that responsibility.

The SCR team formed the opinion that there was sufficient evidence gathered from the “duty to enquire” to warrant a formal investigation under Adult Support and Protection legislation. However, such is the complexity of

legislation and practice in this area of work that there is often more than one option and the final decision should come down to professional judgement based on a comprehensive risk assessment.

Hospital Social Work Team Leader 2 decided that the "duty to enquire" under Adult Support and Protection measures should be closed in favour of the guardianship option.

HSWTL 2 recommended that "the case is considered for case management and the future potential for guardianship should be considered should concerns exist". What followed however, was a critical breakdown in communication between members of the same hospital Social Work team.

The Community Care Assessment and Adult Support and Protection Processes were never cross-referenced. HSW1 was aware of the duty to enquire process and, on her own admission, "would have taken a different case management route' had she been aware of the recommendation. Ultimately the responsibility for coordinating these two work streams should have been at Team Leader Level.

HSW2 processed case transfer to the Anniesland Social Work team. The recommendation that Guardianship should be pursued following hospital discharge was not passed to the Anniesland Community Social Work Team.

With regard to duty to inquire, Glasgow procedures stated that a responsible Team Leader should decide on the initial information and determine the following:

1. Whether immediate action is required in relation to the adult deemed to be at risk to make them safe

2. If further initial inquiry is required to inform any decision or

3. Some other intervention (e.g. assessment and care management procedures) would be a more appropriate response.

4. If a full Adult Protection investigation should be invoked.

The time scale for a duty to inquire was 5 working days. The procedures also stated that an investigation and case conference should take place within 21 days of the referral.

If an Adult Support and Protection investigation had been considered in the case of Mrs Ash this would have resulted in further multi-disciplinary discussion and interviews, gathering of information and the completion of the standard investigation documentation. This document offers a fuller risk assessment, requires a chronology of significant events to be recorded and has trigger questions around advocacy input and carer's views. Furthermore, the document focuses on outcomes and asks if a case conference is being convened.

In some instances where Adult Support and Protection legislation is not thought to be relevant, particularly where capacity is an issue, a decision can be made to progress to an Adults with Incapacity case conference.

It is probable that a case subject to a full Adult Support and Protection investigation would have been subject to more scrutiny at the point of transfer to the area team and would have been treated with priority in terms of allocation.

It may also have been thought beneficial coming out of an Adult Support and Protection case conference that Adult Support and Protection case management could have been helpful. This is procedural only but does ensure that regular review takes place and there is an expectation that the case in question would be regularly visited and monitored.

There was no further follow up between the hospital and community teams.

On 20 December 2012 a Community Psychiatric Nurse logs a conversation when Mr Ash states that “he would be speaking to a lawyer as he realised he will have to arrange Power of Attorney.”

Again there is no record of guardianship, power of attorney or other legal and protective measures being addressed or followed up.

Social Work Services has a statutory duty to lead on the investigative and decision making process associated with Adult Support and Protection legislation and, given the risks and support needs identified in Mrs Ash’s situation, the response was inadequate and placed Mrs Ash at unnecessary risk from neglect and abuse.

This failure to protect was compounded in the sixth and final hospital admission when Mrs Ash is again admitted. Although there is reference to Mrs Ash “previously being considered as a vulnerable adult” there is no record of further consideration being given to statutory measures under support and protection legislation although the grounds undoubtedly existed.

Finding 2

On a number of occasions, statutory agencies failed to meet the individual's need for support and protection.

In particular agencies did not achieve the correct balance between the right to self-determination and the right to support and protection and at no time was an advocacy service provided.

A history of repeated admissions to hospital, a record of self-neglect and allegations of possible abuse by Mr Ash did not trigger a sufficiently comprehensive assessment or appropriately robust action under Adult Support and Protection legislation and protocols.

ISSUES FOR THE ADULT PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

Is this finding unique to this case and point in time or is it still prevalent throughout the system?

Is Committee satisfied there is clarity and sufficiently robust guidance for staff concerning thresholds for initiating a "duty to enquire" and progression to a full Adult Support and Protection investigation?

Is a quality assurance system in place to monitor, review and report on the approach to protection and support for vulnerable adults?

Is the policy and practice for providing advocacy services to vulnerable people who require support and protection sufficiently robust?

Is awareness training in respect of adult support and protection and other relevant mental health legislation fit for purpose and is the impact of this training evaluated?

Finding 3

The Community Care and Health (Scotland) Act 2002 affirms that carers who intend to or provide a 'substantial amount of care on a regular basis' are entitled to an assessment of their ability to provide or to continue to provide care ('carer's assessment'), independent of any assessment of the person they care for.

The legal definition of a carer is someone who provides substantial amounts of care on a regular basis for either an adult or a child, where that adult or child receives, or is eligible to receive, support services under the Social Work (Scotland) Act 1968 or the Children (Scotland) Act 1995. A carer is generally

defined as a person of any age who provides unpaid help and support to a relative, friend or neighbour who cannot manage to live independently without the carer's help due to frailty, illness, disability or addiction.

Glasgow's own procedures "Carer Assessment Policy, Procedures and Practice Guidance" as updated on 01 April 2012, states at paragraph 8.4:

- It is the policy of Glasgow City Council to ensure that carers should be informed of their right to a separate assessment of the impact of caring and their ability to continue in their caring role (risk to sustainability).

At paragraph 9.1 the procedures state:

- In order for the self-assessment and other referral sources to be screened appropriately, it is necessary to determine the nature and extent of the care provided by the carer. This should be determined based on a range of factors which include:

    - The health condition/s of the cared for person
    - Carers own health and well being
    - Whether the carer is providing care for more than one person
    - The length of time the carer has been caring
    - The ability of the person they care for to manage aspects of their own care
    - The types of care provided - moving with assistance, personal care, overnight care
    - The emotional demands of the caring role
    - Whether there is a network of family and friends to support the carer or if they have sole responsibility
    - Economic and environmental factors

There is absolutely no doubt that Mr Ash should have been classified as a carer under terms of both the primary legislation and Glasgow's policy and procedures.

There is no evidence from case file research or from interviews with key staff to suggest that, in terms of the relevant national legislation regulation and local guidance there was a comprehensive assessment of Mr Ash's needs as a carer.

The SCR team could not find any record of such an assessment even being offered.

Following Mrs Ash's third admission to hospital, which lasted from 23 March 2011 to 13 July 2011, Social Work records state "son works away from home a lot". A full assessment of Mrs Ash's risks and needs clearly state she requires nursing home care.

On 6 July 2012 Social Work records state that he (Mr Ash) “appears to have unrealistic views about his mother’s level of needs and a further meeting is necessary to discuss these”.

On 08 July 2011 Mr Ash states that he is not yet ready to put his mother in a care home and is fully understanding of her needs. Mr A advised that he would live with his mother.

This is a key episode. Mr Ash gave up his employment to look after his mother who was assessed as requiring nursing home care. That this did not trigger an appropriate assessment of his needs, as a carer, is an unacceptable breakdown in the carer support system.

On 17 November 2011 a Home Care Assessor from Glasgow City Council, noted Mrs Ash’s needs were very high and discussed carers support with Mr Ash however, her entry in a case record states “he advises that this was not necessary”. Mr Ash did state that he would like his mother to attend Day Care so that he could gain some respite. It was noted that Mrs Ash was reluctant to consider day care but the record states that a referral was made.

We know from subsequent notes that this day care respite did not materialise and there is no other recorded follow up to address Mr Ash’s need for respite.

On Mrs Ash’s fifth admission to hospital on 04 February 2012, medical records state that Mr Ash “asked immediately if he could leave” but staff persuaded him to stay so that they could get a medical history from him.

On 13 February 2012 Mr Ash states that he needs an increased package of care for his mother.

On 9 March 2012 Social Work records state that Mr Ash had again asked about day care for his mother. Subsequent records indicate that day care, as a respite for Mr Ash, was never realised. However, Social Work services did follow up the request and on 13 March 2012 Social Work services advised Mr Ash that day centre staff would need to visit Mrs Ash at home for an assessment.

On 22 March 2012 Social Work records log the need to determine “if Mr Ash was fully willing to act as a carer”. It is not clear how this was followed up but there is no record of this triggering a comprehensive carer’s assessment.

Records relating to Mrs Ash’s final hospital admission on 27 February 2013 indicate that there was a delay of 12 days before hospital staff could locate Mr Ash and discuss discharge arrangements.

Finding 3

Assumptions were made by each agency that the carer would ask for help if he were struggling to cope but there was no evidence of effective collaboration concerning a comprehensive assessment of the carer's needs. There is evidence that he was not coping and was signalling this.

ISSUES FOR THE ADULT PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER

Is this finding unique to this case and point in time or is it still prevalent throughout the system?

Do we have a quality assurance system in place to review and monitor implementation of the Glasgow Partnership's Carer Assessment Policy, Procedures and Practice Guidance?

Is awareness training in respect of support for carers and the entitlement to a full assessment of their needs fit for purpose and is the impact of this training evaluated?

Finding 4

There was a fundamental breakdown in the way that systems shared and made information available. Electronic and paper systems did not push or flag key risk factors for subsequent hospital admissions, Social Work interventions or care at home support plans.

There were repeated examples of breakdowns in communication between key agencies involved in the care, support and protection of Mrs Ash. Indeed there are concerning examples of communications breakdown within individual services and teams.

Perhaps the most vivid example of this was when hospital Social Worker 1 undertook a care assessment of Mrs Ash's needs while hospital Social Worker 2 undertook a "duty to enquire" under terms of the Adult Support and Protection (Scotland) Act 2007. The latter assessment recommended that an application for guardianship under Adults with Incapacity (Scotland) Act 2000 should have been made. This would have had the effect of making a judgement whether Mr Ash was a fit and proper person to hold such a guardianship or whether the Local Authority should intervene on Mrs Ash's behalf.

There is also evidence of frustrations and tensions between acute health

services and Social Work services. On 16 March 2012 hospital case notes state ”Social problems remains primary reason for on-going hospital admission” and on 22 March 2012 when discussing “vulnerable adult status” hospital notes state “Social Work will bring yet more forms to be completed”.

There is also evidence of poor communication between the hospital Social Work service and the community Social Work team.

There is no evidence of continuity and consistency in terms of the approach to risk and needs assessment. In particular there is no evidence of a co-ordinated and multi-agency approach to case management.

There is no evidence from Social Work records of case management communication between Social Work Services (SWS) and Cordia. More specifically, there was no record of outcomes from any community care assessment, inclusive of a needs and risk plan, being communicated. Neither was there any record of specific concerns around vulnerability or risk being communicated to Cordia following hospital discharges.

Cordia had no direct access to SWS electronic care management system (CareFirst) and Cordia had their own standalone system (Care Tracker) for managing cases and workflow. Normal practice was that, in the lead up to a hospital discharge, the hospital ward staff would phone Social Care Direct, a Glasgow Social Work Service (SCD) and request a care package to facilitate a safe discharge home. This request would then be sent electronically by SCD to SWS to advise of the referral and to Cordia to start the care package on discharge home. Social Work Services should follow up after hospital discharge to ensure the care package is appropriate to needs. This was delegated to a Home Care Assessor because there was not an allocated case manager. The HCA told us her function was to assess the level of service against the required care tasks. She did not observe anything in Mrs Ash’s circumstances that would have caused her to escalate concerns to the local Social Work team. On reflection, the HCA agreed that the level of need and risk present in Mrs Ash’s situation should have warranted the appointment of a care manager.

The frontline care diaries were destroyed in the fire and there is only one record within Cordia of any care provider concerns being communicated to Glasgow Social Work Services.

Cordia carried out its own case reviews in accordance with regulatory requirements but standard operating practice was that the outcome would only be communicated to SWS if changes in care package were required.

There was however a process through a “change report” for communicating significant concerns or changes in circumstances to SWS e.g. failure to gain access to premises.

As stated only one such report was received, on 18 November 2012 when Mrs Ash was reported as having a blood shot eye. There were no further

notifications. This despite Mrs Ash being admitted to hospital with conditions including hypothermia and severe skin conditions thought to be caused by poor attention to personal care and hygiene.

There was a specific instance of Mrs Ash being admitted to hospital on 4 February 2012 with a black and necrotic heel and with broken skin on her lower right leg. There is no record of this being communicated to Social Work Services by Cordia. Neither is there a record of this being notified to Cordia's internal management information system.

A Cordia Care Worker told us that, in the lead up to the 4 February 2012 hospital admission, she had noted a number of concerns and reported them to her Area Coordinator. These concerns included a cold house due to a breakdown in the heating system, allegedly caused by Mrs Ash pulling a radiator from the wall. The Care Worker also reported trip dangers from the temporary heating arrangements and also difficulties in getting Mrs Ash to bathe. The Carer also reported the deteriorating condition of Mrs Ash's skin. None of
these concerns were recorded on Cordia's information system and there is no record of them being passed to Health or Social Work services.

Cordia staff had been trained, to an appropriate level, in Adult Support and Protection Procedures. Concerns for the wellbeing of Mrs Ash and the capacity of her son to care for her was recorded in police statements given by a Cordia Carer but this appeared only to reflect the position in the immediate period before her death and was not communicated to SWS. There is no record within Cordia or SWS of such concerns previously being expressed by Cordia's care staff.

Cordia LLP was established as an arms-length organisation (ALEO) of Glasgow City Council (GCC) on April 2009. It is a legal entity distinct from GCC and is governed by a strategic board. The board is made up of elected members and a senior officer from GCC, Cordia's Managing Director and Finance Director. It provides a range of facilities management, catering and care services to GCC, other local authorities in Scotland, the wider public sector and private sector organisations.

Cordia provides home care support to around 6000 service users every week and employs 2,700 home care staff working across Glasgow.

Cordia has a Service Level Agreement in place with Social Work Services who commission the service.

FINDING 4

The process of communication and responses between key services and agencies in this case was not fit for purpose. In particular communications between Glasgow's case management system, the hospital discharge system and Cordia were poor.

ISSUES FOR THE ADULT PROTECTION COMMITTEE AND MEMBER AGENCIES TO CONSIDER:

Is this finding unique to this case and point in time or is it still prevalent throughout the system?

Are information technology systems and information sharing protocols and integrated case management systems fit for purpose?

Do we have a quality assurance system in place to monitor, review and report on communications and coordination between and within agencies?

WHAT NEXT?

The findings contained within this report will be submitted to Glasgow Adult Protection Committee and to all the agencies associated with the case. The Committee will address the issues highlighted for consideration and where appropriate will formulate learning and action plans.

Glasgow Adult Protection committee will be responsible for monitoring progress against learning and action plan outcomes. The Independent Chair will be responsible for reporting progress to the Chief Officer and any successor group responsible for the governance of public protection in the city of Glasgow.