Investigation into the care and treatment of Mrs T

mentalwelfare commission for scotland

Background to Mrs T

Mrs T was an elderly woman who was cared for by her son (Mr F) from 1997 until her admission to hospital in September 2005. On 25 September 2005 Mrs T was admitted (via NHS 24 to hospital). She was disorientated in time and place, frail, malnourished and dehydrated and with a number of bruises on her arms and legs (the cause of which was undetermined). Mrs T was diagnosed with severe Alzheimer's dementia. She was assessed as requiring 24 hour nursing home care with the protection of a Welfare Guardianship Order, as her son wished her to return home to live with him. Mrs T moved to nursing home care under welfare guardianship in January 2006 and died there in July that year.

Mrs T first came to the attention of social work and housing departments in November 2003 when she was admitted to hospital with a fractured pelvis. At that point allegations were made by Mrs T's daughter, denied by both mother and son, that he had deliberately pushed her, was difficult and controlling, and misused his mother's money. There were previous concerns expressed by neighbours about shouting and other disturbances.

While in hospital a full risk assessment was carried out by the hospital's social work department. They expressed concerns about the controlling and possibly abusive nature of her son's relationship with her. Due to her being judged to have capacity, however, it was deemed that little action could be taken.

Mrs T was discharged from hospital on 4 December 2003, with the services of the rehabilitation team in place for a six-week period and on-going support from home care services. Her son, however, immediately cancelled home care services, leading to a case conference on 18 December 2003. A further case conference was held in April 2004, following reports of shouting and possible abuse. There had also been concerns during the rehabilitation team's involvement about Mr F's intimidating attitude, his cancellation of his mother's day hospital attendance and his premature return of occupational therapy aids, designed to assist her. At both case conferences the professionals considered Mrs T alert and capable, albeit dominated by her son and reported that she appeared to be in agreement with her son's decisions. On this basis, both case conferences concluded there were no grounds for social work intervention against Mrs T's wishes. Nevertheless, a warning flag was put on Mrs T's case records to alert staff involved in future. Minutes of the case conferences were circulated to all agencies that might have contact with her.

There was no further contact with mother or son until a referral by the out of hours social work service in December 2004.

During the period December 2004 to September 2005 social work received five separate referrals from Mrs T's neighbours, the local councillor, the concierge and a housing officer. Their concerns related to Mrs T wandering at night in her nightclothes, her increased level of confusion, being

locked in at night, being heard crying and shouting, the adequacy of her dietary and fluid intake, her weight loss and her increasing frailty.

Our concerns

The Mental Welfare Commission's concerns relate to events between the two hospital admissions, but particularly to the 9 month period from December 2004 until September 2005. These concerns originated from our scrutiny of the guardianship papers which we received from the Office of the Public Guardian. We followed up initial concerns by examining all the paperwork from Social Work Department files and written information from the rehabilitation team. We collated this information, highlighted our main concerns and circulated this report to all the professionals involved in the case. A meeting was called to discuss the main points and to gather further views from which we drew up our recommendations.

We considered the response from the social work department in terms of the following:

- Adequacy of their assessment of Mrs T's capacity. An assessment did not take place until Mrs T was admitted to hospital. On two occasions, following referrals in December 2004 and March 2005, duty staff requested psychiatric assessments from old age psychiatry services. The first referral was made via the GP and the second directly. The attempt to have an assessment of capacity via the GP was declined in a letter from Mr F, which was countersigned by Mrs T. On the second occasion the psychiatrist and community psychiatric nurse (CPN) visited but were denied access to Mrs T.

  There was a continuous assumption by social work staff that Mrs T retained capacity, despite the referrals to the department, which indicated the contrary. While legally there should be a presumption in favour of capacity, it appeared that staff adopted a position of assuming capacity and deciding not to intervene on that basis. This was a fundamental error in interpretation of the legislation, which was a direct root cause of the failure to intervene to protect Mrs T.

- Accuracy of social work case records. A letter was received from the psychiatrist saying he had been unable to assess Mrs T. Social work case records suggested that this meant she was still deemed to have capacity. Since Mrs T was refusing service, social workers concluded there was no locus for their intervention.

- Adequacy of mental health officer involvement. We were concerned that there was no specialist mental health social work involvement during the months in question. Involvement of a mental health officer (MHO) may have helped to challenge the assumptions of Mrs T's capacity and identified a route that would safeguard her rights and welfare.

- Adequacy of follow up on the referrals to social work. Duty social work staff only attempted to visit Mrs T following one of the five referrals. They got access but

Mr F denied any problems or need for support. It was unclear, due to Mrs T's hearing problems, if she was aware of what was being discussed. On another occasion the offer of social work support, made by letter, was declined by her son.

- Appropriateness of managing an 'adult at risk' under the social work duty system. Mrs T's case was dealt with by a series of duty workers. On several occasions, these workers suggested the case should be allocated to a designated worker, who could at least monitor the situation. This did not happen. Allocation to a named social worker would have allowed closer monitoring of the situation and more active management of the case. Ongoing contact with the concierge, housing officer, and more active efforts to engage the daughter in a consistent way, might have ensured better information on the risks for Mrs T. For example, Mrs T's daughter's later disclosure of her own concerns about her brother's behaviour, lack of food in the house and standards of personal hygiene, may have been disclosed prior to the application for guardianship.

- Effectiveness of risk assessment and management. Despite indications that this was a very vulnerable woman, probably lacking capacity and living with a potentially abusive son, there were no clearly identified strategies for monitoring risks and developing an action plan. No multi-agency/adult protection case conferences, which would have assisted these processes and ensured better communication, were held during the nine months in question.

We also had a number of concerns about the response by health services during this period.

- Levels of clarity in relation to referrals to old age psychiatric services. There was confusion as to whether the psychiatrist in January 2005 could act without a referral from Mrs T's GP.

- The capacity of systems to effectively prioritise referrals. Despite the risks, it was four weeks before a referral from social work led to an attempt to assess Mrs T's capacity. It is unclear whether the sense of urgency was not transmitted by social work, or not picked up by health services.

- Adequacy of feedback and communication systems between health and social work services. After the first referral, psychiatry failed to inform social work that, following their consultation with the GP, an assessment was not going to be undertaken.

Other concerns related to the need for:

- Systems to alert other agencies to potential risks when visiting previously abusive clients, particularly where agencies' computer systems are not compatible.

- Clearer understanding of the reliability of mental state tests by all staff. We were particularly concerned about the undue importance given to the Abbreviated Mental Test (AMT), which was completed in early 2004, as part of a Canard Falls

Risk Assessment tool. Mrs T scored eight out of 10 on this very brief test. As this was above the "cut-off" score of seven, social work staff appeared to accept this as indicating that her mental function was not impaired. The test is not accurate enough to make that assumption.

- Confidentiality We were concerned that the local councillor attended the second case conference in April 2004 and was party to all of the discussion.

Our recommendations.

We feel many of these issues could arise in a number of agencies across the country. Our recommendations have applicable learning points for consideration by agencies not directly involved in the care and treatment of Mrs T.

Social work services

- Social work departments should issue guidance to front-line staff to remind them that capacity can change and that previous assessments of capacity must be reconsidered, where there is evidence that the person's condition has changed.

- Situations where there is potentially considerable risk, or where there have been multiple referrals indicating concerns, should be allocated to a social worker and not be managed through the duty system. Social work departments need to have a process for consistent screening of referrals to identify and allocate such cases.

- Social work departments need to give clear guidance and training to their staff about the bench mark for initiating adult protection procedures/multidisciplinary case conferences.

- Social work departments need to put a system in place for monitoring the accuracy of case records.

- Social work departments need to ensure all staff are aware of their policy on confidentiality and sharing of information.

Health services

- Old age psychiatry needs to ensure, firstly, that there is written guidance for all referring agencies about the referral process and, secondly, that there is a clear system for prioritising referrals with standard time scales for responding to these.

- Old-age psychiatry needs to ensure there is a clear procedure in place for informing referrers when and if their referral has been actioned.

Health and social work services

- There needs to be a clear understanding of the reliability of mental state tests by all staff.

- Potential risks to staff safety should be clearly identified in the referral process.

We advise health and social work departments to review their own policy and practices in light of these recommendations.

The Mental Welfare Commission for Scotland carries out investigations and inquiries into cases where we feel there has been a significant failure in an individual's care and treatment. We will decide to pursue an in-depth investigation where we feel there are valuable lessons to be learned, not just for the services involved, but for services across Scotland.

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