



MENTAL WELFARE COMMISSION
FOR SCOTLAND

REPORT OF THE INQUIRY
INTO THE CARE AND TREATMENT
OF MRS K

OCTOBER 2001

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Background Information:

1. Mrs K was admitted under Guardianship on 20 June 2000. She went six days later from her home to a residential home. The Mental Welfare Commission visits everyone on Guardianship. Mrs K's case was allocated to Juliet Cheetham, Social Work Commissioner, in the middle of September and was visited by her and a Specialist Registrar working with the Commission in October. They found Mrs K to be angry and distressed about her Guardianship, resentful of her move into residential care, extremely unhappy about her environment and anxious about her property. She was an articulate and lively informant who appeared much more able than most of her fellow residents. Residential staff reported that Mrs K was very unhappy to be living away from her home. She had very few visits from relatives and a small amount of money. She went out very little, although she clearly had the capacity to benefit from activities in and outside the home. Overall the quality of Mrs K's life appeared limited. Mrs K asked for her Guardianship to be reviewed by the Commission.

2. Further enquiries by the Commission revealed that health and social work authorities had had concerns about Mrs K's welfare for six months before an application was made for Guardianship. Her needs had been assessed by a consultant psychiatrist and by a social worker. She was also visited by a community psychiatric nurse and a health visitor. Although Mrs K's flat was well cared for, and she maintained a reasonable standard of personal care in her appearance and cleanliness, she was thought to be very vulnerable. On occasions she would also leave her home for a few hours. She would not always eat adequate meals. She was thought to let undesirable neighbours into her flat. She was regularly supported by her nephew and his wife but would not accept that she needed any further help. When she reluctantly allowed home helps into her house they could do little for her. Residential care had therefore been thought necessary to protect Mrs K's welfare. Because she was adamant she wished to remain in her own home. Guardianship was sought to secure her admission to a care home. No explicit consideration appeared to have been given to using the Guardianship powers of access and attendance to require Mrs K to accept a more substantial package of care at home or in the community and to assist in the management and further assessment of perceived needs.

3. In the Commission's experience of people on Guardianship Mrs K appeared to have been at considerably less risk than some elderly people who are successfully supported at home, on Guardianship, by using the powers of access or attendance to ensure that regular domiciliary help is available, and if appropriate, social and other activities provided outside an individual's home. Such arrangements can delay, or prevent, an unwanted entry into a care home. They may also be used, for a trial period, to test the viability of alternatives to a care home.

4. In November 2000 the Commission decided that Mrs K's Guardianship should continue but that further enquiries should be made into the use of powers of Guardianship in her case and into the measures taken to safeguard her property and to ensure a reasonable quality of life for her in residential care.

5. Preliminary enquiries suggested that Guardianship may not have been used in the least restrictive manner consistent with Mrs K's welfare and that further attempts to provide a more extensive package of care at home may have been appropriate. Concerns also remained about Mrs K's quality of life in the residential home. However, it was also recognised that doctors, health and social workers had shown much concern for Mrs K and had wished to protect her safety.

6. In February 2001 the Commission agreed that an inquiry should be carried out into the care provided for Mrs K before and after she went into a residential home.

TERMS OF REFERENCE

1. The inquiry focused on these matters:
 - a. The assessments made of Mrs K's needs, including the assessments of the risks to which she was exposed.
 - b. The arrangements made for domiciliary care.
 - c. Communication with Mrs K about the options for her.
 - d. Consideration of the use of different powers of Guardianship.
 - e. Arrangements made for choice of, and entry into, residential care.
 - f. The safeguarding of Mrs K's property and finances.
 - g. Maintenance of Mrs K's quality of life after admission to care.
2. The inquiry was conducted by examining records and reports and interviewing Mrs K and those who had been, or who remain, responsible for her care. These interviews were recorded; notes made on the basis of these recordings were given to all interviewees with the request to correct any information which was inaccurate.
3. Those who helped with the inquiry understood that a copy of the Commission's draft report would be made available to them and they would be invited to make any corrections of fact. Interviewees were informed as well that a full copy of the report would be sent to each of them and that an anonymised version of the report would also be more widely available so that useful lessons can be learnt from the inquiry. Interviewees were also informed that a shortened account of the Commission's inquiry would be published, in anonymised form, in its annual report.

THE INQUIRY TEAM

Professor Juliet Cheetham: MA, Diploma in Applied Social Studies, Social Work Commissioner

Ms Alison Thomson: RMN, BSc, Commission Nursing Officer

LIST OF PERSONS INTERVIEWED

1. Mrs K
2. * Dr A General Practitioner
3. Dr B Consultant Psychiatrist
4. Ms C Community Mental Health Nurse
5. Ms D Social Worker, Social Work Centre
6. Mr E Area Social Work Manager, Social Work Department
7. Mr F Mental Health Officer, Social Work Department
8. Ms G Domiciliary Care Organiser, Social Work
(by telephone) Department
9. Ms H Health Visitor
10. Ms I Residential Home Manager
11. Ms J Residential Home Placement Manager
12. Ms L Residential Home Company Director
13. Mr M Head of Operations, Social Work Department
14. Ms N Principal Planning, Purchasing and Commissioning Officer
Social Work Department
15. Mr O Operations Manager, Community Care Services
Social Work Department

**Because Mrs K had changed her general practitioner by the time of the Inquiry Dr H was not able to consult her medical notes. She therefore responded to Inquiry questions from memory and by reference to copies of assessment and the reports sent to her from the Commission.*

ACKNOWLEDGEMENTS

We would like to thank all those who participated in the Inquiry for their willingness to be interviewed and to provide reports and other documentation as requested. The team was impressed by interviewees' openness. Several people said they thought it was important for the Commission to carry out such inquiries to determine whether there are lessons to be learnt from the management of individual cases. Such an approach is to be commended.

We would also like to thank Mr George Kappler, Commission Social Work Officer, for his assistance with one interview and for his advice throughout the Inquiry.

STATEMENT OF FACT

1. **Mrs K** is an 89 year old lady who has lived all her life in one city except for a period of about two years when, as a young woman, she worked as a children's nanny abroad. Mrs K had several brothers and sisters but is the sole survivor of this family. She was married once and this marriage lasted ten years. She has no children. Her sole relatives are her nephew, Mr W, whom Mrs K is said to have cared for as a child, and his wife, and her niece, Sarah, said to be Mr W's estranged sister.

2. Mrs K worked for most of her life as a bookkeeper and as a cook. She lived alone in the same Council flat for over 40 years. This flat was well furnished and maintained and full of Mrs K's treasured possessions, acquired over many years. Her home has been described by interviewees as 'her pride and joy ... her whole life ... her little palace'.

3. Mrs K considers herself to be 'a loner and home body'. She is consistently described as a fiercely independent, ebullient woman, greatly liked by those who have worked with her. She is lively, articulate and clear in her views. She responds well to questions, although her conversation can at times be repetitive. Although Mrs K's short term memory is poor she has a vivid recall of important events in her life, including the arrangements made for the application for her Guardianship.

Contacts with Health and Social Services:

4. Mrs K first came to the attention of her general practitioner, Dr A, in December 1999 following a health visitor screening visit. Mrs K had not consulted the practice for some time. Dr A thought that Mrs K was suffering from some memory loss and might be finding it difficult to care for herself adequately. Mrs K received some regular help from her nephew, Mr W, and his wife. Although they lived some way from her they would visit Mrs K about twice a week.

5. Dr A requested a community care assessment from the local Social Work Centre and an assessment by Dr B, Consultant in Old Age Psychiatry.

Assessment by Dr B, January 2000:

6. Dr B, Consultant Psychiatrist examined Mrs K on 6 January 2000, and also met Mrs W at that time.

7. In his report to Dr A, copied to the Social Work Department, Dr B describes Mrs K as having been relatively well and essentially independent up until about April 1999. Since then there had been a quite sudden and rapid deterioration, characterised by intellectual and functional impairment. Mrs W said that her aunt was persistently forgetful of new information and could be muddled in her talk and thought processes. Mrs K's condition could fluctuate from day to day. She spent large periods of her day in unstructured fashion,

often sleeping. Mrs W in the last few weeks had assumed responsibility for domestic tasks such as shopping and cleaning and paying bills. There had been instances of food being burnt on the cooker, setting off a smoke detector. Mrs W thought Mrs K might also be troubled by dribbling, urinary incontinence.

8. Mrs K was able to wash and dress independently, and it was thought she could manage with simple convenience and pre-prepared food. Her mobility was poor and there was a steep flight of stone steps leading to her front door. Mrs K was resistant to the idea of extra support at home and could perceive few if any difficulties regarding her memory.

9. Mrs K was described as a spirited and ebullient woman with whom it was possible to have a proper conversation. She was neatly and appropriately dressed, without evidence of marked self neglect, and her house was in a well ordered state. There was no evidence of pathological mood disturbance or of psychosis. She scored 21 out of 30 on formal mini mental state examination, was reasonably well oriented to place, day, month, year and season (but not date). She could register new information without difficulty, although her concentration was impaired and she displayed a moderate impairment of delayed recall. There was no personal history of psychiatric disorder. She was physically quite well although it was noted that after a fall in 1996 when she had been stuck in the bath for 17 hours she suffered rhabdomyolysis.

10. Dr B thought that Mrs K suffered from dementia of moderate severity, likely to be of vascular aetiology. He hoped it would be possible to support her in the community with an appropriate package of care, although noted that her independent stance might make this difficult. Nevertheless, he recommended that strenuous attempts should be made to put an appropriate package of care in place to see if Mrs K accepted this; only if this were not the case would it be necessary to consider compulsory intervention. Dr B also thought that Mrs K would benefit from a local day centre or day hospital but would be reluctant to attend such resources. Because Dr A had referred Mrs K to the Social Work Department for a community care assessment and for assistance in applying for attendance allowance and council tax rebate Dr B copied his report to the local Social Work Centre. He also asked Ms C, Community Mental Health Nurse, to visit Mrs K.

Assessment by Ms D, Social Worker

11. Ms D carried out a community care assessment in January 2000. The problems identified were dementia, physical frailty, a little urinary incontinence and some deafness, ameliorated by a hearing aid. Ms D arranged for one hour's home help three times a week for assistance with meal preparation and help with domestic tasks. Mrs W said she thought Mrs K would be very resistant to receiving services at home. Nevertheless, it was agreed that the arrangements for the home help service should stand. Ms D did not consider recommending a personal alarm for Mrs K because people with dementia are not eligible users of the Council's passive alarm system.

However, very late in the inquiry it emerged that Mrs K had had an alarm installed in May 1998 at the request of an occupational therapist. She seldom used it and it was removed when she left her home. The Social Work Department was not aware of this arrangement.

12. When Ms D came to review Mrs K's home help provision after six weeks she was informed that the service had stopped because Mrs K had rarely let home helps into the house. Mrs W said she would resume helping Mrs K and on 10 March 2000 the case was closed by the Social Work Department.

13. On 16 March 2000 Dr A re-referred Mrs K to the Social Work Department because she had been informed by Mr and Mrs W that they were about to go on holiday and therefore Mrs K would be without their help. Dr A also said she had contacted the local Police Station because individuals had been reported to be going into Mrs K's home. She requested a joint visit with Ms D, social worker, to Mrs K which took place on 22 March. At this visit Dr A told Mrs K, clearly and firmly, that she would have to go into hospital unless she accepted home helps while her nephew and his wife were away. Dr A at this point was considering detaining Mrs K if she refused this help. Mrs K agreed to home helps visiting five days a week for one hour a day. From the end of March these visits were made although on two or three occasions Mrs K asked home helps to go away. She was also reluctant to let them help with cooking or other domestic tasks or to help her with personal care. She also refused proposals for more substantial help

14. On 19 April 2000 Dr A contacted the Social Work Department to express her concerns again about Mrs K's vulnerability. There had been allegations that neighbours were stealing from her. The police were said to be aware of these neighbours' identities but had no proof of what they were doing. Dr A thought at this point that residential care would be best for Mrs K if she agreed to this. She had thought there should be a multi-disciplinary meeting in May to consider Mrs K's care.

15. Before that meeting took place Ms C, the community mental health nurse, reported to Ms D her concerns, and those of Ms H, the health visitor, that Mrs K was not able to manage adequately at home. Both Ms C and Ms H told us that they thought Mrs K was managing less well by this time. For example, her clothes were not always as clean as had been usual for her; she was losing more things and becoming upset by this; her flat was sometimes musty.

Second Assessment by Dr B, Consultant Psychiatrist, May 2000:

16. A further assessment was carried out by Dr B on 5 May 2000, again in the presence of Mrs W. Dr B reported that delivering an appropriate support package had been difficult, as had been expected, given Mrs K's lack of insight and independent mindedness. She continued to assert very firmly that

she wished to remain in her own home. Although home helps had been able to visit, Mrs K had not always eaten the meals they prepared. She continued to be reasonably self caring and to care well for her own flat.

17. Dr B also reported the possibility that Mrs K might be subject to financial exploitation by young neighbours. She had been burgled in the previous month, with her pension book, some cash and jewellery being taken. Mrs K had also locked herself in her own house on several occasions and had had to be released by passers by or neighbours.

18. Mrs K had also been outside her house on occasions inappropriately clothed, eg with no coat or wearing slippers. Although she had never become frankly lost Dr B thought she had been returned home by neighbours on occasions.

19. There were continuing concerns regarding Mrs K's safety in the kitchen; she had burnt three or four pans in the previous six weeks. Although the Social Work Department had recommended that her cooker be disconnected, Mrs W was reluctant to do this as she considered it would result in Mrs K constantly telephoning her or others attempting to get the cooker repaired.

20. Mrs K did not want her nephew to have power of attorney and there were occasions when she did not attend to bills.

21. Dr B again found Mrs K to be bright and ebullient with no overt agitation or suspiciousness. She blandly and unconvincingly denied any significant difficulties and some of her conversation and judgements lacked depth and complexity. She did rather worse on cognitive testing than she had done three months previously, scoring 17 out of 30 on formal mini mental state examination.

22. Dr B thought a case conference should be called to discuss applying for Guardianship as well as exploring other avenues of support.

The Case Conference, 2 June 2000:

23. The case conference was chaired by Mr E, Practice Team Manager and attended by Ms D, Social Worker, Mr F, MHO, Mrs W, Dr A, General Practitioner, Dr B, Consultant Psychiatrist, Ms C, Community Mental Health Nurse and Ms H, Health Visitor. We were told this was a lengthy meeting, perhaps lasting two hours. However, the note recording the discussion is quite brief (one side of A4). It reports that Mrs W described her concerns for her aunt (worried telephone calls from neighbours; absence from her house for three to four hours; difficulty with the stairs; losing her keys and locking herself in the house; allowing undesirable strangers into her flat; anxieties about her financial affairs; telephone calls to her nephew and niece at odd times of the day and night). Others present also expressed their concerns. Mrs K's independence was acknowledged and Dr A reported that she had

managed to persuade Mrs K to accept help, albeit reluctantly. Dr B said that the medical grounds for Guardianship were satisfied and that Mrs K had a moderate degree of dementia. Risks could be accepted or a decision made to intervene on a compulsory basis.

24. The case conference note records that an unanimous decision was made that Guardianship should be sought for Mrs K, to make possible her admission to residential care, and Mr F agreed to take the case forward in collaboration with Dr A and Dr B. It was agreed that Mrs K should be informed of the decision by Ms D and Ms C.

25. We were told that the meeting considered carefully the losses that residential care would mean for Mrs K, given her independence and her love of her home. Those attending the case conference certainly recognised the risks to which Mrs K was exposed. However, there is no written record of a detailed and systematic analysis of each of the risks facing Mrs K, with the explicit purpose of estimating their seriousness and trying to see whether ways could be found of removing or reducing these. It appears that risks were discussed in general terms with account taken of the help already given and of Mrs K's unwillingness to accept more.

26. There was also no discussion of the different powers of Guardianship and the possibility of using the powers of access or attendance to ensure more intensive care management, a more substantial care package for Mrs K and her attendance at resources which might have provided some degree of monitoring and social stimulation. There was also no consideration of the potential use of the power of access to assist a more thorough assessment of the perceived risks.

27. There were suggestions from some interviewees who were familiar with these different Guardianship powers that they considered, privately, they would not be appropriate in Mrs K's case. However, these possibilities and doubts were not discussed. Social Work Department's guidelines on the use of Guardianship state explicitly that the different powers of Guardianship must be considered at the relevant case conference.

28. It also appears from the minutes of the case conference, and from what we were told, that it was agreed that an application for Guardianship would be made by Mr F as MHO. In fact this could not be done without Mr F interviewing Mrs K and making his own assessment of the welfare grounds for Guardianship in Mrs K's case, taking into account all the relevant information. Before Mr F attended the case conference he had no knowledge of Mrs K and had not read her notes. It is possible that when he met her he might have thought the welfare grounds were not met or that residential care was not immediately appropriate. Had this happened the case conference would have had to be reconvened to consider other options. This eventuality does not appear to have been considered by those who met on 2 June 2000.

The Application for Guardianship:

29. On 12 June Mr F visited Mrs K, together with Ms D. Mr F's notes record that Mrs K was friendly and communicative although clearly had acute problems with short term memory. She denied any of the problems considered at the case conference, apart from youngsters messing up her garden. Mr F records that the risks to which she was exposed were not manageable through care at home and that the Guardianship application would proceed. Mr F told us that he explained Guardianship to Mrs K, and her right to be represented, but she was not in a mood to take in what was said to her. This was only his second experience of Guardianship.

30. Mr F then discussed the application on the telephone with the District Mental Health Officer, who agreed that it should proceed. Mr and Mrs W were informed about the application and Mr W's right to object and be heard at court. They thought compulsory powers to ensure residential care were required.

31. On 15 June sheriff officers served the Guardianship papers on Mrs K in the presence of Ms C and Ms D who were clear that they wished to be with Mrs K at this time. Mrs K was informed of her right to be represented at the hearing but she refused to consider it, saying that "they would do it anyway". Ms D told us that she would have liked to have obtained a lay advocate for Mrs K at this point but there are no advocates in the city for people with dementia who live in the community. Ms D records a very difficult and distressing meeting with Mrs K who refused to consider leaving her home. She was angry and went to see her neighbours. It was arranged that Mrs W would also visit her and that Dr A should be called if Mrs K remained distressed.

32. On 16 June Ms C visited Mrs K and Guardianship was discussed again with Ms C referring to her right of representation. Ms C also arranged for Ms H, health visitor, to visit her.

33. On 19 June Ms C visited again and found Mrs K very angry although still refusing to contest the application "because no-one will believe my side". She also said she thought she might kill herself but, when challenged by Ms C, agreed she would not do this. Ms C told us, as did Mr F and Ms D, that at this point Mrs K was remarkably clear in her recollection of the procedures for the Guardianship application. On these matters she showed no confusion.

34. On 20 June the Guardianship application was granted at the Sheriff Court. A brief hand-written note by Mr F accompanied the application. This referred to most of the risks that had been discussed at the case conference together with Mrs K's "inability and unwillingness to accept appropriate services". Mr F said that no questions were asked about the application and the consideration of it was perfunctory. No evidence was heard. Responding to an enquiry by the Commission in October 2000 Mr F said he was not aware that, in view of Mrs K's strenuous objection to Guardianship, and her refusal

to be represented at the hearing, he could have asked the sheriff to consider appointing a Curator ad Litem for her

35. Ms H told us that she visited Mrs K on the day of the court hearing and found her in her coat and hat wishing to go to make her own case at the court. Mrs K was aware of the place and time of the application and what would be said about her but was not sure how to get to the court. She was also unsure whether she could “find the right words” to make her own case. Ms H wondered whether if she should take Mrs K to the court but decided that she did not have the authority to do this. Ms D and Ms C have told the Commission that had they known of this situation they would have tried to assist.

36. Ms C also visited on 20 June and noted that Mrs K was aware this was the date of the hearing.

The Admission to Care:

37. On 21 June Ms C and Ms D visited Mrs K and found her quite calm and lucid. She could remember most of the events of the last few days. All the relevant Guardianship correspondence was neatly stored and often referred to. Mrs K was adamant that she would not go into residential care or visit any home offered to her because “there was no place better than her own home.”

38. On 22 June Ms D heard of a vacancy at a nearby residential home. At this time, in part because of recent floods, there were very few vacancies in care homes. Ms D told us she was keen for Mrs K “to have the best”. She also thought she ought to have a choice of home. However, the lack of vacancies and the prevailing view that, now Guardianship had been granted with the specific intention of using the power of residence to secure residential care Mrs K should move as soon as possible into residential care, led Ms D to decide that Mrs K should move immediately to this local home. Mr and Mrs W visited the home and Ms D noted that they were “quite overwhelmed by the number of dementing people walking around”. However, they concluded that the home would be suitable for Mrs K. Two rooms were inspected; one was dark and small and the other shared. This larger room, which would be available as a single room in August, was chosen for Mrs K.

39. Mr and Mrs W agreed to be responsible for Mrs K over the weekend. They would help her pack her belongings in preparation for her move on 26 June.

40. On 22 June Ms D prepared a care needs profile for Mrs K prior to her admission to the residential home. In addition to outlining the risks to which she had been exposed Mrs K was described as follows:

“Mrs K is a quiet woman who lives alone in a 2-apartment flat Mrs K has worked most of her adult life as a cook and a clerical worker and was married for approximately 10 years. When this marriage ended

Mrs K made her home her life. She keeps a lovely home which is clean and tidy. Mrs K is very proud of the fact that she built up her home on her own. She has no friends who visit her and is happy to be on her own. She has turned down the offer of day care, preferring her own company. She has also been reluctant to accept help in the house. She only accepted help when her GP Dr A said she would go to hospital if she did not accept help. Mrs K is a lovely woman who cannot understand why she is being “forced” to go into a home. It may take some time for her to settle into a routine.”

When Mrs D visited Mrs K on 27th June she was described as “tired and a bit distressed”.

41. During July 2000 Ms C visited Mrs K on three occasions noting that, although Mrs K was accepting help from staff, she remained angry about Guardianship, upset about the absence of her belongings and was generally unhappy.

42. Ms H continued to visit Mrs K during this time, because although she had no professional responsibility for her, she regarded her as having become a friend. She also told us that she was distressed that Mrs K had had to go into care.

43. On 7 August 2000 Ms D visited Mrs K and found her angry and upset and insisting she wanted to go home. She did not wish the attentions of other residents and said she would “soon be as bad as them”. Around this time Mr and Mrs W also told Ms D they remained worried that Mrs K had not settled, although staff said that she was better when she was not visited. The Ws said as well they were concerned that other residents were mostly at a more advanced stage of dementia than Mrs K.

44. At the end of August 2000 Ms C, who was concerned about lack of activity for Mrs K and her boredom, discussed the suitability of the placement with Ms D. There were also concerns about Mrs K’s room; the large single one that had been promised on her own had not yet materialised. She was later offered this large room which would have taken all her possessions. This would have been more expensive and too large a financial commitment for Mr and Mrs W. The home then offered Mrs K this room without extra charge but she declined the offer.

45. On 5 September 2000 Ms D and Mr F visited Mrs K and agreed that she might benefit from a move to another home. Mrs K said she was unhappy about the smallness of her room and the difficulty of fitting in her possessions. She also felt different from other residents. The staff were pleasant but she was adamant she wished to leave residential care and have another tenancy. She knew that her own tenancy had been given up.

46. Ms D and Mr F visited Mrs K again on 29 September, in part to explain that the Guardianship was not the fault of Mr and Mrs W which is

what Mrs K believed. Mrs K continued to say that although staff were helpful she was unlike the other residents; she could not go out and walk as she had done in the past and she was very unhappy at remaining in residential care. She agreed, however, to look at two other homes. Two visits to these homes were subsequently paid in October but both the vacancies were in shared rooms which Mrs K did not want. Ms D records that Mrs K would prefer to stay where she was but would like more excursions outside the home. Mrs K was reported as very much enjoying her outings with Ms D.

47. On 26 October the Social Work Department confirmed with the home that Mrs K would stay there.

The Involvement of the Mental Welfare Commission:

48. It is not clear when the Guardianship papers were received by the Commission (there is no date stamp). However, the Commission did not receive notification that Mrs K had moved to Greenfield Park until 21 July although she went there on 26 June 2000. The Commission visits everyone on Guardianship. In 2000 – 2001 over 60 percent of new Guardianships were for people with dementia. In this year too there was an increase of nearly a third in the total number of Guardianships. As a consequence there were delays in the Commission in processing Guardianship papers. Mrs K's case was not allocated to Juliet Cheetham until mid-September 2000 by which time she had been in care for eleven weeks. Mrs K was visited by her and an attached specialist registrar on 20 October. At the time of this visit, despite several requests, the Commission had been sent very little background information about Mrs K. At this meeting Mrs K was articulate, lively and direct. She answered questions appropriately, was a clear informant, and it was easy to create a good rapport with her. Dr B told us that care should be taken not to assume that Mrs K's attractive demeanour and her forthright communication meant she had a deep understanding of her problems; there must remain some doubt about her capacity and judgement. We agree with this assessment but also believe that the most careful attention should be paid to Mrs K's views.

49. There were three themes in this discussion. First, Mrs K spoke eloquently about her flat, how she had cared for it and improved it over the years and how she had enjoyed collecting her many possessions which she described in detail. Although she did not want to have these with her when she first came to the home, because she did not intend to stay there for long, Mrs K now wondered what had happened to her belongings. She also had queries about her money, including bank books.

50. Second, Mrs K was extremely resentful of her Guardianship. She said this had happened suddenly and described, quite accurately, some of the application procedures. She was able to give forceful responses to the various anxieties which had led to the application for Guardianship saying, for example, that the anxieties about burning saucepans and locking herself in and out of the house had been exaggerated ("had we never done such things?"). She also said that she only gave things away to people which she did not need.

It was possible to explain to Mrs K the different powers of Guardianship and to ask whether she knew about these. She said she did not and that the possibility of being required to accept extra help in her home had never been discussed with her. She told us that she would not have liked this but, compared to life in residential care, 'it would have been brilliant'.

51. Third, Mrs K said that, although she appreciated the staff at the home, and especially her key worker, she was most unhappy there. She did very little in the home. Only recently had she had her first outing and "the place is like a prison. I do not think anyone cares about what I want."

52. During this visit Ms I, the Manager, and her key worker, reported that, although Mrs K was more settled she was still most unhappy in the home. There were questions about whether she was appropriately placed, although residential staff felt that alternative homes would be a disappointment for Mrs K whose main wish was to be out of residential care.

53. Ms I and the key worker also reported that, although Mrs K was visited every fortnight by Mr and Mrs W, she was never taken out of the home. There were also financial concerns. Mrs K had come to the home with £50 but over four months this sum had dwindled. She had never received her personal allowance which was collected by her nephew who was her DSS appointee. Mrs K spoke often about her property and her anxieties about its whereabouts. Mrs K was said to have limited interaction with other residents. She spent much of her time on her own either looking at television or "looking at the traffic out of the window". She greatly enjoyed a recent outing, spending some money and going out to lunch. There were, however, limited funds for such excursions to be repeated.

54. The Mental Welfare Commission asked Ms D to investigate these property and financial matters. In November 2000 Mrs K chose some items for her room and the owner of the residential home was made the DSS appointee. Money owing to Mrs K from her personal allowance (after various expenses had been deducted) was paid into the home's account. Mr and Mrs W were, apparently, offended by the enquiries made on behalf of the Mental Welfare Commission and said they no longer wished to take part in decisions about Mrs K's welfare, although they would continue to visit her. It was thought that this was also a reaction to Mrs K's hostility to them during their visits.

55. At a visit made by Juliet Cheetham and Alison Thomson, Nursing Officer in March 2001 Mrs K was clear, forceful and articulate, resentful of her Guardianship and of the home. She again spoke of 'being not so far gone' as other residents, her wish to leave the home on outings and of the absence of any visitors. She was now in a small, narrow, single room and was pleased to have some of her property, for example a china cabinet there. She would still like some other things. The room is large enough for a single bed, the china cabinet, small desk and cupboard, the commode and one armchair. There is

no proper sitting area and no room for a bedside table or light. There is no lock on the door.

56. The manager of the home told us that Mrs K now had no visitors. She very much enjoyed, and benefited from going on shopping expeditions with the activities organiser. These occurred perhaps two or three times a month. The home now had charge of Mrs K's personal allowance which she used for items of clothing and shopping trips. Mrs K was more settled but still spoke of wanting to leave the home although she made no attempts to do this. (The home's doors are locked.)

57. After this visit the Mental Welfare Commission asked for further enquiries to be made about some of Mrs K's property and raised the question of volunteers or additional resources being made available to enable Mrs K to have regular outings. Subsequently we were told by home staff that there was no volunteer scheme which could be used. We were also told that the Social Work Department has no resources to make extra activities possible for residents. However, Mr F said that he had arranged for Mrs K to have some more of her property in her room. He had also talked with Mr and Mrs W about resuming visiting and hoped this would be done.

58. Mrs K remains in residential care. She was told by the Inquiry team that some enquiries were being made about her care.

CONCLUSIONS AND COMMENTS

Contacts with Professionals:

59. In some respects Mrs K has had a good standard of care. She was visited regularly by health and social workers shortly after concerns were raised. Her most frequent visitor was Ms H, health visitor, who saw her at least once a week from the autumn of 1999 until Mrs K went into residential care. Ms H did not, however, have any contact with the Social Work Department until the case conference because Dr A was carrying out this liaison. Given Ms H's frequent contacts with Ms K, and their close relationship, more direct communication between Ms H and Ms D and Mr F who, respectively, were responsible for Ms K's care management and guardianship, would have been helpful.

60. Although Ms H had no particular responsibility for Mrs K after her admission to care, she continued to visit her there for some weeks "as a friend". She stopped these visits when she realised that they were going beyond the bounds of her professional responsibility. Of all the workers in touch with Mrs K, Ms H probably knew her best. She described to us a relationship of trust and openness, Mrs K's pleasure at seeing her and her requests that she (Ms H) do things for her instead of the home help. Ms H told us that she was most anxious to protect Mrs K's welfare and extremely upset by her unhappiness at her move to Greenfield Park and by some aspects of her life there.

61. Ms C also visited Mrs K at least monthly from January 2000 and, around the time of the application for Guardianship, more frequently. She continues to see Mrs K once a month.

62. Dr A, Mrs K's general practitioner, diligently followed up her concerns about her with Dr B, Consultant in Old Age Psychiatry and with the Social Work Department. Dr B made two careful assessments of Mrs K before the application for Guardianship. He visited her again at the time of the renewal of Guardianship (December 2000) and once more before meeting members of the Inquiry team.

63. Ms D made two visits to Mrs K before the case conference in June 2000. She also received telephone calls from other workers who were concerned with her. Ms D met Mrs K again to explain the application for Guardianship and also the day after Guardianship. She paid three more visits to Mrs K after she had been admitted to the residential home and took her on two visits to see alternative homes. In November 2000, following queries by the Mental Welfare Commission, she arranged for Mrs K to have some of her property taken to her in the home. She also sorted out matters regarding her personal allowance. She transferred Mrs K's case to Mr F in December 2000.

64. Mr F met Mrs K with Ms D after the case conference had made a decision that Guardianship would be appropriate. He then visited Mrs K in

the residential home twice before her case was handed over by Ms D in December 2000. Since Mr F became Mrs K's effective Guardian he has paid a further four visits.

65. Mrs K was therefore known to a number of professionals who were actively concerned about her. In addition to visits from the Home Help Service she probably saw a professional person at least once a week.

66. Case notes show regular communication between Dr B, Dr A, Ms C and Ms H. Ms C telephoned Ms D in May and Dr A was also in touch with Ms D by telephone on several occasions. However, as has already been noted, there was no direct contact between Ms H and Ms D until the case conference. It was appropriate for all those involved with Mrs K to discuss her care at a case conference.

The assessments of Mrs K's needs and strengths and the risks to which she was exposed:

67. Dr B wrote two detailed reports for Dr A which were copied to the Social Work Department. Ms D carried out a routine community care assessment. Ms C also refers to Mrs K's needs in her notes. The main risks referred to in these assessments were repeated by Mr F in his note for the Sheriff Court. In his own records Mr F notes that 'Mrs K's wandering and lack of understanding and compliance prevent further reduction of risk by use of a fuller package of care at home. She is not assessed as requiring hospital care and treatment. Risks to her health and safety by use of the residence powers of Guardianship was discussed at the case conference. The disorienting effect of this change was considered a lesser risk than she continues to experience at home. Her nearest relative thought her social nature would increase the appropriateness of a nursing home placement.'

68. There is agreement, in general terms, about the risks Mrs K faced. However, the extent of some of these risks is not clear. For example, we were told by some respondents that neighbours had had to obtain access to Mrs K's flat once or twice and by other people that this had happened on many occasions. We were also told by one interviewee that Mrs K was subject to frequent falls whereas this is not the case. References were made to Mrs K letting undesirable people into her flat but there was no agreement about who these people were or how often these events had occurred. Reference was variously made to a rather undesirable couple who had recently come to live on the same stair; to young children who would ask to use the telephone and (perhaps) take money from her; and to other unknown neighbours whom, it was thought, had been reported to the police, although by whom was not clear. The precise facts of these events do not appear to have been established. It is also not clear whether Mrs K had been burgled once or twice and what property was taken. We were told variously that Mrs K had been robbed of some money, perhaps £100, and jewellery, her pension book (which other respondents said had simply been lost) and "everything she possessed, except

the rings on her fingers”. As Dr A told us, ‘part of the problem with Mrs K is that there is a lot of hearsay’.

69. It would appear that Mr and Mrs W reported the burglary (or burglaries) to the local police. It also seems that Dr A reported her concerns about some of Mrs K’s neighbours to the police. (Dr A could not be definite about this without reference to her notes.) However, the Social Work Department did not contact the police to discuss Mrs K’s safety. Several interviewees told us that they thought these matters (as they understood them) greatly increased Mrs K’s vulnerability. However, there appears to have been no specific discussion of the precise nature and frequency of these risks, and possible responses to them, at the case conference. It is important for there to be clarity about such events if there is to be an accurate assessment of risk and the ways it may be managed. The police were not seen to have any role in contributing either to the assessment or the management of risk in this case.

70. There also appears to have been no discussion about methods of minimising the risk of Mrs K locking herself in or out of the flat, for example by using internal locks which do not require keys; by ensuring that trustworthy people had keys to Mrs K’s flat (such an arrangement had been made with one neighbour); or by leaving a key with the Social Work Department or Alarm Centre for collection in an emergency. At the end of the inquiry it emerged that the Council’s alarm centre had a key to Mrs K’s flat. Mr and Mrs W knew this, and Ms H had observed the alarm system equipment in the flat. However, it was not generally known that this resource was available to Mrs K and so its possible contribution to her care was not considered.

71. The stairs to Mrs K’s flat were hazardous but she had a system of obtaining help from neighbours by leaving her walking aid or shopping bags on the stair. There appears to have been no discussion with these neighbours as to whether they could continue offering help or whether other neighbours might be involved. Should the stairs eventually prove too much for Mrs K a ground floor tenancy might have been appropriate. Again, this possibility was not discussed between the care professionals, although Ms H said she raised the matter with Mrs K several times and she refused to consider it. When we raised this matter with interviewees we were told that such a move would be disturbing for Mrs K; that she would not agree to it; and that unless extensive home care were accepted it would do little to solve her problems.

72. An isolator switch for the gas stove was considered but rejected because Mrs W said she thought it would confuse Mrs K and she would therefore frequently telephone her or her neighbours. The possibility of using a microwave as an alternative to a cooker was not considered or discussed with Mrs K. An assessment by an occupational therapist might have proposed other adaptations but no such assessment was made although it had been proposed by Dr B in his first assessment report on Mrs K. The use of standard assessment protocols, alongside interviews, can assist more systematic collection and review of information about risk and dependency but these are not used by the Social Work Department.

73. It appears that no explicit consideration was given at the case conference to Mrs K's moving to supported housing although there is such local provision. One respondent has told us that he thought there was such a discussion but others said they were clear that this was not considered because such a move would not have been appropriate for Mrs K because she only wanted to stay in her own flat. They also said it was not clear that sufficient help could be arranged for her in supported housing although we understand that up to 21 hours per week can be provided; this is significantly more than the 5 hours a week Mrs K was receiving before she went into care.

74. It is possible that, faced with the alternative of residential care or another tenancy with easier access, Mrs K might have chosen the latter. It would have been appropriate to give her this choice if it was thought that the stairs to her flat presented a significant hazard. Mrs K has told Commission visitors that she would now like her own tenancy although she appreciated she cannot return to her previous flat.

75. None of the possibilities outlined would have ensured Mrs K's safety. However, consideration of their practical potential was necessary if serious attention was to be given to the least restrictive intervention for Mrs K and to a carefully planned attempt to maintain her in her home, which was her clear and repeated wish.

76. Most of these arrangements would also have meant some intrusion on Mrs K and might have had to have been carried out without her full consent. However, the alternative of residential care was a much more serious intervention and one which Mrs K strenuously opposed and which would radically and permanently change her life. When questioned about these possibilities some interviewees said they had considered them privately but had rejected them as a practical possibility. Some respondents also said they thought such interventions would make her unhappy. On the face of it this reluctance to consider lesser statutory interventions to prevent or delay a more drastic one seems surprising. However, experience suggests that some professionals believe that making such arrangements for someone in his or her own home is inappropriately authoritarian. Nevertheless, without such measures much more intrusive intervention may be necessary. There can be an inevitable conflict between a person's autonomy and his or her need for care and protection. Careful judgements have to be made about which intervention poses the least threat to that individual's autonomy and will protect his or her welfare.

How serious were the risks to which Mrs K was exposed?:

77. Respondents all took the view that the matter which put Mrs K quite high on a scale of risk was her refusal to accept services. She was not amenable to persuasion on this point. Even if she allowed people into her flat she would not always let them do what was required, for example, cook meals

or shop for her. Interviewees thought that this continued refusal left Mrs K very vulnerable and with no alternative to arranging residential care.

78. However all respondents also agreed that each individual risk was not great and, as experience shows, could be managed in the community. They were 'part and parcel of what we deal with'. We were told that a possible exception was Mrs K's tendency to allow strangers into her house. Interviewees all said they had experience of older people with dementia living in their own houses whose circumstances were more difficult and more risky than those of Mrs K. All respondents were aware of a range of community services which could be used to support Mrs K and to increase her safety. The Commission is also aware of many people on Guardianship who have lived at home for considerable periods before going into a residential care home, or who are still at home, whose circumstances are much riskier; for example, people with much more severe dementia than Mrs K and much less capacity to manage their own personal welfare. The Commission visits many such people with dementia who have or have had very extensive packages of domiciliary care. These can include visits from home helps and support workers three or four times a day, seven days a week. Some of these arrangements are for people who have initially refused to accept help at home but who have been required to do this through the access power of Guardianship. The Commission thinks it would have been appropriate to try and make such arrangements for Mrs K.

Statutory intervention and powers of Guardianship:

79. Not all those concerned with Mrs K's care knew of the three different powers of Guardianship. Dr B and Ms C were aware of these powers, as was Mr F although he never considered the use of access or attendance. However, Ms D told us that she only learnt about these possibilities from the Mental Welfare Commission.

80. Dr B told us that he did not think that using access powers to provide substantial home care for Mrs K would be practical because Mrs K, partly because of her dementia but also because of her independent minded personality, would not accept the authority of Guardianship. He also thought that requiring her to have more people in her house or, possibly, to attend a day centre or similar resource, would be very upsetting for her. Ms C expressed similar views. However, to an extent it seems that Mrs K has accepted the authority of Guardianship; she went without resistance to the residential home and she has not attempted to leave. She also accepted Dr A's firm statement that she must accept home care to avoid being admitted to hospital.

81. Ms D, although she did not know about these Guardianship powers when she was arranging Mrs K's care, said that she would always prefer to work in partnership with her clients. She would try to persuade them but, in the end, their choices should be respected wherever possible. She had not previously had any experience of Guardianship and, as a social worker,

specialising in community care, she was rarely involved in statutory interventions.

82. Mr F told us that, in his view, Mrs K could have been supported at home if two domiciliary visits per day instead of one could have been arranged. However, he appreciated that others involved with Mrs K's care did not think this would work well. It was also possible she might be out when workers called.

83. There were occasions when Mrs K was told, for example by Ms C shortly after Guardianship had been granted, that if she were willing to accept help at home then she might not have to go into residential care. We heard that this point had been put to Mrs K on other occasions by Dr B and by other workers. Ms H said Mrs K refused suggestions that she attend a day hospital or lunch club. However, Mrs K was never told that she could, under the powers of Guardianship, be required to accept more help at home, and to attend services outside, and that these arrangements would be put into effect as an alternative to placing her in a care home. The possibility of extra services was always presented to Mrs K as a matter of choice for her. The reality of Guardianship is that this choice need not have been left to her. As Dr A told us, 'Mrs K did not have sufficient insight for her refusal of services to be taken as the last word ... the Social Work Department has more creative ways of working than just accepting a refusal'.

84. While it appears that one or two people privately considered using the Guardianship powers of access or attendance, and then, without formal discussion, rejected this as impractical, these possible alternatives to residential care were never discussed at the case conference, or between health or care workers, as a possible context for arranging adequate care for Mrs K. It is not clear why this did not happen. The Social Work Department's Practice Guidance states that case conferences should consider the different powers of Guardianship. It has been suggested to us that some people at the case conference assumed that the mental health experts would have considered all options apart from residential care and these were not discussed because they had already been rejected for various reasons. However, Mr F was not able at this meeting to contribute his own independent view as an MHO because at that point he had not met Mrs K. *The Commission is clear that when decisions are being made about applications for Guardianship there must be explicit and full discussion of the reasons for such decisions and possible alternatives and that a record should be made of the options considered and the reasons for decisions taken. It is also extremely important for the MHO who makes the application for Guardianship and for the social worker who will be responsible for managing the care of the person on Guardianship to be fully informed about all the possible options and to make their own independent judgement about decisions which can have major and sometimes life long implications for vulnerable individuals.*

85. It is not possible to say with certainty whether substantial home care provided using the access power of Guardianship would have secured

sufficient help for Mrs K to reduce substantially the risks she was thought to face. She might well have been most resistant to such interventions. They would also have required some assertive approaches and, perhaps, such practical interventions as obtaining a key to Mrs K's flat for use by care workers. Arrangements might also have had to be made to arrange an escort for Mrs K to ensure, as far as possible, that she attended any day resources thought appropriate. Such interventions would have undoubtedly been an intrusion on Mrs K's liberties. She might have disliked them. However, they could have been a real alternative to the much more drastic action of admission to a care home, with the likely consequence that Mrs K would remain there for the rest of her life. The Commission knows of arrangements such as these, including some arranged by the Social Work Department responsible for Mrs K, which have successfully maintained, in their own homes, people with dementia who have resisted offers of help.

86. When visited by Professor Cheetham in October 2000 Mrs K was clear (and she was correct in this memory) that no-one had posed these possibilities to her. As noted above, she said clearly that she would not have liked such arrangements but "compared to coming to this home they would have been brilliant". The reality might have been different. However, it is relevant to note that when Dr A said very firmly to Mrs K, at the time of her nephew's holiday, that she would go into hospital unless she accepted a home help for five days a week, Mrs K agreed to this arrangement which was partially successful. Ms H's and Ms C's experience of work with Mrs K also shows that, over time, it was possible to establish trusting relationships with her. Such relationships might have developed with home helps or support workers.

87. Some workers may be reluctant to assert their authority when they have established, or are trying to establish, a co-operative relationship with a client. *The Commission believes that, while it is preferable to try and work on a voluntary basis with those who need care but who resist this, using statutory powers assertively may reduce the need for a more drastic intervention. Such possibilities should always be considered and it may well be appropriate to try them out if the least restrictive intervention for an individual is to be achieved. Interventions allowed by mental health legislation can provide an essential therapeutic context for care and treatment.*

Admission to a care home for people at risk:

88. Those responsible for Mrs K's care were much aware of the risks to which she was exposed in her own home, although as discussed above, the extent of these risks was not entirely clear. We were told that the risks posed by admission to a care home were also considered. Interviewees described these as including major disruption for an individual; leaving a loved home; the unstimulating environment of some residential care; removal from a known community; the unhappinesses of living with uncongenial fellow residents; rare but possible abuse by staff; greater likelihood of acquiring common infections and possible shortening of life.

89. All respondents were clear that none of these risks was inevitable; some acknowledged that, although some people did very poorly in care homes, and very much disliked their life there, others could “blossom and flourish” and react well to a more sociable environment than they had in their own homes. Others told us they were extremely unhappy that residential care appeared to be the only option for Mrs K. Dr B told us that the case conference had carefully considered the risks of Mrs K being ‘an angry, reluctant and miserable recipient of residential care’ but some people thought that because she is a bright and chatty person who enjoys company she might respond very well to the companionship and stimulation of a residential home.

90. The reality for Mrs K was that she was, as had been expected, greatly distressed about leaving her much loved home and her treasured possessions; she also had to share a room in the residential home for some months; she correctly regarded many of her fellow residents as suffering much more severe dementia than she did, and she feared she would become like them; she was for several months without many personal possessions; she received few visits from her relatives; there were few activities in the home and very few outings. In August 2000 an activity co-ordinator visited the home only once a month although the Director has informed the Commission that a full time activities co-ordinator was appointed in January 2001 and that there are now many activities Mrs K can attend in and outside the home. The home has no garden, although an outside sitting area is planned. The room Mrs K now has is small and has a commode. The home, as was noted by the Social Work Department’s Registration and Inspection Unit in August 2000, is in some respects quite shabby and institutional and, on occasions, has been smelly. In April 2001 the Unit reported some improvements with an action plan to implement all recommendations by August 2001.

91. Such an environment can be, sadly, a common reality of life in care homes. It is not acceptable and falls far short of the recently drafted National Standards for Care Homes for Older People. All responsible authorities should tackle these deficiencies of care. However, while planning for these improvements the actual environment a person will experience in each home should be taken into account when decisions are being made about the most appropriate care plans for individuals.

92. Although residential staff have been kind and helpful to Mrs K, and she has commented on this positively, there have been several concerns about aspects of Mrs K’s life in the residential home. While she has responded well to a good diet and personal care, Ms C thinks that Mrs K is becoming less mobile because she has insufficient exercise. Concerns have also been expressed about lack of activities and outings for Mrs K and about the relative poverty of her environment. Although Mrs K is said to have some positive contacts with one or two residents, on the whole she is regarded as being more able than the great majority and Mrs K does not find she has much in common with them. This is not a promising context for the more stimulating and sociable environment one or two respondents had hoped residential care would provide for Mrs K.

93. Not surprisingly, given the decision taken by the case conference that residential care was the only option for Mrs K, most respondents thought that the residential home had, on the whole, met Mrs K's needs for personal care and safety. There was, however, agreement that some improvements in her care arrangements would be desirable, but difficult to arrange; and there was a sad acknowledgement by some that the quality Mrs K's life may not be very great.

94. *Some interviewees said that it was very important to provide for individuals' emotional welfare, as well as their physical well-being. A holistic approach is essential. The Commission strongly agrees and notes that such an approach requires an individual's need for personal safety and physical well-being to be weighed against other important components of his or her quality of life. The views of relatives should be taken into account in making this assessment.* The Commission is aware that recent research has found that admission to homes may be encouraged by overemphasising care requirements, by placing an emphasis on safety rather than independence and by inadequate recording of information.¹ It would seem that Mrs K's case is not an isolated one. Difficult judgements may need to be made, carefully recorded and regularly reviewed, that in the interests of an individual's emotional welfare, and in recognition of that person's strong and repeated wishes, a degree of risk with physical safety will be tolerated. The Commission thinks such a judgement, with the ensuing care arrangements, would have been appropriate before a final decision was made that Mrs K should be placed in a care home.

95. Although Mrs K may not have been particularly lucky in the residential placement secured for her, it is acknowledged that her experiences of a care home are not unusual. These circumstances can be all the more difficult to bear when a person has entered a care home against his or her will and remains unhappy to be there. Admission to a care home should be either a positive choice or the last possible resort. For Mrs K neither was the case.

Mrs K's Property

96. When Mrs K went to Greenfield Park Ms D told Mrs W, who collected her benefits, that she would have to have her personal allowance. Ms D also made arrangements for Mrs K's Housing Benefit to be extended and, after about 12 weeks, for her tenancy to be given up. However, this was done before it was confirmed (on 26 October 2000) that Mrs K would be a permanent resident in the home.

97. It is not clear who made the final decision about giving up Mrs K's tenancy but there seems to have been a clear assumption that Mrs K would not

¹ Penrice G et al (2001) Low dependency residents in private nursing homes in Glasgow *Health Bulletin* 59(1) pp15-19

return to her flat; even if the home was not suitable for her an alternative residential placement would be found.

98. Mrs K went into residential care with very few possessions. In part this was because Mrs K did not believe she would be staying there long. Mrs W arranged for her property to be moved to her own house where it was carefully stored in her garage. We were told that the residential home staff encouraged Ms D and Mr and Mrs W to bring in some of Mrs K's possessions. Ms D told us that she had discussed Mrs K's property with her several times

99. Ms H told us that when she visited Mrs K she was upset about her missing property and guarding her few possessions carefully in her room. In mid August 2000, Ms D records that Mrs W had reported that Mrs K now wanted all her furniture. However, when Professor Cheetham visited her in October, she spoke eloquently about her absent possessions and was keen for some to be restored to her. The residential home staff also said that Mrs K now had very little money in her home account. This had not been reported to Ms D who told us she had arranged with Mr and Mrs W that they would top up Mrs K's home account when it was depleted.

100. Following enquiries from the Commission Ms D arranged for Mrs K to visit her nephew's house and to choose items she would like to have with her in the home. Ms D also made enquiries about Mr and Mrs W's arrangements for Mrs K's personal allowance; and because Mrs K's insisted that she had had a bank account Ms D made enquiries at four local banks and established Mrs K had never had accounts there. Ms D therefore helped resolve these difficulties.

101. At the end of November some of Mrs K's property was delivered to the residential home, to her great pleasure. Following Ms D's enquiries Mrs W said that she did not any longer wish to be a DSS appointee for Mrs K and this role was therefore taken over by the owner of the home.

102. It is of concern that Mrs K had hardly any of her possessions with her until the end of November, five months after she went into the residential home. In its Annual Report 1999-2000 the Commission criticises the lack of personalisation in the rooms of many people in care homes. This diminishes their individual identity, and, although home care staff commonly acknowledge the importance of personal possessions for residents, there appears to be some vagueness about whose responsibility it is to ensure that those who wish this have personal possessions in their rooms. On a visit by Commission staff in March 2001 Mrs K spoke again about smaller items she would like to have with her. This was also followed up and we were told in May that some further things had been restored to Mrs K. However, once again, this seems to have been done on the initiative of the Commission.

103. There was also some lack of clarity about the arrangements for Mrs K's personal allowance. Mr and Mrs W told Ms D that they assumed home

staff would tell them when Mrs K needed money. It would have been sensible for the staff to have done this, or to have raised the matter with the Social Work Department, rather than waiting to report financial difficulties until the visit by the Mental Welfare Commission. Mr and Mrs W are also reported as saying they thought that Mrs K's money would not be safe in the home. Again, it would have been sensible for the arrangements for the management of residents' money to have been explained to them.

104. *It is extremely important for careful attention to be paid to the detail of arrangements for residents' property, recognising the fact that their wishes may change after they have spent some time in residential care. There must also be clear arrangements for the management of residents' personal allowances (some £64 per month). It also is extremely important that those residents who would like to go on shopping expeditions or other outings and who wish to make regular purchases should know precisely how to access their personal allowances.*

105. Social Work Departments also need to have clear guidelines and arrangements for giving up individuals' tenancies. With the implementation of the Adults with Incapacity Act such decisions could be made through an Intervention Order if it is thought that a tenant is incapable of doing this.

Support for Mrs K's Carers

106. Although some respondents spoke positively of the support Mr and Mrs W gave Mrs K the help they received appears rather limited. We were told they were given written information about dementia and the telephone numbers of professionals and that telephone calls were made to give advice and reassurance. Dr B met Mrs W twice; and they had some contacts with other health and social care professionals. However, there is no record of explicit support offered to Mr and Mrs W directly either through a carers' assessment or through discussion of the reasons for Mrs K's hostility to them, the difficulties of coping with her rejection in the face of the extensive help they had tried to provide and their possible feelings of guilt and anxiety when Mrs K finally went into residential care. Such help might have prevented the rift in the relationship between Mr and Mrs W and Mrs K which left her effectively isolated.

107. Mr and Mrs W were said to be upset by the enquiries made by Ms D after the Commission had raised concerns about Mrs K's property. They stopped visiting her towards the end of 2000, in part because Mrs K could be extremely angry with them because she blamed them for her Guardianship. Some respondents said they had witnessed this, saying that it was particularly hard for Mrs W, who was not a blood relative of Mrs K, but who had taken much of the responsibility of caring for her. Mrs K and the W family are described as having had a close relationship before Mrs K went into residential care. In all their interests it would be worth exploring the possibility of these relationships being restored. After Commission enquiries in March 2001 about arrangements for activities for Mrs K, Mr F told us that

he had contacted Mr and Mrs W and hoped they would resume contact with her.

Mrs K's Future

108. Residential staff say that Mrs K is now more settled and will not complain about being in residential care unless she is visited by health or social care staff, including Commission visitors. However, with such people Mrs K continues to raise forcefully her great regret at having left her own home and her objections to Guardianship. Although appreciative of the residential staff, Mrs K also says that the home is "rather like a prison", meaning that she cannot leave it on her own. She recognises she needs to be accompanied on excursions but there are few of these. She also fears that she will deteriorate to the same state as other residents. All those now working with Mrs K recognise that she needs more stimulation, more activities in the residential home and many more outings.

109. When it was known she was not settled in residential care, Ms D arranged for her to see two alternative homes. These places were rejected by Mrs K, in part because she would have had, once again, to share a bedroom. It also seems likely that another move for someone in Mrs K's circumstances would seem, at least initially, as extremely disruptive and unsettling for her.

110. Mrs K now has her own room and, to her great pleasure, some of her possessions. However, this room is small and there is little space for Mrs K's other property. The home had offered Mrs K a much larger room, eventually at no extra cost, but she rejected this, perhaps in part because she feared the disruption of another move. Mrs K continues to state that she would like her own tenancy.

111. Following this inquiry the Commission believes there should be a full review of Mrs K's care arrangements, in consultation with a senior member of the Social Work Department who is familiar with the full range of resources for people with dementia. At this review all the options that were not considered before Mrs K went into residential care should be explored. If no viable alternative can be found and Mrs K has to accept that she will spend the rest of her life, perhaps several years, in residential care, further attempts to provide a larger room for Mrs K, in which she could be surrounded by her possessions, may be appropriate.

The Use of Statutory Measures

112. *The Commission has in the past criticised failures to take account of the risks to which a vulnerable person is exposed and to consider the protection of that person through statutory intervention². In Mrs K's case the Commission recognises the concern health and social care staff had for her welfare and the difficulties they faced in persuading Mrs K to accept the help*

² The Report of the Inquiry into Deficiency in Care and Treatment Inquiry for Ms P MWC Annual Report 1998-99

she needed. An application for Guardianship for Mrs K was therefore appropriate; and the Commission decided that Mrs K should not be discharged from Guardianship when she requested that it should be reviewed.

113. *The purpose of Guardianship is to provide care and protection for persons suffering from mental disorder in the community when it cannot be provided without the use of compulsory powers. It enables the establishment of a statutory framework for working with a person to achieve as independent a life as possible but still recognises the risks which threaten the individual. Guardianship allows an individual's circumstances to be closely monitored and, if they deteriorate, for swift action, including admission to respite care. Guardianship must be part of a person's overall care and treatment plans and should be considered after non compulsory options such as care management have been assessed as insufficient. Care management of the individual may offer the same range of services and protection but lacks compulsory powers. The three powers of Guardianship can allow, as experience across Scotland demonstrates, for extensive care to be provided for individuals in their own homes. Although resistant to receiving domiciliary help many people accept this, albeit reluctantly, when required to do so because they are on Guardianship; they have responded and benefited from the positive use of authority. Applications for Guardianship made from April 2002 under the Adults With Incapacity (Scotland) Act will allow for a much wider range of powers to provide services for vulnerable people who need but resist help.*

114. *In this case the Commission believes that careful consideration should have been given to the use of the different powers of Guardianship. Mrs K had not had an extensive care package (at most five hours a week). The Commission thinks that she should have been told that, in the interests of her own welfare, and to prevent the admission to care she so strenuously resisted, more help was to be provided in her home, both to monitor her safety and to meet some aspects of her personal care. Such arrangements should have been regularly and carefully reviewed and if found not to reduce the risks to which Mrs K was exposed to an acceptable level, residential care would indeed have become the option of last resort.*

115. *It is established good practice to pursue the least restrictive option when statutory measures are to be used. With the implementation of the Adults With Incapacity Act 2000 there should be no intervention unless the responsible authorities are satisfied that this will benefit the adult and that such benefit cannot reasonably be achieved without that intervention. Any intervention must also be the least restrictive option consistent with the welfare of the individual. When intervention is planned account must be taken of the wishes and feelings of the adult, as well as the views of the nearest relative or carer. The adult should also be encouraged to use existing skills and to develop new ones. These principles will be the required context for future decisions about Guardianship and other statutory interventions for people who lack capacity. Had these principles guided decisions about Mrs K's care it is likely that further attempts would have been made to provide a more extensive package of care for her at home, using the powers of Guardianship, before making any final decision about admission to care.*

116. *The Commission appreciates the onerous responsibilities of those who have to take decisions about the welfare of vulnerable people and their anxieties about the appropriate management of risk. It is aware that these health and social care professionals sometimes feel that they are criticised both for being too intrusive and assertive in the care they provide and for being too laissez-faire. The Commission recognises that it is not possible to guarantee a vulnerable individual's complete safety and welfare. It strongly supports careful and systematic risk assessment as a foundation for decisions about care arrangements which will protect and promote the welfare of vulnerable people while respecting their autonomy as far as possible. For people with dementia there is increasing understanding of the approaches and services which can support them in their own homes and communities³. Although provision of such resources is still patchy the Commission is aware of some excellent care arrangements for people with dementia who have little or no insight into their needs and who have resisted services. Guardianship can give supportive, flexible and statutory framework for providing such services. The Commission recognises that Guardianship has not been widely used to enable people to be cared for in their own homes but hopes this will change⁴.*

117. *Analysis of Mrs K's needs and problems, and of the difficulties of those who were responsible for her care, reveal many questions relevant to the management of the help of vulnerable people with mental disorder and to the implementation of the Adults With Incapacity Act 2000. The Commission hopes that these matters will be widely and carefully considered and lessons learnt from the inquiry which will be relevant for the care of people with dementia for whom statutory intervention is appropriate.*

³ Alzheimer's Scotland/Action on Dementia (2000) *Planning Signposts for Dementia Care Services*.

Advice and information is also available from the Dementia Services Development Centre at Stirling University.

⁴ Barber JM and Crean TG (2000) 'Guardianship in the Elderly and the Community Care Act: more of the same?' *Health Bulletin* 60(6) 471-477

FINDINGS

- (i) Health and social care professionals showed much concern for Mrs K's welfare. Assessment and help were promptly arranged and there was considerable involvement by health and social workers.
- (ii) There was a lively awareness of the actual and potential risks to which Mrs K was exposed but insufficient investigation and analysis of their nature and extent.
- (iii) Insufficient efforts were made to attempt to reduce each of these risks individually.
- (iv) A modest package of domiciliary care was arranged for Mrs K because she denied she needed any further help.
- (v) Guardianship was the appropriate statutory intervention. Insufficient consideration was given to using its different powers. In this respect the Social Work Department's practice guidelines on Guardianship application were not followed.
- (vi) The decisions of the case conference did not take account of any independent assessment by a Mental Health Officer.
- (vii) Mrs K's refusals of help were allowed, inappropriately, to shape professionals' choice of the intervention for her.
- (viii) Mrs K was not told that, because she was on Guardianship, she would have to accept a more substantial package of care; and no such arrangements were made, either because workers were not aware of the different powers of Guardianship, or because they thought their use would make Mrs K unhappy, and/or be ineffective.
- (ix) With good intent, but without attempting less restrictive interventions, Mrs K was moved into a residential home through use of the Guardianship power of residence. This was much against her will, and she was greatly distressed by the move.
- (x) There was inadequate exploration of the most appropriate placement for Mrs K because of the absence of available placements and the belief that the most important priority was to place Mrs K in residential care.
- (xi) Mrs K did not receive her personal allowance in the residential home until the Commission made enquiries about her property.
- (xii) Likewise Mrs K did not have chosen possessions in the home until after these Commission enquiries.

- (xiii) Mrs K has appreciated the help of residential staff but has felt out of place in the home.
- (xiv) The personal care and regular meals provided by the home have benefited Mrs K physically.
- (xv) There have been insufficient activity, exercise and outings for Mrs K in the home.
- (xvi) The Commission would normally have visited a person on Guardianship earlier but did not do so because of staffing difficulties.
- (xvii) Mrs K did not have the capacity to agree to give up her tenancy and, in the absence of an appropriate legal framework, this was done on her behalf by the Social Work Department.
- (xviii) Interviewees have shown a thoughtful willingness to learn lessons from the Inquiry.

RECOMMENDATIONS

(Some of these recommendations will be relevant for health and social care authorities throughout Scotland)

Care of Mrs K

- a. *The Social Work Department and her Guardian should undertake a full review of Mrs K's future care and take account of all options which might give her greater autonomy.*
- b. *If Mrs K has to remain in residential care the Social Work Department and her Guardian should consider obtaining a larger room for her and the restoration of more of her possessions.*
- c. *The residential home and Mrs K's Guardian should make arrangement for more outings and activities for her.*
- d. *Mrs K's Guardian, perhaps with the assistance of another social worker, should try to re-establish the relationships between Mrs K and her relatives.*

Assessment, Care Management and Statutory Intervention

- e. *Social Work Departments and other organisations responsible for assessments should consider using some standard protocols, alongside interviews, to assist the assessment of risk, and its management, for people with dementia.*
- f. *When risks are being assessed careful attention must be paid to the evidence for any risk which is being considered. There should be written records of significant incidents and the responses made to them.*
- g. *In reaching decisions about statutory intervention case conferences must formally take account of the risks that have been identified, noting the evidence referred to above; different ways of managing each risk should be considered and records made of the decisions taken.*
- h. *Those formulating care plans for people with mental disorder should take full account of assessments made by Mental Health Officers.*
- i. *The Social Work Department should make more widely available information about sheltered housing, and similar options, for people with dementia living in its area, to those who make decisions about their welfare.*
- j. *The local authority should consider the eligibility of some people with dementia to be included in Council's passive alarm system.*

- k. *Health and Social Work authorities throughout Scotland should develop greater awareness of the possible contribution of technological provisions in securing individuals' safety in their own homes.*
- l. *Social Work Departments should make available a wide range of support for carers.*
- m. *Managers should encourage health and social workers, in appropriate circumstances, to use authority positively, including statutory intervention, to promote the welfare of individuals. Account should be taken of whether such approaches might reduce more disruptive interventions for individuals. This issue should have a prominent place in qualifying and continuing professional education and training.*
- n. *Trusts and Local Authorities should make available general information about Mental Health Act Guardianship and about the provisions of the Adults with Incapacity Act to health and social care workers responsible for people with mental disorder.*
- o. *When an individual refuses to be represented at a court which is hearing an application for an intervention under the Mental Health (Scotland) Act 1984 Mental Health Officers should invite sheriffs to consider appointing a Curator ad Litem.*
- p. *Consultation, supervision and training should be readily available to Mental Health Officers to ensure that full consideration is given to the different powers of Mental Health Act Guardianship, and to framing the more extensive and complex powers which will be available with the implementation of the Adults With Incapacity (Scotland) Act 2000.*
- q. *Trusts and Local Authorities throughout Scotland should ensure that advocacy services are available for people with dementia and their carers.*

Care Homes

- r. *Registration authorities, care managers and Guardians must make it clear that staff of care homes can raise concerns about residents' welfare with any individuals who are responsible for them and, particularly, with an individual's Guardian and with the Social Work Department when it has arranged an individual's placement.*
- s. *Care managers, Guardians and the staff of care homes should pay explicit and repeated attention to arrangements regarding residents' property.*

- t. *When a decision has been made that an individual needs a care home every effort should be made to secure the most appropriate placement for that individual. The risks of delaying admission must be weighed against the disruption of moving a person from an inappropriate placement.*

The Scottish Executive

- u. *The First Minister should consider issuing a directive that local authorities must reapprove all Mental Health Officers at three year intervals in accordance with requirements to be established by the Scottish Social Services Council*