

dignity &
rights
ethical treat
respect ca
& equality

INVESTIGATION REPORT

Who benefits?

The benefits assessment
and death of Ms DE

Contents

Introduction	5	DWP/Atos Processes	21
Terms of Reference and Method of Investigation	6	Further Interviews	23
Chronology	8	Our Survey of Psychiatrists	29
About Ms DE	10	Analysis and Findings	31
Ms DE's Benefit Assessment	11	Recommendations	36
Clinical Care	14	Appendix 1 – “Functional Areas” of the assessment	38
Our Interviews	15	Appendix 2 – Glossary	39

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

This investigation was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 gives the Mental Welfare Commission (the Commission) the authority to carry out investigations and make related recommendations as it considers appropriate in a number of circumstances.

The Associate Medical Director (Mental Health) of NHS Board A wrote to the Commission to inform us that Ms DE had unexpectedly taken her own life after an assessment for continuing eligibility for welfare benefits. She had been told that she would not receive Employment and Support Allowance. He had brought this to our attention because the psychiatrists in that area felt that changes in the benefits system were having a major adverse effect on their patients. He felt that it might be helpful to look more closely into the circumstances to see whether any lessons could be learned.

We discussed this at the Commission and agreed that this was a significant case, with issues relevant to many people. Similar concerns had been raised with us by service users, carers and professionals across Scotland. We decided to undertake an investigation into the circumstances of Ms DE's death.

The investigation team was chaired by Mr George Kappler, Deputy Chief Executive and Chief Social Work Officer of the Commission. The lead investigator was Dr Steven Morgan, Medical Officer. Administrative support was provided by Mrs Alison Smith, Casework Manager.

Terms of Reference and Method of Investigation

We set terms of reference for our investigations. In this case, the terms of reference were:

- 1) Review medical casenotes for an overview of Ms DE's care and treatment prior to and after the Atos Work Capability Assessment.
- 2) Examine the process by which the Atos Work Capability Assessment was organised and undertaken, including the nature of the clinical assessment.
- 3) Examine the process by which the result of the Atos assessment was communicated to Ms DE.
- 4) Explore the relationship, if any, between the Atos Work Capability Assessment and the impact on Ms DE's mental health.

We gathered information for our investigation using the following sources:

- 1) Review of Ms DE's GP casenotes
- 2) Review of psychiatry notes
- 3) Review of psychology notes
- 4) Review of psychotherapy notes
- 5) Review of Atos assessment and Department for Work and Pensions (DWP) correspondence
- 6) Interview with Dr A, the consultant psychiatrist
- 7) Interview with Dr B, the GP
- 8) Interview with the Local Authority Welfare Rights Officer, Mrs A
- 9) Interview with Mrs B, a close friend of Ms DE
- 10) Interview with Dr C (the Atos doctor who performed the Work Capability Assessment) and Dr D (an Atos clinical manager)
- 11) Interview with Mr A, DWP officer who carried out a review of the case on behalf of DWP
- 12) Written materials provided by DWP in response to our questions.

We were able to make contact with Ms DE's family but they did not accept our invitation for an interview.

We took independent advice from a consultant in occupational health. We also undertook a survey of psychiatrists in Scotland to obtain their views on the effect of benefits changes on their patients.

We are aware of numerous reviews, research and widespread public debate on this subject. One of the reasons we undertook this investigation is because the issues identified may affect many people in similar circumstances. However, the remit of the Mental Welfare Commission relates to individuals and this is a detailed investigation into how the nature and process of the Work Capability Assessment may have contributed to pressures that led to Ms DE taking her own life. We hope that our findings and recommendations can complement those of the reviews that have taken place, to the benefit of the health and welfare of other individuals with mental illness, learning disability or related conditions who undergo the Work Capability Assessment in future.

We sent a draft of our report to the DWP and to everyone we interviewed to ensure factual accuracy. We took on board comments as necessary. We also met representatives of the DWP to discuss our recommendations.

We are grateful for the cooperation of all parties who participated in this investigation.

We have included a glossary of relevant terms and abbreviations in Appendix 2.

Chronology

1985

Ms DE's first contact with psychiatry.

1992

Became an out-patient of Dr A, consultant psychiatrist. Diagnosis of recurrent depressive disorder with some features of anxiety.

21 May 2007

First day on Incapacity Benefit. Ms DE had three periods on Incapacity Benefit (21/5/07 – 4/5/08, 15/11/09 – 24/2/10 and 28/6/10 to her death).

28 June 2010

First day of final period on Incapacity Benefit.

18 July 2011

Selected for benefit reassessment by the DWP. Computer-generated letter sent.

27-29 July 2011

An unsuccessful attempt made on each of these three days by the DWP contact centre to telephone Ms DE to give further information and advice about reassessment process and identify if she needed help with the process.

26 October 2011

Assessment by Atos.

1 December 2011

Separate appointments with Dr A and Dr B, her GP.

9 December 2011

DWP decision made – not entitled to ESA, ESA to stop 12/1/12. Two unsuccessful attempts by the DWP decision maker to telephone Ms DE to explain the decision, obtain any additional information and advise options available to her. Notification of decision letter sent by the DWP to Ms DE.

15 December 2011

Telephone call from Ms DE to Dr A. Very distressed due to change in benefits. Dr A put her in contact with welfare rights officer.

19 December 2011

Telephone consultation with Dr A.

20 December 2011

Meeting with Welfare Rights Officer, Mrs A.

22 December 2011

Out-patient appointment with Dr A. No evidence of risk identified. Arrangements made for appointment on 5 January 2012. Also arranged that Ms DE could contact Dr A's team from 29 – 30 December 2011, and out-of-hours service if required. She also had a separate appointment with Dr B on this day.

29 December 2011

Ms DE spoke to Dr A's ST6 registrar, no evidence of risk identified.

31 December 2011

Ms DE found dead at her house after overdose.

23 March 2012

Letter sent to Mental Welfare Commission from the Associate Medical Director of the relevant NHS Board. A number of clinicians had expressed concern about the impact on patients of this process and reassessment.

About Ms DE

Ms DE was in her early fifties at the time of her death. She had worked in several different jobs during her career, including a position in the financial sector and some clerical posts, but was unemployed for the last 21 months of her life. She was divorced with one teenage son, who she saw regularly. She had been in a relationship for several years and was engaged. She lived in her own home, paying a mortgage on this property.

She had been seeing her consultant psychiatrist, Dr A, and her General Practitioner, Dr B, for some 20 years. Dr A usually saw Ms DE in a clinic based at Dr B's GP surgery, which allowed easy verbal communication between the doctors in addition to the usual clinic letters.

Her diagnosis was recurrent depressive disorder with some features of anxiety. She had been prescribed several different medications over the years but at the time of her death she was taking an antidepressant of the SSRI class (a commonly used class of antidepressant) augmented with lithium, indicating an illness that had proved difficult to treat. She also had some significant physical health issues, including cardiac and gynaecological problems. She was signed off work, with the reason stated on the relevant form as "depression". She was clear that she wanted to return to work when she was well enough.

As well as her fiancé and her son, she had regular contact with her parents. She had several friends who she saw regularly. She had met some of these friends through a local church. She also did some voluntary work.

Ms DE's Benefit Assessment

Ms DE had three periods on Incapacity Benefit; the third period started on 28 June 2010. On 18 July 2011 she was sent a letter from the Department for Work and Pensions (DWP) telling her that "the benefit you receive is changing". Ms DE was contacted as part of the Incapacity Benefit Reassessment project. This reassessment began in April 2011 and involved all of the 1.5 million people on Incapacity Benefit being assessed for eligibility for Employment and Support Allowance (ESA). This reassessment of all Incapacity Benefit claimants was planned to take place over a three year period. This was due to changes made in the benefit system as a result of decisions made by the UK government, which were being implemented by the DWP. Ms DE entered the reassessment process in July 2011.

The letter said that she would be assessed to see if she was eligible for Employment and Support Allowance, the benefit that was replacing Incapacity Benefit.

The process would normally involve a claimant completing a self-assessment questionnaire (called "Limited Capability for Work", also referred to as an ESA50). After this, if indicated, the claimant would attend for an assessment, known as a Work Capability Assessment (WCA), carried out by a company called Atos. Atos are contracted by the DWP to perform these assessments on their behalf. After the assessment, Atos send a report to the DWP.

Ms DE later told a Welfare Rights Officer that she had not received the self-assessment questionnaire. The DWP could confirm that Atos had sent Ms DE the questionnaire on 4 August 2011. We could not confirm that it had been delivered. The DWP told us that these questionnaires are not sent by recorded delivery and attempts to make contact with Ms DE by telephone had been unsuccessful. In any event, there was no questionnaire completed.

The usual practice was that when the ESA50 questionnaire was returned a decision was made on the next step in the process. In Ms DE's case, when the ESA50 was not returned it was decided by a healthcare professional at Atos that they would go ahead with a face to face assessment. We were informed that not returning the ESA50 questionnaire would stop the claim unless there was a good cause for not returning it or the claimant had a mental health condition. As the latter was the case, the Work Capability Assessment process continued.

We were told that based on Ms DE's original Incapacity Benefit claim it was felt that there was little to suggest that she would meet the criteria for ESA, so a decision was made not to request further medical evidence from either the GP or hospital consultant before the Work Capability Assessment.

The assessment by Atos went ahead on 26 October 2011. The report was subsequently sent to the DWP.

The DWP staff member who decides on eligibility for ESA is known as the "decision maker". Based on the Atos assessment report, the decision maker decided that Ms DE did not meet the criteria to receive ESA.

The record of the decision made by the DWP decision maker is quoted below:

"The Limited Capability for Work Assessment test of incapacity assesses the ability to perform specific physical activities and, where there is a mental illness, to cope with day to day living. Points are awarded to reflect limitations and a score of 15 points is needed to satisfy the test. The assessment cannot take account of the requirements of a person's normal occupation.

[Ms DE] did not complete a questionnaire.

On 26/10/11 [Ms DE] was examined by a Healthcare Professional of the Medical Services in connection with the Work Capability Assessment and [Ms DE] described problems with Depression, Heart Failure, Abdominal Problem and Under active Thyroid.

[Ms DE] lives alone and gets up independently most days at the same time, she takes her medication and is able to wash in a shower which is over the bath standing for 10-15 minutes most days. On days when she does not shower she is still able to wash herself. She sits down to dress as she feels tired but is able to complete this herself. She manages to do her housework and does it in stages and usually completes it if getting visitors. She is able to manage stairs by holding on to the rails. She is able to drive and goes out driving every few days and, once a week she drives to the local shop, church, bible study group and drives to her voluntary work. She occasionally drives to her parents' home but her Mum visits a couple of times a week and is able to drive to any appointments. She attended to the examination centre by public transport alone. Once a month she goes to the supermarket and can walk about for 60 minutes pushing a trolley. She watches television in the evening and is able to cook herself simple meals and do things safely in the kitchen. Her adult son (18 years) visits her once a fortnight. The HCP observed that she was able to sit on a chair with a back for 50 minutes; she rose once from this chair which had no arms without physical assistance from another person. She was able to stand independently for 2 minutes without difficulty and walked 15 metres normally into the examination room and had no problems getting on to the couch. She was not breathless on examination and her chest was clear, her lower limb examination was normal.

[Ms DE] is able to self care, and interacts with her family, she does voluntary work with teenagers and speaks to the people at her church. The HCP states she was timid during the assessment but her everything else was normal in the mental state and despite her regular review by a psychiatrist there was no evidence of significant disability of mental health function.

I am satisfied that the descriptors have been fully justified with clinical findings, observations and extracts taken from the typical day history provided by [Ms DE]. The medical report of 26/10/11 was appropriate, complete and covered all the area of incapacity described by [Ms DE] as well as including a comprehensive typical day history and full set of clinical findings.

The Decision Maker has considered the Healthcare Professional's report and has decided that [Ms DE] has not achieved 15 points from the appropriate descriptors. As a consequence, the existing award(s) of [Ms DE] does not qualify for conversion into an award of Employment and Support Allowance. The existing award(s) and entitlement to be awarded credits will terminate from and including 12/01/12."

Instead of receiving ESA, Ms DE would have had to move onto Jobseeker's Allowance (JSA). This would have led to a significant drop in her income. The decision was communicated to Ms DE by two letters on 9 December 2011, after two unsuccessful attempts to telephone her. The first letter stated that she

would not be entitled to ESA from 12 January 2012 because she had been “found to be capable of work following your recent Work Capability Assessment.” The second letter stated “We recognise that you have a disability or health condition. But to get Employment and Support Allowance you have to score at least 15 points from your assessment. You scored 0 points using the information from the report of the medical assessment you had on 26-Oct-2011.” It then proceeded to state that all 17 “Functional Areas” of the assessment and the assessment result for each functional area, scored at zero points. The functional areas and corresponding assessment results are quoted in Appendix 1.

These letters also included information on how to appeal the decision.

Not being eligible for ESA would have caused a significant reduction in Ms DE’s benefit payments. She was receiving £94.25 per week on Long Term Incapacity Benefit. Jobseeker’s Allowance would have been paid at £67.50 per week (although The DWP subsequently informed us that she might have been entitled to additional funds). If she appealed against the decision she would have received £67.50 per week (on the ESA Appeal Rate) until the appeal was heard. Either way, her welfare benefits would have been reduced by £26.75 per week (a 28% reduction). It is notable that she would have experienced this drop in income even though she was appealing the decision. If she won her appeal she would have received ESA of either £94.25 or £99.85 per week (depending on whether she was placed in the “work-related activity group” or the “support group”) backdated so that she did not suffer a financial loss.

Ms DE was upset by the DWP decision and spoke to both Dr A, her consultant psychiatrist, and Dr B, her GP. Dr A introduced her to Mrs A, a Welfare Rights Officer then based at Dr A’s hospital. Mrs A gave Ms DE some more information about appealing the decision. Ms DE decided that she did wish to appeal and Mrs A helped her to prepare her written appeal. As part of the appeal Mrs A asked Dr A and Dr B if they would submit supporting letters and both doctors were happy to do this. The appeal form was submitted to the DWP on 21 December 2011.

As Ms DE had been distressed by these developments, Dr A put extra measures in place to support her at that time, which coincided with the Christmas period. She was seen by Dr A on 22 December 2011 and given a phone consultation on 29 December 2011 with Dr A’s experienced Specialty Registrar doctor. At both of these appointments she denied any thoughts of suicide or self-harm.

On 31 December 2011 she was found dead at her home. The post-mortem examination found that she had taken an overdose of medication. Toxicology results revealed that some of the medication that she had taken was prescribed, but she had also taken tablets that she had not been prescribed.

Clinical Care

We looked at the clinical care provided to Ms DE by Dr A and Dr B. When Ms DE sought help after learning she would not receive ESA she was seen promptly. Dr A introduced her to the Welfare Rights Officer without delay.

Extra appointments were put in place over the following days. A consultation was arranged for the period between Christmas and New Year. Ms DE was stating that she did not have any ideas of self-harm or suicide. A "safety-net" arrangement was put in place in case she did contact services in a crisis situation. We did not think that there was any fault with the clinical care. A joint Significant Event Review held locally did not identify any defects in the care provided.

Our Interviews

Interview with Consultant Psychiatrist, Dr A

Ms DE had first become a patient of Dr A in 1992. Dr A told us that Ms DE had a recurring depressive illness. The frequency of appointments varied according to her clinical condition.

Dr A told us that Ms DE had been working in the financial sector when he first met her. She had given up that job due to a depressive episode. Dr A described Ms DE as having a very difficult time from 2006 to 2010. He felt that a large part of this was due to stress at work. Ms DE had worked for the NHS locally. At times Dr A was seeing Ms DE on a weekly basis. She had also developed some physical health problems. Ms DE had told Dr A that her job was very stressful. The local Occupational Health Service was involved. She had become more anxious and had taken the decision to resign from work because she could not cope with the stress any longer. Dr A told us that after this Ms DE had tried to get back to work. She wanted to be well and working again.

We asked Dr A about Ms DE's clinical condition around June 2011. Dr A felt that she had been doing well. She had been looking at returning to work but had found some options ruled out due to her physical health.

Dr A heard about the outcome of the benefits reassessment on 15 December 2011 when Ms DE phoned him, very upset about the letter she had received saying that she had received "zero points". Dr A arranged for Ms DE to speak to Mrs A, the Local Authority Welfare Rights Officer, as this was very important for her in terms of considering an appeal against the decision. Dr A felt that the Welfare Rights Officer had a very good knowledge of the benefits system and knew who to contact. She had been located in the office next door to his, which meant that patients could be seen in a familiar setting at short notice. Dr A also arranged to speak to Ms DE again on 19 December 2011. He had spoken to Ms DE about the risk of self-harm or suicide. He had felt that she wasn't at risk and she had assured him that she would contact him if she had any such thoughts.

Dr A was aware of some financial pressure on Ms DE. The subject came up intermittently in clinic. He thought that Ms DE did not have a lot of money but had been managing her finances in a capable way. When Ms DE had received the decision letter from the DWP she had been very worried about her financial situation.

Dr A informed us that there had been no contact from the DWP or Atos requesting any information from him as part of the benefit reassessment process. He said that both he and the GP, Dr B, had felt that their medical opinions should have been sought. He told us that they both felt that they could have worked with the DWP and given an indication of Ms DE's progress towards being able to work again.

When Dr A saw Ms DE again on 22 December 2011 he felt that she was slightly less distressed. She had lodged her appeal against the decision by this point. Dr A hoped that she would get through this upset. He was unaware of any other possible precipitants which could have contributed to her decision to take her own life. He had not thought Ms DE was likely to take her own life.

We asked Dr A if Ms DE had ever expressed any suicidal thoughts or ideas of self-harm. Dr A told us that Ms DE had occasionally had some passive thoughts about self-harm but had never talked about any active plans or done anything about them. When he saw Ms DE on 22 December 2011 there had been no

thoughts of self-harm or suicide. Dr A arranged for Ms DE to speak by phone to his experienced registrar doctor on 29 December 2011. This call took place on the scheduled date. Dr A's registrar had recorded that there were no thoughts of suicide or self-harm, and advised her that she could contact the out of hours service over the holiday period if she needed any help.

We asked Dr A if he thought that anything could have been done differently in this case. Dr A said that he thought that it would have been helpful to have known that Ms DE was going to be assessed regarding her benefits. He felt that the DWP could have informed him as Ms DE had said that she had told the DWP that she was in contact with him. He would have liked the opportunity to discuss Ms DE's situation.

Dr A felt that Ms DE may have been able to go for the Work Capability Assessment and present herself well for an hour. She would have tried to do her best for the assessment. Dr A did not think she was fit for work yet at the point when she was assessed. In addition to her mental health problems she had significant physical health issues.

When Dr A found out about Ms DE's death he informed Healthcare Improvement Scotland and his local Clinical Governance Group. This group felt that the case should be referred to the Mental Welfare Commission. A joint Significant Event Review was held with the GP surgery. The review did not identify any faults in the care provided.

Dr A described concerns about other patients undergoing this assessment process. He described patients asking for advice after receiving a letter about an impending assessment. Dr A told us that he advises patients to attend the assessment, and also informs patients that he is happy to write a letter of support. Dr A said that it appeared there was no system by which he would routinely be asked for an opinion or informed that a patient was about to go through this assessment process.

Dr A told us that, in his opinion, patients are very stressed about the assessment but they do go as they see it as a meeting with an "authority". He felt that people "got dressed up" and tried to look their best. Dr A said that he had started writing letters to the DWP for patients who he thought would be greatly distressed by the assessment, asking that they be excused attendance. He told us that some of his patients had been very distressed by the process of reassessment, including a patient who had actually remained on the same level of benefits. Dr A had become increasingly aware of the process patients were going through.

Interview with General Practitioner, Dr B

Dr B had been Ms DE's GP since 1987. Ms DE consulted Dr B quite frequently for both physical and mental health issues. She also saw her consultant psychiatrist, Dr A, at Dr B's surgery.

Dr B recalled that in 2011, Ms DE had been experiencing multiple health problems. She had been undergoing investigations for an impairment of heart function and was to be reviewed by her consultant cardiologist in early 2012. She had other significant physical symptoms which were being investigated. Dr B felt that her physical problems had an effect on her depression and anxiety. Despite this, she made her best efforts to appear well.

Dr B said that he saw Ms DE on 1 December 2011. At this appointment they had discussed what it would be like to make a very gradual return to work on reduced hours at some point in the future. When he saw Ms DE on 22 December the situation had changed. She was very unhappy that her benefits would

be changing for the worse. At this appointment she had said that she would appeal and Dr B indicated that he would support this appeal by providing a letter to be submitted. Some extracts from this letter written by Dr B are quoted below for information:

"I would say at the outset that I strongly support this appeal."

"[Ms DE] has a very long history of significant mental illness starting with depression, anxiety and obsessive compulsive behaviour back in December 1985. She has continued to have significant depression and has been seen regularly by Psychiatrists since that time."

"[...] unfortunately this assessment has dented her confidence and caused a worsening of depressive symptoms [...] and as such at present she is certainly unfit for work."

"[...] she is unfit for work mostly due to depression but also her physical symptoms which are due for investigation in the first few months of 2012."

Dr B was shocked when he heard of Ms DE's death. He recalled that she had not been perceived to be at risk of self-harm or suicide on the day that he last saw her. She had never self-harmed in the past and had not been assessed as a high-risk patient. There were no special measures in place relating to the dispensing of her medication as this was not felt to be necessary. Dr B had not been able to identify any other possible precipitants for Ms DE's suicide. He said that she would have had some support from people at her church and the charity she volunteered with.

We asked Dr B if Ms DE had discussed the ESA50 self-assessment questionnaire with him. Dr B said that it was common for patients to discuss this questionnaire but Ms DE had not done this, which made him think that she may not have received the form. Dr B said that neither Atos nor the DWP had contacted him for information before the assessment. He said that, unfortunately in his view, it was standard practice that he was not contacted before assessments.

Dr B said that he had recently been sent some "ESA113 forms" to complete for other patients. Some patients suffering from certain specified severely disabling conditions may be treated as incapable of work without undergoing the Work Capability Assessment. An ESA113 report completed by a GP provides information that may be used to decide that the patient does not need to be examined. There had not been an ESA113 form sent regarding Ms DE.

We asked Dr B about the Significant Event Review held at the practice after Ms DE's death. We also looked at the report completed after the review. The review had been attended by Dr A, Dr B and another GP at Dr B's surgery.

The review noted that Ms DE was hoping to return to employment at some point. It was recorded that she had been seen by the psychiatric team on the same day that she saw Dr B for the last time and she had denied any intent of suicide or deliberate self-harm. The review noted that the benefit assessment may have been the trigger – there was no other known trigger. Ms DE was being dispensed medication on an eight weekly basis but this was not considered unusual for a stable patient. It was felt that the clinical management of Ms DE had been good, with proper engagement of mental health and GP services. The review emphasised the importance of explicitly recording the risk of suicide and deliberate self-harm at all contacts with patients who have a severe and enduring mental illness.

We asked Dr B if he had changed his clinical approach as a result of Ms DE's case. Dr B said that it had highlighted to him the importance of asking about suicidal ideation in a patient with a mental illness. He felt that he had covered this subject with Ms DE.

Interview with Welfare Rights Officer, Mrs A

Mrs A was the Welfare Rights Officer who assisted Ms DE to make an appeal against the DWP decision regarding eligibility for ESA. She was a qualified social worker, employed by the local authority but funded by the NHS.

Mrs A had received a telephone call from Dr A, the consultant psychiatrist, on 15 December 2011. He had explained that he had seen Ms DE at his clinic at the GP surgery and she was very distressed about her benefit situation. Mrs A had spoken to Ms DE on the phone that day and advised her on possible courses of action. On the 19 December, Ms DE phoned to say that she did wish to appeal so a meeting was arranged for 20 December.

At this meeting, Ms DE confirmed that she wanted to appeal. She signed an authorisation form which would allow Mrs A to obtain information from the Job Centre and to act on Ms DE's behalf.

Mrs A said that she hoped the appeal could be resolved in a few weeks, although sometimes it took months. Mrs A thought that it could possibly be resolved quickly as the Job Centre often changed their decision on receipt of medical evidence. Mrs A felt that the decision would be overturned when letters from Dr A and Dr B were submitted.

Mrs A had outlined the actual reduction that Ms DE would receive in her benefit payment. Her £94.25 per week Long Term Incapacity Benefit would be reducing to £67.50 per week (which was the rate for both Jobseeker's Allowance and the ESA appeal rate). Ms DE had become very upset at this point. She had been crying and saying that she didn't know how she was going to manage. She was extremely worried about how she would pay her mortgage. She had already re-mortgaged and was unable to do this again.

Mrs A and Ms DE filled in the appeal form and posted it to the Job Centre that day (20/12/11). Part of the text of the appeal read: "I have both physical and mental health problems which impact greatly on each other. I feel the medical just focussed on my physical health though. I have found going from being an independent working woman to being on benefits extremely hard and has made my depression worse. My heart problems are still being investigated and I see a consultant in February. My health problems affect all activities of daily living."

As part of the appeal they were lodging medical evidence so Mrs A wrote to Dr A and Dr B to request letters of support. Both doctors were happy to provide letters supporting the appeal. The standard practice of Mrs A was to forward this medical evidence once received.

Mrs A explained that the appeal would be logged on the Job Centre system, which would ensure that there was no break in the claim. Benefit would continue to be paid, but at a lower rate from the date that the Incapacity Benefit was due to stop. If Ms DE won her appeal she would receive the shortfall backdated. There would have been a hearing regarding the appeal, with the option of a paper hearing or an oral hearing. Mrs A would have attended the hearing and she thought that Ms DE would have won her appeal.

When Mrs A returned to work after the festive period on 4 January 2012 the letter supporting the appeal from Dr A was waiting for her. The letter from Dr A included the following passages:

"[Ms DE] has been an outpatient under my care for many years and indeed has suffered from a significant and disabling depressive illness for a lengthy period which unfortunately continues to compromise her ability to work."

"She has symptoms including low mood, anhedonia, lack of motivation and drive, poor concentration and poor sleep pattern and marked negative thinking..."

"My opinion therefore is that at present [Ms DE] is totally incapable of work due to these ongoing symptoms ..."

Mrs A forwarded Dr A's letter to the Job Centre. Later that day she was informed of Ms DE's death by Dr A's secretary. Mrs A was shocked and upset by this news. Dr B's letter of support arrived later the same day. This letter was not forwarded to the Job Centre. Instead she wrote informing them of Ms DE's death and requesting a copy of the Work Capability Assessment report.

On 23 January 2012, Mrs A received a letter from the DWP (incorrectly dated 24 November 2011) saying they were sorry to hear of Ms DE's death. A copy of the WCA report was provided.

Mrs A felt that Ms DE wanted to get back to work and would have been well enough to do this at some point in the future. She thought that Ms DE needed some time to get well before going back to work.

Mrs A said that she had been involved in lots of appeals against ESA decisions. This work took up the majority of her working week. In her opinion the success rate for appeals was quite high. Appeals are heard by the First-tier Tribunal, an independent tribunal administered by HM Courts & Tribunals Service. Mrs A thought that this body reviewed all the information and also considered the impact of a claimant's mental health problem.

Importantly, Mrs A recalled that Ms DE had said that she had definitely not received the ESA50 self-assessment questionnaire.

Interview with Mrs B, a friend of Ms DE

Mrs B had first met Ms DE in 2007. Mrs B ran parenting courses for a charity and she met Ms DE through this course. Ms DE had then gone on to take other courses on offer and had become involved with the charity as a volunteer in 2009. Mrs B recalled that around that time Ms DE had been depressed. Ms DE started attending the same church as Mrs B. They were in the same bible study group and Mrs B got to know her well.

Mrs B recalled that in mid-2011 Ms DE was trying to get back to work. An earlier phased return to work had been unsuccessful and this had caused a dip in Ms DE's mood. Ms DE was also suffering from physical health problems.

Mrs B said that Ms DE was worried when she received the letter about the benefit assessment. Ms DE did want to get back to work but was worried about returning at that point, especially after the previous attempt. Ms DE also had financial worries.

Ms DE told Mrs B after the Atos assessment that she was confused about it. She felt that she hadn't been asked the right questions. She thought that she hadn't been allowed to express herself. After hearing that she had received zero points and wasn't eligible for Employment and Support Allowance, Ms DE had been very worried about how she was going to manage financially. She had been tearful and was wandering around her flat.

Mrs B saw Ms DE for the last time on Christmas Eve, 2011 when she delivered a Christmas present. Mrs B received a phone call from Ms DE's brother on New Year's Day, 2012, telling her that Ms DE was dead. Mrs B was shocked by the news, as were their mutual friends.

Mrs B was unaware of any stressful events in Ms DE's life, other than her benefit assessment. Her relationship with her son seemed to be going well – he usually visited twice per week. Ms DE had been sad when her son decided to live with her ex-husband but they had built a good relationship. Ms DE was close to the other members of her family.

Mrs B was also able to tell us about Ms DE's relationship with her fiancé. It seemed to be going well and they had set a wedding date for mid-2012. Preparations were proceeding for the wedding.

The DWP/Atos Processes

The Incapacity Benefit reassessment process was dictated by changes to the law and authorised by the UK Parliament in the Welfare Reform Act 2007 and the Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) (No. 2) Regulations 2010 (S.I. 2010/1907).

The process to determine eligibility for ESA is called a Work Capability Assessment. Atos are contracted to perform part of this process, including the sending of the ESA50 questionnaire and the face to face assessment. In the face to face assessment the Atos healthcare professional assesses the claimant using a structured framework, combining history-taking and examination. Ms DE was assessed by an experienced doctor with six months' training in psychiatry. The assessment is documented on a computerised system and a report is generated which is sent to the DWP. The Work Capability Assessment uses a points system to give an indication of capability for work. Points are allocated for an assessed lack of functional capability in multiple categories. The points allocated are then summed and compared against thresholds to indicate the assessed level of capability for work.

Ms DE's assessment lasted approximately one hour. The only information that the assessing doctor had before interviewing Ms DE was the one word "depression". This was the reason given for her incapacity benefit claim. As previously stated there was no ESA50 questionnaire and no medical reports. Based on the assessment, Ms DE was allocated zero points.

The Atos report (also known as an ESA85) is sent to the DWP and considered by a DWP staff member who is known as the "Decision Maker". The decision maker may have other information available to them, in addition to the ESA85 report. Before making a decision of disallowance the decision maker attempts to contact the claimant to discuss the likely decision, allowing the claimant to provide relevant additional information. The decision is then made. If the claimant is subsequently unhappy with the decision then there is a right of appeal and information on the appeal procedure is also supplied to the claimant.

The DWP decision maker in Ms DE's case only had the Atos report to consider in making the decision on eligibility for ESA. There were no other medical reports or self-assessment questionnaire. Based on the Atos report, the decision maker decided Ms DE was not eligible for ESA. We asked the DWP about the processes undertaken by the DWP decision maker once the Atos assessment had been received. We received the following answer:

"The Decision Maker (DM) determines whether the claimant has Limited Capability for Work (LCW) by reviewing the ESA50 (where available), the Atos medical report and personalised summary and any other medical evidence obtained by Atos or provided by the claimant. The DM will consider the merit of each answer and decide what weight to give to the content of the medical report, especially where there are differences between the answers from the claimant and the Health Care Professional (HCP). The level of each activity is measured by points. Part 1 contains activities characterising physical function. Part 2 contains activities characterising mental, cognitive and intellectual function, both are broken down into descriptors. The extent to which a claimant can or cannot carry out an activity is determined by which descriptor applies to that claimant. The test is the ability to perform any work not a specific occupation. If a total of 15 points is reached then the claimant has LCW. The DM must record the final scores for each descriptor

and the reasons for the decision. If the claimant has LCW the DM will consider whether they also have Limited Capability for Work-Related Activity (LCWRA) and be entitled to the ESA Support Component. The ESA regulations allow the DM to treat a claimant as having LCW even if they do not reach 15 points if they are suffering from a life-threatening disease that is uncontrollable or suffering from a specific disease or bodily or mental disability and there would be a substantial risk to the claimant's mental or physical health if they were not treated as having LCW or LCWRA.

As a result of the Harrington Review of the WCA process all disallowance decisions are, where possible, communicated to the claimant over the phone via a Decision Assurance Call. These calls are designed to explain to the claimant what evidence has been considered, as well as offer the opportunity to submit any further evidence that the claimant feels may affect the decision prior to disallowance and to advise the options available at this stage. Two unsuccessful attempts were made on 9 December to phone [Ms DE], with a gap in between of at least three hours. No messages were left on her answering machine. A decision letter was sent in the post on the same day.

As mentioned [elsewhere] following the WCA when all the evidence had been considered and the DM was minded to disallow on no LCW before that decision was input they would try to contact the claimant by phone to explain what the decision was and to give them the opportunity to supply any further medical evidence they may wish to put forward for consideration. They would also, at this point, if no further evidence was to be presented, explain the claimant's options e.g. claim JSA or request a reconsideration of the decision or appeal. A reconsideration of the decision involves another DM looking at all the evidence again and deciding if it can be "changed".

If they are unable to contact a Mental Health claimant or the DM feels they have not fully understood the situation they could decide to request a departmental Visiting Officer to go and see the claimant and explain the same information and gather any further information from the claimant. The claimant is only disallowed from a "safe date". This would be the next pay day following the issue of the disallowance letter. Until the final decision to disallow is made and the decision letter is issued following this above process the claimant remains in receipt of benefit."

We used this information to guide our interviews with the DWP peer reviewer and Atos medical staff.

Further Interviews

Interview with Mr A, DWP Peer Reviewer

We spoke to Mr A, a DWP Senior Executive Officer, who conducted the DWP peer review of the handling of Ms DE's benefit reassessment. The peer review in this case is a solely paper-based internal process. It reviews all the relevant DWP documentation. Mr A had been asked to carry out the peer review by a senior executive within the DWP in September 2012. Mr A carried out the peer review on a single-handed basis, without any contribution from medical staff. As such, there was no effective peer review carried out.

We heard that the peer review process involves creating a timeline and examining the five stages of the benefit claim. We were told that the five stages are: the initial letter being sent; the ESA50 form; the Atos examination; the decision making; and appeal and closure.

Mr A told us that his review had found that staff had followed the agreed process. He added that he found nothing in the Atos report or in Ms DE's comments during the assessment to suggest that she was likely to take her own life. In his role as peer reviewer, Mr A told us that he had not identified any deficiencies in the DWP processes in this case. However, in his personal opinion (as opposed to his opinion as peer reviewer), he had identified some "missed opportunities". He said that it was difficult to know if these would have made any difference to the decision making. Mr A then talked us through the five stages of the claim listed above.

Stage 1 - initial letter being sent

We were told that Ms DE's case had been selected for review on 18 July 2011 and a computer-generated letter was sent. Ms DE had indicated a preference for telephone contact. DWP staff made three phone calls to Ms DE on separate dates but all were unanswered. The purpose of these calls was to offer advice about the assessment process and to find out if she needed any additional help with the process. Mr A told us that it had been noted that Ms DE had an answering machine. It was not part of the DWP guidance for staff to leave messages. In Mr A's personal opinion (as opposed to his opinion as peer reviewer), if DWP staff had left messages then Ms DE might have called back. We were subsequently informed by the DWP that guidance on leaving telephone messages was introduced in late 2011.

Stage 2 - the ESA50 form

Mr A told us that the ESA50 form had been issued on 4 August 2011 according to the DWP records. We had previously heard that Ms DE had said that she did not receive this form. There was no proof that the form had actually been delivered to Ms DE. We asked Mr A if it was common for claimants not to complete an ESA50 form. Mr A said that he was aware that some people do not complete the form. He told us that he thought that claimants should supply the information requested as it was in their best interests.

Stage 3 - the Work Capability Assessment (performed by Atos)

Mr A said that he had not found anything in the process of the Work Capability Assessment that had not been done properly. He noted that the Atos assessing practitioner did not have any additional information, such as the letters submitted with the appeal. However, he felt that everything contained in the letters was discussed at the interview and the Atos professional had come to a different conclusion about Ms DE's capability for work.

Mr A said that if the ESA50 had been available it might have provided more information, but that could never be known. We were told that the claimant would not be routinely asked as part of the assessment process if they had received an ESA50. There was also no process at the DWP to telephone a claimant to ask if they had received the ESA50.

Mr A was satisfied that the Atos report had been completed in line with the DWP guidance.

Stage 4 - the decision making process

The decision making process was based on the information available, namely the Work Capability Assessment report only. Mr A told us that the decision makers are Executive Officers with experience in the benefit system and specific training for the role they are performing. The decision taken was that Ms DE did not have limited capability for work and correspondence was sent advising her of this decision. The DWP decision maker was required to make two efforts to phone the claimant (with the calls at least three hours apart) to offer an opportunity to talk about the decision and to allow the claimant to provide additional relevant information. The calls were made but there was no answer and no messages were left on Ms DE's answering machine. Again, it was not part of the DWP guidance to leave messages on answering machines. There had been no indication to the decision maker that Ms DE was at risk of suicide or self-harm. Mr A felt that the steps taken by the decision maker and the decision reached showed "nothing untoward."

Stage 5 - the appeal and closure

The appeal form was received within the required timescale. Mr A said that he could not add much more information due to Ms DE's death shortly after the form was received.

Overall observations

Mr A felt that DWP staff had worked appropriately within the relevant guidance. He told us that he had recommended that the DWP guidance on vulnerable claimants should be re-publicised. This guidance defines vulnerable claimants as those people who have difficulty in coping with the demands of the service. It is there to help staff identify and make judgements about those claimants for whom it would be more appropriate to deliver services face to face. Ms DE had not been regarded as a vulnerable claimant. Had she been regarded as a vulnerable claimant she might have had a home visit to explain the decision and discuss her options. We were subsequently told by the DWP that new guidance on vulnerable claimants has since been issued.

As peer reviewer, Mr A had not mentioned the subject of leaving messages on a claimant's answering machine.

We were told that Ms DE's entitlement to Incapacity Benefit would have stopped on 12 January 2012 as a result of the decision made on 9 December 2011. Normally the period between the decision of non-eligibility and the stopping of the benefit would have been two weeks. In Ms DE's case the period was extended to allow for the festive period.

Mr A had reviewed the communication between the DWP and Atos in this case. He did not identify any defects in the communication process.

Interview with Dr C (the Atos Doctor who performed the Work Capability Assessment) and Dr D (an Atos Clinical Manager)

Dr C had been working for Atos as a Medical Adviser for around 14 months when she saw Ms DE for a Work Capability Assessment (WCA). Dr C's role was described to us as involving giving advice and providing impartial functional assessment reports following face to face assessments, mostly in ESA cases. Dr C was a GP with six months' experience of psychiatry as part of her General Practice training. She had also undertaken Atos training in "moderate to severe mental health conditions".

We heard that Dr C would normally have four clients scheduled for WCAs over a half-day session. This allowed an average time of between 50 and 60 minutes for an assessment. There was no set time for an assessment and no cut-off time by which it had to be completed.

We were told that the assessing practitioner would note the history (i.e. the claimant's description of events and symptoms) during the interview. The form completed by the practitioner would be finalised after the interview. In some assessments there would be information available to the practitioner before the client arrived – for example an ESA50 (limited capability for work questionnaire), an ESA113 (information requested from a healthcare professional regarding an ESA claim) or letters from doctors or social workers. In Ms DE's case there was no such information available. There had been no ESA50 received from Ms DE. As she was known to have a mental health problem the assessment process continued without an ESA50. The information that Dr C had was that "depression" was quoted on the MED3 form (statement of fitness for work, completed by a doctor) and the date of the claim was 28/6/10.

When no ESA50 was received by Atos a "scrutiny process" occurred. The scrutiny process is carried out by an Atos practitioner. There are three options available to this practitioner:

- i) Atos cannot advise on level of disability so the client will need to be called for a face to face assessment.
- ii) evidence available shows that the client meets the support group criteria – the case is returned to the DWP.
- iii) evidence available shows that the client may meet the support group criteria but further medical evidence is required to support this. An ESA113 will be requested, usually from the client's GP.

In Ms DE's case, based on the period of incapacity and the one word "depression" on the MED3 form, the decision was taken that it was very unlikely that additional evidence from the GP would have led to the client being assessed as meeting the criteria for the support group. Dr D told us that due to the limited information and the fact that most people with depression do not meet the support group criteria, the decision taken by the scrutinising Atos practitioner would have been that a face to face assessment was appropriate.

Dr D explained that it is not a standard process to obtain further information about clients. Some clients would incorrectly assume that the Atos practitioner had access to medical notes.

After the scrutiny process an appointment to attend the Assessment Centre was arranged with Ms DE. Dr C described the face to face assessment she conducted with Ms DE. Dr C had begun by asking Ms DE what problems she had. Ms DE had listed her problems and Dr C had asked further about the various conditions. Dr C recorded the details on a computerised system which allowed the use of both "standard phrases" and free text in order to accurately reflect the history. Dr C said that Ms DE had said

that she had problems in almost every area other than upper limbs. Dr C told us that she was doing an assessment of a number of physical health issues as well as mental health. Ms DE had told Dr C that she felt unable to take up a new job because of depression and physical health problems.

We asked if it was possible to request a psychiatric report as part of the assessment. We were told that the Atos practitioner cannot delay during an assessment to request further information, such as a medical report.

Dr C told us that she would not have contact with a client's GP or hospital doctor unless she was specifically worried about something or an unexpected discovery came up, in which case they could ask for information in exceptional circumstances. We asked what would happen if an Atos practitioner found that a client had suicidal ideation. Dr D told us that there is a process called "unexpected findings" by which they can raise concerns with the person who has clinical care responsibility, often the GP, sometimes a hospital practitioner. Dr C said that if a client voiced suicidal thoughts she would arrange for the person to see their GP – she would want to ensure that the GP had taken over the clinical care.

Dr D explained that Atos were not looking at diagnosis or treatment but were focussing on function. The Atos remit was to provide a "stand back independent functional assessment of the person's ability". Advising on the client's condition or treatment was not part of their role. It was not part of the assessment process to adjourn the assessment to obtain further information, or to follow up after the assessment to find out the outcome. After the report was completed, with an opinion on the client's functional capability, the advice was sent to the DWP and a DWP decision maker would decide how to proceed.

We then looked at Ms DE's assessment report in detail. It was recorded that the examination took 59 minutes. There was additional work after the client had left, which included writing a "Personalised Summary Statement".

Near the beginning of the report there is a "description of functional abilities". Recorded under the heading of "depression", it states that in the last few weeks there has been a dip in mood, lack of motivation and problems with housework and form-filling. It is recorded that there were no current thoughts of self-harm or suicide, but "has had thoughts in the past many years ago". We were told that asking about thoughts of suicide or self-harm was always part of the assessment if the client has a mental health problem.

We asked about the section of the report that is titled "Mental State Examination". We had observed that there is very little in this section relating to mood. The two headings recorded under "mood" in this section of the WCA are "demeanour" and "self-harm". Under each of these headings the assessing practitioner would choose a phrase to be the best representation.

In Ms DE's case the "mood" section reads: "Mood – Ideas of Self Harm: No ideas of self harm. Demeanour: Timid". It is possible for the practitioner to add free text to this section if required, but there was no free text added to this part of Ms DE's report. The options available for selection under "ideas of self harm" are: not assessed; client declined; none; firm and detailed; frequent but non specific; occasional; infrequent. The options available under "demeanour" are: not assessed; normal; confident; over-familiar; timid; irritable; hostile; aggressive; labile; withdrawn. In a mental state examination performed in a clinical setting there would usually be a subjective and objective assessment of mood, respectively involving

recording the individual's description of their own mood and the assessing professional's description. Biological and cognitive features of depression could also be recorded in this section of the mental state examination.

Dr D told us that the discrepancy between the WCA "Mental State Examination" and the usual clinical examination was due to the fact that the Atos practitioner is performing a functional assessment, not a diagnostic assessment. Earlier versions of the assessment (for Incapacity Benefit, prior to ESA) had recorded an evaluation of mood. The assessment had subsequently been changed as it was felt that these descriptive terms were not helpful as part of an assessment of function. These changes were made in conjunction with DWP requirements and at their direction.

We asked about the lack of recording of cognitive symptoms of depression such as hopelessness, guilt and worthlessness. It was reiterated by Dr D that the Atos practitioner was not assessing Ms DE's depression, but how the depression affected her. We found it difficult to understand how an assessment of function could be made without considering these symptoms.

We asked about the assessment of Ms DE's motivation. Dr C said that Ms DE had come to the interview by herself and had coped well with it. Dr C had noted that Ms DE was engaged with appropriate services and was able to cook for herself. Dr C also added that Ms DE attended church and did some voluntary work. This had contributed to the assessment of Ms DE's functioning.

We asked about the "15 points system". We were told that there would be 0, 6, 9 or 15 points awarded for each "descriptor". The total for the assessment as a whole is taken and if it is 15 points or above then the person will qualify for ESA within the work-related activity group. If any of the support group criteria are met then the person moves into the support group. We were informed that conditions with mild or moderate functional effects will probably generate a score of less than 15 points, while if there are substantial functional effects the score will probably be 15 points or more.

If a client does not meet the 15 points threshold there is a further consideration, called "non-functional descriptors". The non-functional descriptors were described to us as a "safety net" for people who have scored less than 15 points, in cases where there could still be difficulties in a workplace setting despite not having been assessed as having significant functional restriction. There are two non-functional descriptors. One relates to life-threatening disease which is uncontrollable or uncontrolled, which was not applicable in this case. The other non-functional descriptor relates to risk to health. The relevant wording is: "the claimant is suffering from some specific disease or a bodily or mental disablement, and by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if they were found not to have limited capability for work". We were told that the key word was "substantial" and an assessment of that would be made by the Atos practitioner. In Ms DE's case it had not been felt that there was a substantial risk.

We asked about the "Personalised Summary Statement". In Ms DE's case the last of the five paragraphs in the statement relates to her mental health. It reads:

"She has depression, she regularly gets reviewed by psychiatry. She was started on mood stabilisers last year. She lives alone, self cares, and is able to do a variety of cooking and housework tasks. She is able to drive. She attends bible study classes and to do volunteer work speaking to teenagers. She does not get in to fights or arguments. She was timid at interview but otherwise

her mental state appeared normal and despite her regular review by psychiatrist there is no evidence that she has a significant disability of mental health function.”

We were surprised about this paragraph for a person who had been seen by a consultant psychiatrist over the course of a 20 year period, was being frequently reviewed and was prescribed significant medication. Dr C said that the key word here was “function”. Dr D told us that he did not feel that Dr C was saying that there was nothing wrong with the client, she was commenting on the claimant’s functioning.

We asked if there had been any changes to the assessment process since Ms DE’s assessment took place. We heard that there had been some changes to wording and support group criteria but no fundamental changes to the descriptors or the application of the descriptors.

Our Survey of Psychiatrists

As part of this investigation we conducted a survey of psychiatrists in Scotland. We wrote to Associate Medical Directors in Psychiatry at health boards across Scotland and asked them to distribute an invitation and a link to an online survey to Responsible Medical Officers (RMOs) in their area. RMOs have overall responsibility for the psychiatric care of their patients and are usually consultant psychiatrists, although there are some senior psychiatric trainees and specialty grade doctors who act in this capacity.

We received 70 responses to our survey. For comparison, the most recent NHS Scotland Information Services Division report on workforce statistics shows a headcount of 320 consultants working in general adult psychiatry in Scotland in June 2013. Of the 70 responses, 56 were completed by RMOs who had patients who had undergone a Work Capability Assessment (WCA). All percentages quoted relate to these 56 responses, unless otherwise stated.

We asked RMOs if their opinion had been sought by the DWP or Atos at any point in the WCA process. 75% said they had not been asked for their opinion at any point in the process. 25% had been asked for their opinion, some before the WCA and some after.

We then enquired if patients had asked our survey respondents to provide medical evidence. 95% had been asked to provide medical evidence at some point. 70% had been asked before their patients attended for the WCA. 29% had been asked after the WCA but before the decision was made. 73% had been asked as part of the appeal process against the DWP decision.

We asked RMOs if any of their patients had lost ESA or Incapacity Benefit after undergoing the WCA. 78% said that some of their patients had lost entitlement, 9% said that their patients had not, and 12% did not know. We also enquired if any of their patients had won an appeal against a decision made by the DWP to stop entitlement to these benefits. 80% of our respondents said that at least one of their patients had won an appeal.

We asked RMOs if any of their patients had been distressed by the process of undergoing the WCA and 96% replied that this had been the case. In addition, 93% of respondents said that at least one of their patients had been distressed by the outcome of the WCA.

We then asked RMOs about patient experiences following the WCA to which the assessment process or outcome contributed (in the RMO's opinion). 85% of the 52 respondents to this question told us about an increased frequency of appointments. 65% had at least one patient who required an increased dose of medication and 35% reported at least one patient who had changed medication. 40% had at least one patient who had self-harmed after the WCA. 13% of respondents reported that a patient had attempted suicide and 4% (two RMOs) stated that a patient had taken his/her own life. 35% said that at least one of their patients had been admitted to hospital as a consequence of the WCA and 4% told us about a patient being detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

RMOs told us of other patient experiences after the WCA. Commonly reported were increased stress, anxiety and thoughts of suicide. In some cases the stress had severely destabilised patients. Some patients had experienced a worsening of a low mood. We heard about one patient who had increased psychotic symptoms, requiring referral to the local Intensive Home Treatment Team.

We asked in our survey if respondents could give us examples of patient experiences of the assessment. Several RMOs told us that patients had described the Atos practitioner performing the assessment as lacking sensitivity and knowledge relating to mental illness. Several patients found the process distressing and demeaning. Many patients were surprised that their psychiatrists were not contacted as part of the assessment process. Worryingly, some patients described feeling stigmatised and victimised.

Some patients had told their psychiatrist that the assessment report did not match the questions and answers within the assessment appointment. There was also a feeling from some patients that the assessment had judged their physical health rather than their mental health. Another frequent theme was a worsening of symptoms before the assessment, particularly symptoms of depression and anxiety. Some patients had a worsening of psychotic symptoms, others had self-harmed or experienced thoughts of self-harm. One example given was of a patient with a psychotic illness who had incorporated the assessment process into his system of delusions, leading him to believe that he was being followed by the DWP.

We also asked RMOs if they had any other comments they would like to share with us. The level of distress caused to patients was raised again. We heard about the pressure the assessment process had put on psychiatrists' clinics, due to an increased frequency of appointments for some patients and requests for support relating to the assessment. Several respondents thought that they should have been contacted for information about their patients. Some RMOs expressed the opinion that it was unfair that the responsibility for gathering medical evidence was put on the patient.

There were examples given of patients who had stopped receiving ESA despite their doctors being adamant that the patients were completely unable to work. A point made by one of our respondents was that some patients are less able to appeal an ESA decision and will consequently be less likely to achieve the overturning of the original decision on appeal.

We heard of examples where community psychiatric nurses were attending assessments with their patients to offer support and to attempt to prevent a crisis situation occurring.

One of our respondents pointed out that the level of distress experienced by a patient about the assessment process did not always correspond to the severity of the patient's mental illness. Another RMO told us that some severely ill patients were relatively unperturbed by the process. We heard about a patient who had neurocognitive deficits and was actively psychotic. He had answered questions at the assessment by stating that he was "fine". His ESA had been stopped despite the fact that he was completely unable to self-care.

The overall theme of the responses was the distress caused to patients and consequent demands on mental health services. We are very grateful to the doctors who completed this survey.

Analysis and Findings

In Ms DE's case, Atos and the DWP were satisfied that there had not been any errors or omissions on their part. The DWP had decided that Ms DE was not eligible for ESA. This decision contrasted with the opinion of two doctors who knew Ms DE very well, who were certain that she was not ready to return to the workplace at the time of her assessment.

Our investigation raised numerous issues. These issues are discussed below in an order corresponding with the benefit reassessment process.

Telephone Calls to Claimants

When Ms DE was selected for benefit reassessment on 18/7/11 a computer generated letter was sent. Ms DE had expressed a preference for telephone contact and efforts were made to speak to her by telephone. However, these calls were not answered. It was noted that Ms DE had an answering machine. No messages were left on the answering machine. The DWP guidance did not state that messages should be left. It may have been the case that messages left may have led to Ms DE returning the call and being given more information about the benefit reassessment process.

Similarly, when telephone calls were made to Ms DE to inform her of the DWP decision there was no answer and no messages were left, again in line with the DWP guidance. Messages may have prompted her to phone back. At this point in the process an explanation of the decision and a discussion of the options available to Ms DE might have allayed some of her concerns and reduced the distress she described. The DWP requirement was that two calls were made with a minimum time of three hours between the calls. This contrasts with the requirement for three calls on separate dates when a claimant starts the process. Introducing a requirement for attempts on separate dates to discuss the disallowance decision would increase the likelihood of telephone contact with the claimant.

We were informed by the DWP that guidance on leaving telephone messages was introduced in late 2011.

We think that the DWP should review its guidance on this subject to ensure that its procedures are working well. We are of the opinion that attempts to telephone a claimant to discuss a disallowance decision should be made on separate dates.

Notifying Doctors of the Start of the Reassessment Process

We heard from our survey that psychiatrists are not routinely informed when their patients enter the assessment process. This is despite the fact that the process can have a significant impact on the mental health of their patients. In some cases the first time that psychiatrists and GPs heard that a patient was going through the process was when the person presented in crisis.

We think that when an individual with a mental illness, learning disability or related condition is about to undergo this assessment process a letter should be sent to the person's GP and, if applicable, the person's psychiatrist to inform the doctors of the potentially challenging situation being faced by the individual.

Medical Reports

We heard that psychiatrists and GPs are not routinely asked to provide medical reports for patients with a mental illness. This is despite the fact that it may be more difficult for some individuals to put in place the necessary arrangements to provide medical evidence supporting their claim.

Medical reports from the doctors with the best knowledge of the individual's condition would provide valuable information for the Atos practitioner and the DWP decision maker. In some cases the medical reports would contain details which had not been discussed in the ESA50 self-assessment questionnaire or the Work Capability Assessment.

We think that medical reports should be routinely obtained for individuals with a mental illness, learning disability or related condition entering the assessment process. A request for a report could be combined with a letter informing doctors that their patient will be undergoing the process of assessment.

Vulnerable Claimant Guidance

We heard during our investigation that Ms DE had not been considered to be a "vulnerable claimant" by the DWP. We looked at the DWP guidance on this topic. The guidance aims "to help staff identify and make judgements about those claimants for whom it would be more appropriate to deliver services face to face, particularly where it appears that the claimant is vulnerable".

We noted the following sentence regarding identification of vulnerable claimants: "When considering whether a claimant is vulnerable it is important to talk with them." This does not appear to have happened in Ms DE's case, casting doubt on the decision not to treat her as a vulnerable claimant. Attempts to contact Ms DE by telephone had been made but were unsuccessful. Later in the guidance it is stated: "The following may be relevant to identifying vulnerable claimants where they have/are (not an exhaustive list):". The first item on the list is "Mental health conditions". Ms DE was known to have depression as this was recorded on her MED3 form. Despite this information she was not considered to be a vulnerable claimant. If she had been designated as a vulnerable claimant then additional safeguards would have been put in place.

We think that the DWP should examine the decision that Ms DE was not a vulnerable claimant and identify any shortcomings that led to this decision.

We also think that the DWP should strengthen its vulnerable claimant guidance and audit adherence by its staff to the guidance.

The ESA50 Self-assessment Form

We heard in our investigation that Ms DE had said that she did not receive a self-assessment ESA50 form. The DWP confirmed that it had been posted. There was, however, no evidence of delivery.

The ESA50 form is an important source of information for the Atos assessing professional and the DWP decision maker. In some cases it can also act as a trigger for the claimant to start gathering supporting evidence for their claim. Not receiving the ESA50 would, therefore, be of significant detriment to the claimant. In Ms DE's case there were no efforts from the DWP or Atos to look into the non-return of the ESA50 form - the assessment process simply continued. We were subsequently informed by the DWP that Atos send an automated reminder to the claimant if the ESA50 is not returned within two weeks. The lack of an ESA50 form was not discussed at the Work Capability Assessment.

We are of the opinion that non-return of the ESA50 form should lead to further enquiries being made. If there is no ESA50 form at the Work Capability Assessment the reasons for this should be tactfully explored by the Atos assessing practitioner.

The Work Capability Assessment

We heard in our interview with the Atos clinical manager and doctor that some claimants would incorrectly assume that the Atos practitioner had access to medical notes. This could lead to some claimants not giving a complete account of their situation, due to the mistaken belief that the Atos practitioner was already in possession of relevant information from the medical notes.

We think that when claimants meet the Atos practitioner they should be told what information the Atos practitioner possesses about their case.

We are also of the opinion that when claimants are invited to a face to face assessment, it should be fully explained to them that the Atos practitioner will not have access to their medical notes. They should also be given comprehensive information describing what will take place at the assessment and advice on possible sources of help to prepare for the assessment.

The evidence we heard was that Atos and the DWP considered the Work Capability Assessment to be satisfactory, both in Ms DE's particular case and in general. We have major concerns that the WCA is not sensitive enough to capture the elements of mental illness that mean a person is unable to function in a workplace.

The seven mental, cognitive and intellectual functions assessed, as quoted in a letter to Ms DE from the DWP, are: learning how to do tasks; being aware of danger; starting a task and finishing it to the end; coping with changes; coping with getting about on your own; dealing with other people; behaviour with other people. The assessment of these functions will identify some people with a mental illness who do not have a sufficient level of functioning. However, we think that there are some people with mental health conditions (such as a depressive illness) and insufficient functional ability to cope in the workplace who are not being identified by the WCA.

Ms DE's WCA "Personalised Summary Statement" contained the text: "She was timid at interview but otherwise her mental state appeared normal and despite her regular review by psychiatrist there is no evidence that she has a significant disability of mental health function." We were surprised about this statement for a person who had been seen by a consultant psychiatrist over the course of a 20 year period, was being frequently reviewed and was prescribed significant medication.

We heard many examples in our survey where individuals lost their ESA despite their psychiatrists being adamant that their patients did not have a sufficient level of functioning. In Ms DE's case her psychiatrist and GP were certain that she was not well enough to return to a workplace at that time, although they hoped that she would be well enough in the future.

We think that the Work Capability Assessment should be reviewed with expert input from specialists in occupational health and psychiatry, to increase the ability of the assessment to identify functional level in individuals with a mental illness.

The Work Capability Assessment Mental State Examination

The "Mental State Examination" contained within the Work Capability Assessment is notable for significant omissions compared to a clinical mental state examination. In a mental state examination performed in a clinical setting, there would usually be a subjective and objective assessment of mood. Biological and cognitive features of depression are also often recorded in the mental state examination.

In Ms DE's particular case, despite the fact that she was presenting with a depressive illness, there was no assessment of her mood within the WCA mental state examination. We think that a more comprehensive assessment of Ms DE's mental state would have identified factors that were highly relevant to her level of functioning.

We think that the Work Capability Assessment mental state examination should be reviewed to remedy these significant defects.

Attending the WCA as "Evidence of Functioning"

We heard that the fact that a claimant managed to attend the WCA was considered as evidence of functioning. We think that this is unfair and incorrect. Some individuals with a mental illness may somehow manage to reach the assessment despite their illness, aware that this is an appointment with "authority" and perceiving that their benefits may be at risk if they do not attend. We do not think that this one-off attendance can be extrapolated to assess the ability of a claimant to attend and function in the workplace on an ongoing regular basis.

We think that attendance at the Work Capability Assessment should not be used as evidence of being able to function in the workplace.

Information Used in the DWP Decision-Making Process

In Ms DE's case the DWP decision was made based entirely on the WCA report written by the Atos practitioner. In turn, this report was based solely on a face to face assessment lasting around one hour. This appears to be scant information on which to make such a significant decision.

We think that the DWP decision maker should consider at least two distinct sources of information when coming to the decision.

The Appeal Process

We were told that the law requires that even though Ms DE had lodged an appeal against the DWP decision, her benefit payment would still have been significantly reduced once the disallowance date of 12 January 2012 was reached. This seems to be unfair to the claimant, in that there is a substantial financial loss to the claimant even though the assessment process is ongoing.

We heard about the significant rate of successful appeals against disallowance decisions. We were told about harmful episodes experienced by individuals after initial disallowance decisions which were subsequently overturned on appeal. We think that an improved initial assessment process would lead to a reduction in the number of appeals made.

DWP Peer Review Process

The DWP peer review appears to be incorrectly titled. We would expect a peer review to be carried out by staff of the same grade as those involved in the actual assessment process. In this case the review was carried out by a Senior Executive Officer of the DWP. Consequently, it appears that the document is actually a managerial review, rather than a peer review. When we interviewed the officer who wrote the review we were in the unusual position of hearing both the opinion of the "peer reviewer" and the distinct personal opinion of that individual.

We think that the DWP should look at its Peer Review Process and examine its title and suitability as a quality assurance tool.

DWP Correspondence after Notification of Ms DE's Death

The chronology attached to the DWP Peer Review has the following entry for 13 January 2012, nine days after the DWP received notification of Ms DE's death:

"Employment & Support Allowance awarded at assessment phase rate from 12/1/12; this is payable until the appeal outcome is known. Automatic system issued notification of award sent to [Ms DE]. (Correct procedure/timescale)"

This suggests that a letter was sent to Ms DE despite the DWP having received notification of her death. This letter could possibly have been opened by relatives or friends of the late Ms DE and could have caused considerable upset.

We think that the DWP should investigate if this letter was sent. If the letter was sent then the DWP should consider how such events can be prevented.

Recommendations

We have made several recommendations to the DWP. If the DWP contracts with an agency other than Atos for Work Capability assessments, the same recommendations still apply.

We discussed these recommendations with the DWP. We have been encouraged by the DWP's willingness to engage with us. We will continue to work with them.

The Assessment Process

We recommend that:

- The DWP routinely obtain medical reports for individuals with a mental illness, learning disability or related condition who are entering the assessment process.
- The DWP and Atos jointly ensure that when claimants are invited to a face to face assessment it is fully explained to them that the Atos practitioner will not have access to their medical notes. Claimants should also be given comprehensive information describing what will take place at the assessment and advice on possible sources of help to prepare for the assessment. The DWP and Atos should ensure that when claimants meet the Atos practitioner they are told what information the Atos practitioner possesses about their case.
- The DWP decision maker consider at least two distinct sources of information when coming to the decision.
- The DWP and Atos review the Work Capability Assessment with expert input from specialists in occupational health and psychiatry to increase the ability of the assessment to identify functional level in individuals with a mental illness. The DWP and Atos should also review the Work Capability Assessment mental state examination to remedy the significant defects we identified.
- The DWP and Atos jointly ensure that attendance at the Work Capability Assessment is not used as evidence of being able to function in the workplace.

Communication

We recommend that:

- The DWP review its guidance on leaving telephone messages to ensure that its procedures are working well. Attempts to telephone a claimant to discuss a disallowance decision should be made on separate dates.
- The DWP arrange that when an individual with a mental illness, learning disability or related condition is about to undergo the assessment process a letter should be sent to the person's GP and, if applicable, the person's psychiatrist to inform the doctors of the potentially challenging situation being faced by the individual.
- Non-return of the ESA50 form should lead to suitable further enquiries being made by Atos or the DWP. If there is no ESA50 form at the Work Capability Assessment the reasons for this should be tactfully explored by the Atos assessing practitioner.
- The DWP and Atos ensure that their communication with claimants is compliant with the requirements of the Equality Act 2010.
- The DWP investigate if it sent a letter to Ms DE despite being aware of her death. If this letter was sent then the DWP should consider how such events can be prevented.

Support

We recommend that:

- The DWP examine the decision that Ms DE was not a vulnerable claimant and identify any shortcomings that led to this decision. The DWP should strengthen its vulnerable claimant guidance and audit adherence by its staff to the guidance.

DWP Processes

We recommend that:

- The DWP look at its peer review process and examine its suitability as a quality assurance tool. The peer review process should include a review by a suitably qualified medical practitioner of an assessment made by an Atos healthcare professional.

Recommendation for Scottish Government

We recommend that:

- The Scottish Government, in conjunction with user, carer and professional groups, commission a study examining the impact of the Work Capability Assessment process on people with a mental illness, learning disability or related condition, and put in place the support necessary to address this impact.

Appendix 1

The 17 "Functional Areas" of the assessment of Ms DE and the assessment result for each functional area, all scored at zero points, are quoted below:

Functional Area	Assessment result
<i>Physical Functions</i>	
Moving around	You can move more than 200 metres on flat ground (Moving could include walking, using crutches or using a wheelchair).
Standing or sitting	You can usually stay in one place (either standing or sitting) for more than an hour without having to move away.
Reaching	You can raise at least one of your arms above head height.
Picking things up and moving them	You can pick up and move objects such as an empty cardboard box or a carton of liquid.
Using your hands	You can use a computer keyboard or mouse and a pen or pencil with at least one hand.
Speaking, writing and typing	You can convey a simple message to strangers.
Hearing, or understanding messages	You can understand simple messages from a stranger.
Getting around safely	Your vision doesn't prevent you from finding your way around familiar and unfamiliar places.
Control of bladder, bowels or stoma	You do not need to change your clothes because of difficulty controlling your bladder or bowels or using a stoma.
Staying conscious when awake	Any fits, blackouts or loss of consciousness happen less than once a month.
<i>Mental, cognitive and intellectual functions</i>	
Learning how to do tasks	You can learn how to do new tasks.
Being aware of danger	You are aware of everyday dangers and can keep yourself safe.
Starting a task and finishing it to the end	You can usually manage to begin and finish daily tasks.
Coping with changes	You can cope with small unexpected changes to your daily routine.
Coping with getting about on your own	You can get to somewhere that you don't know without someone going with you.
Dealing with other people	You can deal with people you don't know.
Behaviour with other people	You behave in a way that would be acceptable at work.

Appendix 2

Glossary

Atos	Company contracted to perform WCA
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
ESA50	Self-assessment questionnaire to be completed by claimant
ESA85	ESA medical report completed by Atos Healthcare professional
ESA113	Information requested from a healthcare professional about an ESA claim
GP	General Practitioner
HCP	Atos Healthcare professional
IB	Incapacity Benefit
JSA	Jobseeker's Allowance
MED3	Statement of fitness for work, completed by a doctor
RMO	Responsible Medical Officer, a psychiatrist who has overall responsibility for the psychiatric care of their patients
ST6	In psychiatry, a doctor in the final year of training before being eligible to apply for consultant posts
WCA	Work Capability Assessment





Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer freephone:
0800 389 6809
enquiries@mwscot.org.uk
www.mwscot.org.uk