# SERIOUS CASE REVIEW (GF)

## PRESS RELEASE

I am releasing today the report from the independent review panel for Safeguarding Adults Board in Surrey.

This review was commissioned by the Board in order to ensure that there was an independent view of the circumstances surrounding the loss of care for Mrs Foster.

Our terms of reference were:

i. To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
ii. To establish what those lessons are, how they will be acted upon and what is expected to change as a result.
iii. To improve inter-agency working and better safeguarding of adults at risk including the review of procedures where there may have been failures.

Serious Case Reviews are not inquiries into who is culpable for the death or harm suffered by the vulnerable adult but to review multi agency working and make recommendations for improvements in working practices.

The report gains its information from the friends of Mrs Foster, conclusions of individual organizations internal management reviews and the links across the services involved.

One of the important things to remember is that this is about an individual and the circumstances surrounding an incident which left them without care for several days when they were vulnerable. Whilst we talk a lot about process always at the forefront of this review, is that it is about Gloria Foster.

The report lays out the circumstances which led to the situation around the loss of care and the areas where the agencies involved could learn from this case and how we are recommending to the Surrey Safeguarding Adults Board to implement actions across agencies to improve working and safeguard adults at risk. They will be accountable to do this to their stakeholders.

It is up to individual organizations to follow through proper process any disciplinary action deemed appropriate. It is not the job of the panel to do this.

There are certainly lessons to be learned here and by implementing the actions recommended, we are looking to ensure the circumstances which caused Mrs. Foster to be without care for several days can be prevented from happening again.

## Recommendations

**That the Surrey Safeguarding Adults Board:**

1. Consider all the recommendations of the agency IMRs (see Appendix A) collectively and sort them into a practical programme of work such that partners can be accountable to each other for their completion.

2. Request Surrey County Council to ensure that its disciplinary actions related to the care of Mrs Foster include investigations of:
   i) how the key safe and client lists supplied by the Metropolitan Police prior to the raid were made use of by Surrey ASC,
   ii) the absence of any record in their telephone systems of a call being made to Mrs Foster to check her welfare,
   iii) the veracity of recording of key events.

3. Prepare multi-agency guidance on best practice in recording

4. Advise all safeguarding professionals chairing meetings, in Sutton and Surrey, of the importance of having the right people in attendance, that clear and concise minutes are written and that the right actions are taken and known to be taken.

5. Ensure that partners agree a clear policy and practical arrangements for multi-disciplinary assessment, review and care coordination for people with complex needs and long term conditions - irrespective of their funding, current care package or with which agency the need arises.

6. Request Epsom and St Helier University Hospitals NHS Trust to review its policy and practice regarding people returning home to improve multi-agency coordination of care.

7. Suggests that the Community Matron and Virtual Ward service has continued funding and investment to develop and embed the service on a long-term basis and is appropriately commissioned with key performance indicators that lead to the right outcomes. Further that this service is continued to be promoted amongst GPs, health and social care professionals.

8. Create a regular forum where partners can bring, share and discuss data, information and intelligence about safeguarding concerns with service provider organisations in the spirit of sector-led improvement.

9. Test the provider failure protocol with a view to establishing multi-agency ownership

10. Develop a simulation training exercise around the provider failure protocol as part of leadership development.

11. Advise Surrey County Council to continue its focus on ensuring that it's organisational and social work cultures are ones that develop and sustain best practice.

12. Consider carrying out an audit of organisation and profession specific Mental Capacity Act training to see if there are any gaps requiring attention.

13. Support health professionals, who undertake home visits and need to gain entry using a key safe number, to develop an access policy and procedure that combines the need for privacy, security and ease of entry.

14. Promote the use of assisted living technology in improving quality of life and personal safety.

Simon Turpitt
Independent Chair of the Surrey Safeguarding Adults Board