



## **Surrey Safeguarding Adults Board**

### **Serious Case Review – Executive Summary**

#### **The Death of Mrs Gloria Foster**

**September 2013**

**Serious Case Review panel chaired by Simon Turpitt**

#### **Acknowledgements**

Thank you to all the people who have contributed to this report including Mrs Foster's friends, family, the people who held Power of Attorney for her, the professionals who have supported the Review Panel and colleagues from CPEA.

# A Serious Case Review – Executive Summary

## The Death of Mrs Gloria Foster

September 2013

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## The Circumstances that led to the Review

1. On 9<sup>th</sup> January 2013, Reigate and Banstead locality team of Surrey County Council, Adult Social Care (ASC), was informed by the London Borough (LB) of Sutton of concerns notified by the UK Border Agency (Home Office) in relation to illegal immigrants working for Carefirst24<sup>1</sup>. A safeguarding meeting on 11<sup>th</sup> January 2013 was attended by an Assistant Senior Manager in the role of the coordinator for the Surrey ASC response as some of the clients lived in the county.
2. At a further safeguarding meeting on the 14<sup>th</sup> January, the UK Border Agency and the Metropolitan Police advised that the premises of the agency would be raided in a planned way on 15<sup>th</sup> January 2013. It was agreed that it was highly likely that following this raid the company would not be able to continue trading.
3. Surrey ASC had themselves identified 13 service users before the meeting for whom they commissioned services from Carefirst24 including those who received direct payments.
4. The Metropolitan Police had secured a key safe and client list dated July 2012 from a Carefirst24 whistle-blower as part of evidence gathering. It was presented to the meeting of the 11<sup>th</sup>. The minutes of the safeguarding strategy meeting state a complete list was required as LB Sutton and Surrey ASC clearly expected to ultimately identify everybody on the Carefirst24 client list and offer support and/or alternative care. This is the subject of a recommendation in the report.
5. The identities and addresses of service users<sup>2</sup> were seized as part of the raid. There were details of a further 8 residents amongst them Mrs Foster. Alternative care and support were put in place for seven of them. Mrs Foster was the exception.
6. On the 25<sup>th</sup> January it was recorded in the Surrey ASC Adults Integrated Solution (AIS<sup>3</sup>) that there was no reply to a telephone call made to Mrs Foster on 16<sup>th</sup> January 2013. Further inquiries have since established that Surrey County Council's telephone systems (landline and mobile) do not contain a record of a call being made to Mrs Foster. The SCR panel have made a recommendation about this and concluded it should be the subject of further Surrey County Council investigations
7. On 24<sup>th</sup> January 2013, at approximately 10:00am Mrs Foster was visited at home by a nurse from the district nursing service. This was a planned visit. The nurse gained access to the property via the key safe. On arrival the nurse found Mrs Foster in a collapsed state. She was very poor physically, was cold, lying partially off her bed which was sodden with urine and faeces and she appeared dehydrated with cracked lips. She immediately contacted the GP who requested an emergency ambulance.
8. On admission to the Accident and Emergency Department (A&E) at Epsom and St Helier University Hospitals NHS Trust, a provisional diagnosis of metabolic acidosis, urinary sepsis with severe dehydration was made. Fast atrial fibrillation was recorded. A 'do not attempt cardiopulmonary resuscitation' (DNAR) order was signed and dated.

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<sup>1</sup> Carefirst24 Limited is registered with the Care Quality Commission to provide personal care and support in the home for, amongst others, people over 65years and people with dementia

<sup>2</sup> The information supplied by the Metropolitan Police on the 15<sup>th</sup> January 2013 regarding Mrs Foster included name, address, key code, phone number, date of birth and start date of the service (30<sup>th</sup> September 2007)

<sup>3</sup> Adults Integrated Solution (AIS), is an electronic information system which is a product of the software company Northgate.

9. Mrs Foster was transferred to a ward, there were investigations and a care plan was agreed. Mrs Foster received nursing care, specialist equipment and medications. A scan revealed right frontal infarct of the brain and she was referred to the stroke team.
10. A review on 1<sup>st</sup> February noted that Mrs Foster was eating and drinking well with support, aware of her surroundings. A joint neurological physiotherapy and occupational therapy assessment was undertaken to establish her future needs in the community.
11. Despite the recorded progress she began to deteriorate. The DNAR order was reviewed. At 7:00am on 4<sup>th</sup> February the nursing staff called the junior doctor and at 7:45am Mrs Foster died. The death certificate, after postmortem, stated pulmonary thromboembolism and deep vein thrombosis. The coroner is yet to determine the precise cause of death.
12. The multi-agency safeguarding procedures were invoked shortly after Mrs Foster's admission to hospital. A senior strategy meeting was held on 30<sup>th</sup> January 2013 which established this Serious Case Review (SCR) prior to Mrs Foster's death.
13. The records kept in Mrs Foster's home by Carefirst24 – the agency she engaged to provide her with essential care and support – showed a final entry on the afternoon of 15<sup>th</sup> January 2013. She had apparently not received any care services for almost nine days.

### **About this Serious Case Review (SCR)**

14. The SCR was commissioned by Surrey Safeguarding Adults Board (SSAB). It was overseen by a panel lead by an independent chair. Partner agencies provided panel members that were separate from the any involvement with Mrs Foster. An independent author offered expert opinion and prepared the report based on information provided in Internal Management Reviews (IMR) from all involved agencies.
15. The terms of reference for the independent Serious Case Review are:
  - To establish the chronology of events in relation to Mrs Foster between January 2006 and her death in February 2013.
  - To review the effectiveness of Surrey's present procedures (both multi-agency and those of individual organisations)
  - To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies currently work together to safeguard vulnerable adults
  - To establish what those lessons are, how they will be acted upon and what is expected to change as a result
  - To improve inter-agency working and better safeguarding of vulnerable adults
  - To prepare an overview report bringing together and analysing the findings of the various reports from the key partner agencies, in order to make recommendations to Surrey Safeguarding Adults Board for future action.
16. The terms of reference agreed for the IMRs were:
 

Between January 2006 and 4<sup>th</sup> February 2013

  - With reference to work undertaken regarding CareFirst24 identify the role and responsibility of (i) your agency and (ii) lead professionals within your agency, specifying timescales of their involvement

- With reference to work undertaken with Mrs Foster between January 2006 and February 2013, identify the role and responsibility of (i) your agency and (ii) lead professionals within your agency, specifying timescales of their involvement
- Evaluate the adequacy of assessments undertaken, the decision-making and planning by your agency concerning CareFirst24 and Mrs Foster
- How were Mrs Foster's (i) medical diagnoses, (ii) mental health and (iii) care and support needs addressed by your agency?
- Comment on the effectiveness of information sharing (i) within your own organisation (ii) with other agencies, (iii) with Mrs Foster and her wider friends and family
- Identify any organisational factors such as capacity and culture which may have impacted on practice in working with Mrs Foster or with Carefirst24.
- Consider the effectiveness of your agency's response – its practices and internal processes as measured against the expectations set down in the multi-agency policies and procedures for safeguarding adults and (i) propose ways in which practice can be improved within your own agency; and (ii) specify how and within what timescales they will be enacted
- Identify the lessons to be learned from this case about the way in which professionals and organisations work individually and together

## Mrs Foster

17. Mrs Foster was an 81-year-old woman who lived alone in a ground floor flat in Banstead, Surrey. She was born in India in 1931 and returned to England when she was 16. She joined Shell and worked as a company secretary in Canada and Nigeria - where she met her husband Bob. Two years after their marriage in 1971, he died in a road accident whilst in Tehran<sup>4</sup>. She was said to enjoy travel, bridge, the theatre, tennis and other sports.
18. There was a registered enduring power of attorney (POA) in place concerning her financial matters. It was jointly held for Mrs Foster by her friend Ann Penston and Lesley Pond (a colleague of her solicitor, Mrs Grant).
19. Ms Penston described Mrs Foster as a gregarious person who would sit down and chat with anybody<sup>5</sup>. She was also described as fiercely independent and becoming increasingly reclusive in later life – refusing to see her friends.<sup>6</sup> She said that Mrs Foster was a keen sportswoman, dog lover and bridge player with a big circle of friends at the golf club. She said they had met through bowls although this was not Mrs Foster's favourite sport. Adding, there was always a slight element of the reclusive in Mrs Foster Ann Penston went on to say she was a full and reflective character. People enjoyed her company. She enjoyed the theatre and was a big social lady<sup>7</sup>.
20. Mrs Foster had been diagnosed with anxiety and depression during 1977, and in 2008 with vascular dementia. She had physical health problems including atrial fibrillation, type 2 diabetes, high blood pressure, cataracts and early age macular

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<sup>4</sup> Sourced from news items in the Daily Telegraph

<sup>5</sup> Press Association

<sup>6</sup> Sourced from news items in the Daily Telegraph

<sup>7</sup> Notes of meeting with Ms Penston and Mrs Grant 16<sup>th</sup> July 2013

degeneration. She had a TIA (Transient Ichaemic Attack or mini stroke) in 2006 from an embolism.

21. Surrey ASC knew Mrs Foster from August 2007, when she was referred by her solicitor and a psychiatrist after in-patient mental health treatment. At that time, she was described as suffering from depression, not eating properly and confused. Mrs Foster agreed to an assessment on the 5<sup>th</sup> September 2007. This resulted in a personal care package of four visits per day which was put in place by Surrey ASC using the Carefirst24 agency which was based in the LB Sutton. The package was funded for the first 6 weeks by Surrey ASC and then directly by Mrs Foster.
22. Following a stroke Mrs Foster was hospitalised for 3 weeks at the end of 2011. On discharge she became confined to her home. Ms Penston said: she started to become wobbly and Carefirst24 got her a frame. She spent most her time sat in her chair and was not very mobile being reluctant to do anything and being polite but firm about declining. She was described as having lost the will<sup>8</sup>. The care workers from Carefirst24 provided a full range of personal care from getting her out of bed, dressing and washing her to ensuring she took her medications.

### Key events and service interventions

23. The pertinent headlines gleaned from an extensive composite chronology prepared for the SCR are included in the main report

### Summary of the key themes

#### Fulfilment of agency and professional roles and responsibilities

24. Surrey ASC had created an expectation<sup>9</sup> from 2007 that Mrs Foster would have annual reviews which they did not meet. Her changing health and care needs justified multi-disciplinary review and responses.
25. At the point when it was definitively known that the anticipated raid on Carefirst24 would have an impact on Mrs Foster's care package then a check of her needs should have been forthcoming followed by proper information, advice and support. As Mrs Foster was a service user already known to Surrey ASC the nature of the action needed was palpable from the information available in the files. Surrey ASC did not fulfil its agency function adequately in this respect.
26. Professionally, the worker involved seems negligent in not following up the telephone call<sup>10</sup> she recorded several days later as being made on the 16<sup>th</sup>. The files would have told her that the circumstances appertaining to Mrs Foster warranted follow up by a home visit. Equally there appear to be supervisory management failings in allowing the piece of work to be 'signed off' and thus enabling the council and its partners to believe the work had been completed successfully.

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<sup>8</sup> Ibid

<sup>9</sup> The revised Surrey IMR 2<sup>nd</sup> August 2013 acknowledges that there is no statutory duty to undertake reviews saying: *Notwithstanding that there is no statutory responsibility for the council to review people who are self-funding their own support and no third party concerns were raised about the stability or appropriateness of her self-funded care, the council had raised an expectation that it would provide support through the provision of regular reviews. The pattern of reviews was irregular with an 18 months gap between the review in August 2009 and the next one in March 2011. The intended review in March 2012 did not occur meaning that at the time of her death Mrs Foster had not been formally reviewed by the council for 22 months. However, it is reasonable to conclude that Carefirst24 and any health provider would have been routinely reviewing their own support and would have alerted the council had they considered there was a need for social care support or involvement.*

<sup>10</sup> Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.

27. The GP could have followed up an unanswered home visit on 22<sup>nd</sup> January but having sought assurances and ascertained that Mrs Foster was due a nurse visit on 24<sup>th</sup>, judged not to do so.
28. Mrs Foster's returned home from hospital three times during 2012. These ought to have prompted a multi-agency reassessment and/or an assessment for Continuing Health Care or for the Virtual Ward.
29. The CMHT discharged Mrs Foster in March 2009 which meant she no longer had the regular visits of a specialist mental health community support worker. One of the roles of the community support worker was to seek to reduce isolation. However, once Mrs Foster's mental state, medication and the implementation of community care package had stabilised she was appropriately discharged from the service. Whilst proper it altered the input into care coordination.
30. Police investigations concluded the action or lack of action of any person did not meet the criminal threshold of wilful neglect or ill treatment. The actions involved, or rather inaction, were not intentional or deliberate. Nor can the employing council be shown, at senior manager level, to have criminally breached their duty of care. Following liaison with the Crown Prosecution Service (CPS) the outcome of the enquiries was that no criminal charges should be brought against any individual employee or Surrey County Council<sup>11</sup>.
31. The agencies engaged with the enforcement of immigration law in respect of Carefirst24 should not be faulted. They were clearly conscious of the priority to identify and ensure the safety of potentially vulnerable people from the outset. Documented good practice in collectively taking enforcement action that closes a social care service provider is valuable.
32. With hindsight there were some warning signs about Carefirst24:
  - They did not pass the Surrey ASC procurement quality standard in 2012
  - All CQC inspections found that the outcomes inspected were met but they brought forward an inspection at the end of 2011 - presumably because of a safeguarding alert
  - The issues with migrant workers were beginning to emerge during 2012 through a whistle-blower but concrete evidence was not forthcoming.
  - In general GP's and community health workers have strong contacts with most clients and the input of an NHS lead may have been useful in enhancing intelligence about Carefirst24 and the subsequent actions to protect people.
  - Mrs Foster's SCR panel and her joint attorneys are keen to be assured that Carefirst24 is formally de-registered by CQC notwithstanding pending criminal action.

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<sup>11</sup>The Crown Prosecution Service (Specialist Case Directorate) has advised that there is insufficient evidence of any criminal offence committed by any individual or organisation relating to the death of Mrs FOSTER. The Senior Crown Prosecutor that reviewed the case advised that in relation to an offence of Corporate Manslaughter it would be impossible to show from an organisational perspective that senior managers (as required in the Corporate Manslaughter and Corporate Homicide Act 2007) within Surrey County Council Executive were aware of the working practices / neglected practices of their employees and as such had committed a gross breach of a duty of care to Mrs FOSTER. In respect of individual culpability; the Senior Crown Prosecutor acknowledged that those that had failed to transfer Mrs FOSTER to an alternative care provision had made a serious mistake that had brought tragic consequences, but it was not a case of wilful neglect. It would have been extremely hard to show 'beyond reasonable doubt' that an employee's failure to transfer Mrs FOSTER to an alternative care provision led directly to her death. Mrs FOSTER died of a pulmonary thromboembolism (she had suffered an embolism previously) eleven days after being admitted to hospital. There would be evidential difficulties in showing that the nine day interruption of her dosage of Warfarin was the direct cause of her death

## **Adequacy of assessments, decision-making and planning**

33. Mrs Foster's initial assessment, care planning and reviews processes worked well. However, ASC reviews became sporadic until March 2011. After that the key care management processes were absent and at the time of her death Mrs Foster had not had a review for 22 months.
34. Notwithstanding the lack of regular ASC reviews there were no concerns raised about Mrs Foster's care or any absence of professional contact and oversight. The GP oversaw the health care assessment, decision-making and planning. There were health focussed reviews and Mrs Foster benefited from monitoring by district nurses.
35. There were three opportunities to trigger a multi-agency/professional re-assessment of needs in 2012. If these had been taken then Mrs Foster may not have been in the situation where she became a victim of events.
36. Although there were gaps in ASC reviews and only intermittent contact after 2008, a basic look at the file before attempting to contact Mrs Foster would have revealed her history of dementia, anxiety and depression with a number of physical health problems. It would also have revealed the names of her two friends who had power of attorney who could have been contacted

## **Meeting of medical, mental health, care and support needs of Mrs Gloria Foster**

37. The initial community care assessment in 2007 identified a range of medical, mental health and care issues that were affecting Mrs Foster and the package of support seems to have been largely effective in helping to support her. All in all Mrs Foster's care and support constituted a good example of what can be provided in a person's own home.
38. Surrey ASC knew<sup>12</sup> about the discharge plan involving restarting the same care package and district nursing in January 2012 but not about the A&E admissions in October and December of that year for UTIs. If they had held the review as scheduled for March 2012, they would have been better informed, but that said, the hospitals involved missed three opportunities to initiate or prompt Surrey ASC to undertake a review. A multi-disciplinary review, engaging with those closest to her, could have improved the coordination and quality of how Mrs Foster's medical, mental health and care needs were met.

## **Effectiveness of information sharing**

39. Information sharing followed a fairly normal pattern in the first couple of years of Mrs Foster's care (2007-2009). It then became more fragmented and less consistent. After March 2011 information sharing became ineffective and, as far as Surrey ASC was concerned, ceased. The 'In Touch' team provided no practical benefit<sup>13</sup> to Mrs Foster.
40. In the last year of her life, Mrs Foster's service revolved around the GP, the district nursing service and Carefirst24. Information was not shared about the hospital

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<sup>12</sup> Surrey ASC IMR chronology entry 63

<sup>13</sup> Surrey ASC issued revised guidance regarding the In Touch teams on 18<sup>th</sup> March 2013

admissions in late 2012 but there is no reason why this should not have continued successfully despite the absence of reviews.

41. Everyone in Surrey ASC knew what was supposed to happen when Carefirst24 closed and management took steps to make it happen. Notwithstanding this it did not happen as it should have for Mrs Foster. The IMR suggests that perhaps the sheer volume of communication – especially by email – was too much and describes<sup>14</sup> an approach that may have contributed to lack of focus on the task, insufficient priority given to a significant occurrence and absence of accountability for follow-up on the outcomes of actions.
42. For whatever reason the manager of the worker tasked with contacting Mrs Foster thought (or assumed) that a telephone call had been made and that Mrs Foster had been spoken to.
43. The information sharing by the agencies undertaking enforcement action of immigration laws was largely effective.
44. There remain some discussions to what the list of Carefirst24 clients shared at the 11<sup>th</sup> January safeguarding meeting actually contained. It had been garnered as evidence from the whistle-blowing Care Coordinator at Carefirst24. The Metropolitan Police IMR says it was key safe codes. LB Sutton says it was key safe codes and addresses<sup>15</sup>. Both say Mrs Foster's name was on the list. The Surrey Assistant Senior Manager present says she was not provided with a copy and that there was no indication in her mind that Mrs Foster was on the lists. It remains important to properly track what happened to client lists from start to finish for Surrey ASC and its residents. The SCR panel puts forward a recommendation in this respect.

### **Impact of organisational capacity and culture**

45. Mrs Foster was one of 40,000 self-funding older people living in Surrey. Having created an expectation<sup>16</sup> it is apparent that Adult Social Care may not have the capacity to provide the best practice of care coordination in Reigate and Banstead for Mrs Foster from 2009 onwards. Understandably Surrey ASC is committed to issuing guidance to bring clarity to this area of practice.
46. Both the GP and the district nurses comment on the increasing numbers of people with complex long-term conditions amongst their customers. They suggest that this impacts on the capacity to undertake proactive work such as liaison with partner agencies<sup>17</sup>.
47. A&E policies and practices at Epsom Hospital are rightly designed to rapidly re-establish care arrangements at home if there have been no change to a patient's circumstances or decline in their health. However, with Mrs Foster having two admissions for UTI within 7 weeks there is a suggestion that her health may have been deteriorating to the extent that a more substantial review of home circumstances was warranted.

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<sup>14</sup> Surrey IMR page 28

<sup>15</sup> In a clarifying letter of 24<sup>th</sup> July 2013 the LB Sutton Interim Executive Head of Service says: *At the meeting the police gave a key safe list and a client list, dated July 2012, which had been obtained from the whistle-blower, to the London Borough of Sutton and Surrey County Council. The key safe and the clients lists included the name, and the client list the address, of Mrs Foster (Banstead Surrey) as a user of Carefirst24 But ASC Surrey have no evidence that she was on any list until the 15<sup>th</sup> January 2013*

<sup>16</sup> Revised Surrey IMR 2<sup>nd</sup> August 2013

<sup>17</sup> Central Surrey Health IMR

48. The cessation of Carefirst24 services created a spike in work for Surrey ASC of 8 people requiring contact and likely to have needs to accommodate. The worker assigned to make contact with Mrs Foster acknowledged that she had not followed up what she recorded in a file entry made on 25<sup>th</sup> January as a telephone call<sup>18</sup> - 'no reply'. She said she had not made the entry at the time because she was busy setting up emergency care for other service users who had the same care agency.
49. That Mrs Foster's file was not consulted prior to attempting any telephone contact, is a basic omission. The management request was that such contact be made today - the 15<sup>th</sup> January 2013 – yet the worker recorded some time later (on the 25<sup>th</sup> January) that she made the call<sup>19</sup> on the 16<sup>th</sup> without any explanation for the delay. She recorded there was 'no reply'<sup>20</sup>. Additionally, she could have undertaken further actions such as a call to those with power of attorney (the contacts were on file) or by making a home visit. The practitioner did not inform her manager that she had not spoken to Mrs Foster or to either of the people who held Power of Attorney for her.
50. She recorded that she assumed the service user would be able to make her own care arrangements because she was a self-funder. There is a need to check whether this is an isolated assumption. The information was on file that Mrs Foster was known to have dementia and also to have experienced anxiety and depression. Surrey ASC will want to undertake further analysis of the implications of this file note.
51. The Surrey IMR reveals little about the working environment or social work culture in the team in which the practitioner involved worked. It does indicate she was a senior social work practitioner with the title senior operational lead, that the task of contacting Mrs Foster had been delegated by the Team Manager<sup>21</sup> and it recommends mechanisms for monitoring and controlling workloads.
52. There is no evidence in the review documents that there are any problems with the working environment or social work culture in Surrey ASC. The IMR does say: there was a set of circumstances where an error may have been more likely to happen. Surrey ASC is beholden to assure itself that that neither the organisational nor the social work cultures were amongst these circumstances. Implementing a workforce development strategy<sup>22</sup> and organisational health checks, as Surrey are doing, could ensure this.

## Effectiveness of multi-agency policies and procedures – how they may be improved

53. The multi-agency policies and procedures for adult safeguarding appear to have been followed at all times.

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<sup>18</sup> Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.

<sup>19</sup> Ibid

<sup>20</sup> Surrey ASC IMR chronology entry 123

<sup>21</sup> It was noted by the panel that the other areas in Surrey ASC did not delegate the task from Team Manager

<sup>22</sup> The work being undertaken by Surrey ASC on its workforce strategy, including the priority of *development of a positive workforce culture*, is documented on <http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/adult-social-care-strategies-policies-and-performance/making-it-real-personalised-and-community-based-support/Adult-Social-Care-you-said-and-we-did/adult-social-care-workforce> accessed on 18th July 2013

## Lessons

### Communication, data and information

54. Too much data and information can be as problematic as not enough. For data and information to become useful intelligence they have to be channelled, sorted, prioritised and directed. If the topic is not routine, less than effective communication flows can have serious implications. Recommendations address both ensuring focus to communications and making effective use of data and information available.
55. With Carefirst24 there were early indications that things were going awry, but not all the pieces came together in one place. Once it was obvious that action was required, the data and information were communicated according to plan.
56. With Mrs Foster there were early indications that her care plan was probably not meeting all her physical, mental health and care needs. The data and information were there across the agencies but the coordination mechanism to pool and share it in order to do better was not used.

### Service closure

57. Closing any social care service, particularly in crisis, requires planning across agencies. The work of the enforcement agencies with their respective care partners in LB Sutton and Surrey ASC offers a good practice template about the crisis of closure from which others can learn.
58. Surrey ASC now has a revised Provider Failure Protocol which has a chapter on the closure (with little notification) of a community services provider. As observations:
  - People have to follow protocols and to do that they need to own and understand them. One effective way of doing this is through using simulation in training.
  - There are always gaps in protocols, however well drafted, so it is best to ensure leaders have the capacity and capability to exercise discretion.
  - The protocol is essentially a County Council document. There is merit in considering multi-agency ownership – through the Health and Well-being Board, Safeguarding Boards (Adults' and Children's) and Community Safety Partnerships.

### Care coordination<sup>23</sup>

59. With Mrs Foster reviews as necessary linked to her changing needs would have been one way to coordinate across agencies and professionals. Whilst it was not necessarily the sole responsibility of Surrey ASC to assume the lead in care coordination, it was clearly a best practice expectation that it took reasonable steps to ensure this happened.
60. Mrs Foster had complex long-term conditions and care needs that required imaginative coordination, review and planning. This is not something that can be done by telephone or with a checklist. Every support and intervention needed looking at through the lens of mental capacity. So as a minimum, a multi-agency annual review should have been undertaken that engaged with the client and her

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<sup>23</sup> See Kings Fund – coordinated care for people with complex chronic conditions <http://www.kingsfund.org.uk/projects/co-ordinated-care-people-complex-chronic-conditions> accessed on 7th July 2013

circle of support – not least her GP and in the case of Mrs Foster those with Power of Attorney.

61. Surrey ASC acknowledged that some staff have used terms such as 'review', 'contact', 'monitoring', 'in-touch' interchangeably and synonymously. They said that this had led to unhelpful and avoidable confusion for the staff themselves and in recording actions. There are some 40,000 self-funding older people living in the county and understandably Surrey ASC is committed to issuing guidance to bring clarity to this area of practice. The lessons from this SCR can contribute to a developing multi-agency approach.

### **Use of assisted living technology**

62. That people who have alarms do not always use them when they really need to is not a new lesson. Why Mrs Foster did not make use of hers may not be fully understood, but her dementia, anxiety and depression may well have played a part.

### **Access to people's homes**

63. Use of the key safe at Mrs Foster's flat suggests that there are lessons to be learned about how there can be ready access to people's homes by giving the key safe number to home visiting health professionals in a way that will not jeopardise the person's privacy or safety.

### **Care packages – people with complex long-term conditions**

64. The lesson is that, although reports were that the care package was successful, a care coordinator should be more aspirational about quality of life than what was probably just basic daily living. Mrs Foster may have been resistant to socialising but that does not mean she sought isolation.

### **Self-funding**

65. Self-funding does not equate to ability to access information, advice, guidance and advocacy in respect of choices. Nor does it mean that a person has mental capacity. Incorrect assumptions can be made that people who are self-funding can make their own arrangements unsupported.
66. Local authorities need to find out much more about their care market-place – who is paying for what? Mrs Foster was a self-funder who had come through the Surrey ASC assessment and care planning process. They knew of her and should have kept closer involvement. There are many more people using services that Surrey County Council and other local authorities know nothing about at present - those whose arrangements are entirely private.

### **Social work**

67. The Surrey IMR says that: the direct cause of what happened to Mrs Foster appears to have been a set of circumstances where an error may have been more likely to happen. This set of circumstances culminated in a series of professional social work practice omissions.
68. The Surrey IMR has a recommendation requiring it to consider mechanisms for monitoring and controlling workloads. It is suggested that there may be lessons for Surrey ASC in reassuring itself, at the same time as it considers workloads, that the steps it is undoubtedly taking to build and sustain a professional social work culture

are having the desired outcomes. Its recent implementation of organisational health checks is a big step along this road.

## Conclusions

69. Mrs Foster was left alone for nine days without her essential privately funded care and support service when the provider company ceased trading. That she endured harm is self-evident. She died eleven days after being discovered by a visiting district nurse and her admission to hospital. Police investigations concluded the action or lack of action of any person did not meet the criminal threshold of wilful neglect or ill treatment. The actions involved, or rather inaction, were not intentional or deliberate. Nor can the employing council be shown, at senior manager level, to have criminally breached their duty of care.
70. This SCR finds that Mrs Foster would have benefited from better multi-agency care coordination and review from August 2009. Besides offering a potential improvement to the quality of her life this may have avoided her falling victim to events.
71. The provider failure protocol put in place by Surrey addresses the necessity to treat service closure as a significant occurrence demanding of focussed leadership. It includes, for example, the use of timed handover logs and scheduled debriefings that would have picked up the omissions that left Mrs Foster without home care for nine days.
72. A serious mistake seems an inadequate description of what happened. But leaving aside all the 'what ifs', that is exactly what happened. Certainly, a number of professional omissions were made by a social worker at the Reigate and Banstead office, ones which seem rooted in false assumptions and left unquestioned at supervisory level.
73. Mrs Foster's death confirms that serious mistakes have serious consequences. It is now for the employer and the Health and Care Professions Council to consider the evidence and determine what further consequences should ensue<sup>24</sup>.
74. Surrey Safeguarding Adults Board will do well to give Mrs Foster a practical and positive legacy by demonstrably learning the lessons that have emanated from this serious case review.

## 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,

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<sup>24</sup> It has been confirmed that both the worker and manager involved are subjects of internal disciplinary action by Surrey County Council.

- 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 its 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.