Surrey Safeguarding Adults Board

A Serious Case Review

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.

Contents

The Circumstances that led to the Review **3**
About this Serious Case Review (SCR) **5**
Mrs Foster **7**
Key events and service interventions **9**
Analysis of the Internal Management Reviews (IMRs) **17**
Fulfilment of agency and professional roles and responsibilities 17
Adequacy of assessments, decision-making and planning 20
Meeting of medical, mental health, care and support needs of Mrs Foster 21
Effectiveness of information sharing 22
Impact of organisational capacity and culture 23
Effectiveness of multi-agency policies and procedures – how they may be improved 25
Lessons **25**
Communication, data and information 25
Service closure 26
Care coordination 26
Use of assisted living technology 27
Access to people's homes 27
Care packages – people with complex long-term conditions 27
Self-funding 28
Social work 28
Conclusions **28**
Recommendations **30**
Appendix A: Recommendations in IMRs **33**
Appendix B: References – Legislation, Policy and Guidance Context **37**
Appendix C: Independent Serious Case Review Panel Members **39**
Appendix D: Key to Acronyms **40**

The Circumstances that led to the Review

1. On 9th 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[1]. As Carefirst24 provided services to people living in Sutton and in Surrey, the team was invited to attend the LB Sutton safeguarding meeting on 11th January 2013. An Assistant Senior Manager attended in the role of the coordinator for the Surrey ASC response.
2. At a further safeguarding meeting on the 14th January, the UK Border Agency and the Metropolitan Police advised that the premises of the agency would be raided in a planned way the next day. It was agreed that it was highly likely that following this raid the company would not be able to continue trading due to the potential numbers of staff involved.
3. Surrey ASC had themselves identified 13 service users, on the 9th January, for whom they commissioned services from Carefirst24 including those who received direct payments. Welfare checks and steps to arrange alternatives were underway by the time of the meeting on the 11th. Ultimately alternatives were successfully arranged for these 13 people.
4. On the 10th January, the Metropolitan Police secured a key safe and client list from a Carefirst24 whistle-blower as part of evidence gathering. It was dated July 2012.[2]. The lists were presented to the representatives of LB Sutton and Surrey ASC at the meeting of the 11th January 2013. In total there were understood to be 49 names with LB Sutton having identified 24 residents and Surrey ASC 13 residents at that stage. The minutes of the safeguarding strategy meeting state that the representatives of LB Sutton and Surrey will look at the lists. Dedicated workers will be put on this case to review the services[3]. The minutes record that a complete list is needed.
5. LB Sutton and Surrey ASC clearly expected to ultimately identify everybody on the Carefirst24 client list and offer support and/or alternative care. However, this SCR has only been able to conclusively determine that the client list seized on the 15th January 2013 named Mrs Foster with any detail as far as Surrey ASC is concerned. It remains important to try and understand the timing of attempted contact with Mrs Foster. This is analysed in more detail in the report and is subject of a recommendation.
6. At the meeting it was agreed that a full client list would be seized by the Metropolitan Police at the time of the raid and would be sent to LB Sutton and to the Surrey ASC, Assistant Senior Manager as soon as the Metropolitan Police were able to access the company's records. The raid went to plan and as expected the care agency

[1] 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
[2] LB Sutton clarification of IMR 24th July 2012
[3] LB Sutton Safeguarding Strategy meeting 11th January 2013 - minutes

ceased trading on 15th January 2013. The identities and addresses of service users[4] were seized on the day and passed to LB Sutton and Surrey ASC.

7. It transpired that in this list there were more details of a further eight Surrey residents who were self-funding, amongst them Mrs Foster, and alternative care and support (or appropriate information and advice given) were put in place for seven of them. Mrs Foster was the exception.
8. 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 across a three week period including 14th – 16th January 2013. Yet on the 25th January it was recorded in the Surrey ASC Adults Integrated Solution (AIS[5]) that there was no reply to a telephone call made to Mrs Foster on 16th January 2013. Mrs Foster's phone did not have an answer-phone facility but the police have confirmed there were no incoming calls from any relevant party. The SCR panel have made a recommendation about this and concluded it should be the subject of further Surrey County Council investigations.
9. On 24th 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 to undertake a finger prick blood test for Near-Patient testing for INR levels[6] since Mrs Foster was receiving medication for anti-coagulant therapy. It was the first time that this nurse had visited but she was aware that Mrs Foster had dementia and was receiving visits four times daily from a home care agency. The nurse gained access to the property via the key safe.
10. On arrival the nurse found Mrs Foster in a collapsed state. She undertook an initial nursing assessment and immediately contacted the GP. The GP requested an emergency ambulance and the nurse remained with Mrs Foster until an ambulance arrived. The ambulance service (SECAmb)[7] was 999-called at 10:36 and arrived at 10:41.
11. The notes indicate that Mrs Foster was in a very poor physical state. She was cold, lying partially off her bed which was sodden with urine and faeces and she appeared dehydrated with cracked lips. The ambulance crew were unable to record a blood pressure or find a radial pulse (wrist) indicating that her blood pressure was extremely low. A second ambulance crew was requested to attend the scene to allow Mrs Foster to remain flat whilst being transported to the vehicle in an effort not to cause any further deterioration to her blood pressure. The second ambulance crew arrived at 10:59 and they left with Mrs Foster at 11:22. Pre-arrival information was passed to Epsom Hospital about Mrs Foster (regarding the presentation of the patient being transported,) in advance of the ambulance's arrival at 11:52.
12. On admission to Epsom and St Helier University Hospitals NHS Trust it was observed that Mrs Foster's temperature was 33, her blood pressure 129/77, pulse

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

[5] Adults Integrated Solution (AIS), is an electronic information system which is a product of the software company Northgate.

[6] Near-Patient testing is the organised monitoring for the adverse side-effects of drugs close to the patients home. The INR (International Normalised Ratio) test relates to the 'stickiness' of blood.

[7] South East Coast Ambulance Service (SECAmb)

98, respiration rate 22, and her blood glucose score 18[8]. A neurological assessment showed Glasgow Coma Scale 11/15[9]. A provisional diagnosis of metabolic acidosis, urinary sepsis with severe dehydration was established in A&E. An ECG recorded fast atrial fibrillation. A peripheral cannula was inserted and intravenous fluids commenced, a sliding scale of insulin was prescribed and bloods taken for analysis. A skin assessment identified broken areas on shoulders, back and sacrum. A urinary catheter was inserted and electrical warming blankets applied. A 'do not attempt cardiopulmonary resuscitation' (DNAR) order was signed and dated by the consultant physician in A&E.

13. Mrs Foster was transferred to a ward and during the next few days there were further investigations involving the medical team, a diabetic nurse specialist and a physiotherapist. A care plan was agreed and Mrs Foster received nursing care, specialist equipment and medications. She remained drowsy but rousable throughout. She was visited by her friend Ms Penston and the senior operational lead for Surrey ASC at the hospital.
14. A computerised tomography (CT) scan revealed right frontal infarct of the brain and she was referred to the stroke team. The consultant reviewed the care plan and medications. As a result Mrs Foster was seen by a neurological physiotherapist and a speech and language therapist.
15. A review on 1st February noted that Mrs Foster was eating and drinking well with support, aware of her surroundings but was drowsy with intravenous fluids in situ. A joint neurological physiotherapy and occupational therapy assessment was undertaken to establish her future needs in the community.
16. Over the next three days Mrs Foster continued to be cared for according to the care plan with daily reviews by the medical team. Despite the recorded progress she began to deteriorate while still remaining drowsy. The DNAR order was reviewed. At 7:00am on 4th February the nursing staff called the junior doctor for an urgent review. At 7:45am Mrs Foster died. The doctor attended, certified and referred Mrs Foster's case to the coroner. The death certificate, after post mortem, stated pulmonary thromboembolism and deep vein thrombosis. The coroner is yet to determine the precise cause of death.
17. The multi-agency safeguarding procedures were invoked shortly after Mrs Foster's admission to hospital by Central Surrey Health, South East Coast Ambulance Service and Epsom and St Helier Hospital. A senior strategy meeting was held on 30th January 2013 which established this Serious Case Review (SCR) prior to Mrs Foster's death.
18. On 24th January the district nursing service made six attempts to contact Carefirst24 - the agency Mrs Foster engaged to provide her with essential care and support. Eventually their internet search established that the company was no longer trading

[8] This is a high score – Mrs Foster had type 2 diabetes

[9] The Glasgow Coma Scale is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale). Wikipedia accessed 22nd July 2013

and Surrey Adult Social Care was informed. They confirmed that Carefirst24 were no longer trading.

19. The records kept in Mrs Foster's home by Carefirst24 showed a final entry on the afternoon of 15th January 2013. She had apparently not received any care services for almost nine days. This SCR concerns the origins, planning, conduct and aftermath of the actions that resulted in Carefirst24 ceasing to trade.

About this Serious Case Review (SCR)

20. The SCR was commissioned by Surrey Safeguarding Adults Board (SSAB). It was overseen by a panel (see Appendix C for membership) 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:
    - Care Quality Commission
    - Central Surrey Health
    - Epsom and St Helier University Hospitals NHS Trust
    - Home Office Crime Directorate Immigration Law Enforcement (was UK Borders Agency)
    - Independent General Practitioner
    - London Borough of Sutton
    - Metropolitan Police
    - Mole Valley District Council, Community Alarms
    - South East Coast Ambulance Service NHS Foundation Trust (FT)
    - Surrey and Borders Partnership NHS FT
    - Surrey County Council, Adult Social Care
    - Surrey Police

21. The SSAB protocol sets out three purposes for an SCR. These are:
    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.

22. 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 Mrs Foster's 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.

23. The terms of reference agreed for the IMRs were:

Between January 2006 and 4th 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

24. 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[10]. She was said to enjoy travel, bridge, the theatre, tennis and other sports.

25. There was an enduring power of attorney (POA) in place dated 24th April 2006 concerning her financial matters. It was jointly held for Mrs Foster by her friend Ms Penston and Lesley Pond (a colleague of her solicitor, Mrs Grant). Mrs Foster had put this in place in 2002 as part of her will instructions after taking best practice advice from her solicitor. One of the original joint POAs had passed away. This was for financial and property matters and was registered in 2007. The solicitor dealt with financial affairs and Ms Penston undertook liaison with the care agency. They met every 6 months[11]. Ms Penston said that the care agency Carefirst24 would always get in touch with her when something needed to be done[12].
26. Ms Penston described Mrs Foster as a gregarious person who would sit down and chat with anybody[13]. She was also described as fiercely independent and becoming increasingly reclusive in later life – refusing to see her friends.[14] 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. Ms 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[15].
27. Mrs Foster has an older sister who lives in a care home in Kent[16].
28. 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 degeneration. She was receiving medication for these conditions and medication for high cholesterol. She had a TIA (Transient Ichaemic Attack or mini stroke) in 2006 from an embolism. The last documented assessment, on discharge from Leatherhead Hospital in January 2012, indicated Mrs Foster was mobile.
29. Surrey ASC knew Mrs Foster from August 2007, when she was referred by her solicitor after what she described as a less than satisfactory discharge from West Park Hospital. A discharging psychiatrist also made a referral in early September because of her need for support. This was after in-patient mental health treatment over a four-month period. At that time, she was described as suffering from depression and was also not eating properly and was confused. Mrs Foster agreed to an assessment on the 5th September 2007. This resulted in a personal care package of four visits per day which was put in place from 30th September 2007, by Surrey ASC using the Carefirst24 agency which was based in the LB Sutton. The

[10] Sourced from news items in the Daily Telegraph
[11] Notes of meeting with Ms Penston and Mrs Grant 16th July 2013
[12] Press Association
[13] Ibid
[14] Sourced from news items in the Daily Telegraph
[15] Notes of meeting with Ms Penston and Mrs Grant 16th July 2013
[16] She is aware of Mrs Foster's death but, on the advice of the Care Home Manager as she was in hospital herself, has no further information and is not aware of the circumstances

package was funded for the first 6 weeks by Surrey ASC and then directly by Mrs Foster assisted by her solicitor's colleague and her friend Ms Penston.

30. Following a stroke Mrs Foster was hospitalised at the end of 2011 and into the third of week January 2012. On discharge she became confined to her home. Ms Penston said: she started to become wobbly and Carefirst24 got her a frame (Wheeled Zimmer Frame). She spent most of 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[17]. 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

31. The following represents the pertinent headlines gleaned from an extensive composite chronology prepared for the SCR:

2006

March Mrs Foster had a Transient Ichaemic Attack (TIA or mini-stroke)
She had a community alarm installed after making direct contact with the supplier

May to Nov. Various follow up appointments and CT scan confirm evidence of previous stroke

2007

The year was characterised by numerous medical appointments including continence review, foot screening assessment and eye checks

Complaints of Mrs Foster being neglected at Epsom General were made by Ms Penston and GP receives criticisms. The Independent GP reporting to the SCR panel has read the relevant correspondence and says the matter appeared to be settled and in his opinion is of no relevance to the circumstances of the SCR.

April Mrs Foster was diagnosed by GP as having anxiety alongside various physical symptoms and depression

May Early cataracts and age related macular degeneration were diagnosed

May to Aug. Admitted to the care of consultant psychiatrist – depression with psychotic features
Described in the Independent GP report as a substantial mental illness
Missed podiatry appointments

August Mrs Foster discharged home
Referral from solicitor to Surrey Adult Social Care (ASC) related to discharge – depression, not eating and confused

September Psychiatrist also referred to Surrey ASC and Mrs Foster agreed to an assessment

[17] Notes of meeting with Mrs Penston and Mrs Grant 16th July 2013

	After various referrals and re-referrals an assessment was completed on 17th September. Mrs Foster confirmed as self-funding. The care package was agreed on the 19th to include help with dressing and medication prompts Various to-ing and fro-ing to refine the care package with additional support from the Community Mental Health Team, Community Support Worker (CMHT, CSW)
October	Frequent contact from Surrey ASC and CMHT, CSW
November	Enduring Power of Attorney registered with the Office of the Public Guardian[18] Mrs Foster needed a continence assessment as she was experiencing double incontinence Regular and frequent contact from CMHT, CSW
December	Regular and frequent contact from CMHT, CSW Various telephone dialogues took place between agencies about the adequacy of the care package. There was an out-patients review where the psychiatrist reduced medications. The Independent GP report says: the combination of drugs suggests to me that the patient had really quite serious mental disorder. It is confirmed that ASC was monitoring and that Mrs Foster was self-funding. There was a consideration of possible respite care with an aim of longer term residential care.

2008

January	Continence assessment completed for Mrs Foster. A review took place on the 10th which looked at day care as Mrs Foster did not want residential care. There were continued and regular home visits from the CMHT, CSW A referral was made to a day centre and a telephone discussion took place with the solicitor about the costs. Mrs Foster attended a day centre once but was said to be resistant.
February	There were continued and regular home visits from the CMHT, CSW. On the 21st a medication review took place which reduced the medications and recorded that the care package is working well
March	Mrs Foster was diagnosed as having vascular dementia by her GP. The GP received a letter from both people with power of attorney querying whether medication might be causing incontinence. He and psychiatrist think not but run checks. Both professionals requested to be advised of changes in Mrs Foster's medical condition. Community alarm was disconnected as client does not want it. There were continued and regular home visits from the CMHT, CSW A review took place on 18th

[18] The Office of the Public Guardian was established on the 1st October 2007 replacing the Public Guardianship Office

	The solicitor made telephone contact with Surrey ASC communicating concerns from Ms Penston about whether the medications were working
April	There were continued and regular home visits from the CMHT, CSW Various telephone communications took place between Surrey ASC/CMHT/solicitor and Ms Penston. A planned review was postponed from 29th April to 27th May. The Care Manager[19] advised, without recorded explanations, that reviews are usually annual but Mrs Foster will have quarterly reviews[20] On 22nd CMHT undertook a review.
May	The postponed review took place on 27th There were continued and regular home visits from the CMHT, CSW
June	On 26th Ms Penston paid an outstanding bill for the Community Alarm and requested re-installation There were continued and regular home visits from the CMHT, CSW
July	The Community Alarm was re-installed on 1st There were continued and regular home visits from the CMHT, CSW
August	A continence clinic appointment requested in April is cancelled and rebooked for September – in the event Mrs Foster did not attend There were continued and regular home visits from the CMHT, CSW
September	Nothing recorded
October	CMHT were discussing discharge planning from their service for Mrs Foster
November	Nothing recorded
December	There were continued and regular home visits from the CMHT, CSW

2009

January	Nothing recorded
February	One home visit from CMHT, CSW
March	Mrs Foster was discharged from CMHT and a letter sent to the GP explaining the rationale. Surrey and Borders Partnership NHS Trust IMR indicated that the rationale was stabilisation of Mrs Foster's mental state, medication and implementation of community care package
June	Community Alarm test
August	26th review – no details
November	ASC transfer summary – manager signed off (no further explanation provided)
December	Community Alarm test

2010

February	Podiatry check up at GPs – diabetic foot assessment advice given

[19] A Care Manager in Surrey ASC at the time was a qualified social worker, nurse or occupational therapist

[20] It is possible that the reference was to the intention of the service, at the time, to make quarterly contacts – three by phone and a 'review'. The report analysis discusses the question of reviews.

March Community Alarm test
April Community Alarm anxiety call
July Community Alarm test
August Community Alarm error

2011

Community Alarm test calls throughout

March ASC noted that review is very overdue.
It was arranged for the 8th and carried out. No outcome recorded

Carefirst24 applied for licence to employ migrants

May ASC transfer to Reigate and Banstead where it was noted that a review is due during 2012

June ASC opened to In Touch team[21]

July Carefirst24 granted A rating sponsor licence[22] to employ skilled migrant workers

November CQC brought inspection forward because of a safeguarding alert (The case of LS investigated by LB Sutton). Up until here the chronology notes are all positive about CQC inspections.

December Mrs Foster taken to A&E on the 11th after 999 call from carer at the scene. It was determined that she had suffered pulmonary embolus (clot to the lungs). On 28th Mrs Foster was discharged and transferred to Leatherhead rehabilitation hospital. During the stay she requested to be left alone and not to be disturbed. Whilst this was respected it did appear that consequent care planning was left wanting.

CQC inspection of Carefirst24 shows it to be compliant with all outcomes inspected.

2012

January CQC/Sutton safeguarding enquiry related to a Carefirst24 client (TC)
Mrs Foster discharged home on 23rd to agreed care package from Carefirst24 and district nursing support. She was able to mobilise alone (Score14)[23] and independent in the activities of daily living

[21] In Touch is a professional telephone-based service for older people that is free of charge. It was launched in 2008 and is now operating across the county. The service is aimed at people who would benefit from professional support, e.g. people who can pay for their own care and carers who are not in receipt of a Surrey County Council service. The In Touch Team provides support and information to help older people live independently at home. Requests from Surrey residents are broad, ranging from finding a suitable cleaner or resource centre, finding a befriending service, asking for financial advice about benefits to which they may be entitled, transport information, a vet for their pet, or seeing if there is a meals on wheels service available in their area (Extract from staff guide applicable at the time – the guidance has been revised in March 2013)

[22] UKBA award an A rating to employers where they consider there to be no evidence of abuse and think all the necessary systems are in place to meet employer's duties.

[23] Scores of 14 and over on the Elderly Mobility Scale (EMS) generally mean that *these patients are able to perform mobility manoeuvres alone and safely and are independent in basic ADL (activities of daily living).*

	On 24th she self-removed a urinary catheter with the district nurse recording a subsequent discussion involving the patient and her choice. (They assessed Mrs Foster as having capacity and able to make her own decisions and choices.)[24]
February	Considerable and detailed involvement of district nursing recorded
March	Surrey ASC review due on 8th March but not held – no reason recorded
April/May	District nurse INR testing
June	In Touch team closed Mrs Foster case on 13th - no explanation documented Pressure sores treated by district nurse after request from carer. Various nursing actions ensued including for fluids, nutrition, skin, continence, positioning and posture.
July	District nursing visits increased to include wound management Community Alarm test Surrey ASC re-opened Mrs Foster case to In Touch team – no explanation of purpose. UK Borders Agency/Home Office make pre-arranged visit to Carefirst24
August	Continued substantial district nursing support for wound management and INR testing Community Alarm test
September	CQC/Surrey safeguarding enquiry related to Carefirst24 client (VS) Continued pattern of district nurse visits, alarm tests and eye check at outpatients
October	On 31st Community Alarms called ambulance as carer thought Mrs Foster has had a stroke. She was taken to Epsom General Hospital A&E where she was diagnosed as having a urinary tract infection (UTI) and treated with intravenous antibiotics.
November	Mrs Foster was discharged home on 1st (the following day) On 4th there was a false alarm that at first suggested an ambulance was needed but is recorded as a Community Alarm fault INR testing continued weekly On the 24th a whistleblower alleged illegal working and practices at Carefirst24
December	CQC/Sutton safeguarding enquiry related to Carefirst24 client (MS) From 12th to 20th Immigration Field Officers were investigating Carefirst24 for corroborative evidence. The Director of the agency denied any wrong doing. On the 20th Mrs Foster was admitted to hospital via ambulance after indicating to the district nurse and carer she did not feel well, having nausea and showing more confusion than normal. She remained in hospital for less than 24 hours and was treated for UTI. The A&E doctor

[24] Central Surrey Health IMR

checked with the GP about return home who indicated it would be fine as long as the care package was in place.

On 21st there was further whistle-blowing to CQC about illegal working at Carefirst24 – alleged employment of foreign students with no visas – this was referred to UKBA/Home Office

A Safeguarding Strategy meeting was held by LB Sutton on 28th and a subsequent conference on 4th January 2013. This involved a Care Manager from Carefirst24 and was to consider anonymous allegations via CQC of illegal working and malpractice. The concerns of the 28th meeting centred on 5 illegal student workers with false papers and their possible contact with vulnerable people in Sutton, Surrey and in hospitals.

2013

January

INR testing of Mrs Foster by the district nurse took place on the 3rd and on the 10th when the district nurse reported that the care worker was friendly and helpful and was talking to Foster when she arrived. She does not recall seeing a community alarm. The flat was clean and tidy she had no concerns.

An immigration warrant was executed on 6th in respect of the whistle-blower who were themselves confirmed as an 'overstayer'. Agreeing to leave the country they made various allegations against the Director of Carefirst24[25]. Between 7th and 9th records show that there was substantial coordination activity between LB Sutton/CQC/UKBA-Home Office/Metropolitan Police and Surrey CC.

It was on 9th January that Surrey ASC identified 13 funded service user's names of Carefirst24, as it had become clear that action would most likely ensue that would lead to closure.

On 11th and 14th January LB Sutton convened Safeguarding meetings. The key safe code and client list secured from the whistle-blower were available at the meeting. A decision was taken to coordinate the change-over of support from Carefirst24 to other agencies with the police and UK Border Agency investigation[26].

The Safeguarding meetings made arrangements, amongst other things, for the continuing care and support of Carefirst24 service users when the planned raid was executed on 15th by warrant. A manager from Surrey ASC was present. The records are clear that the first priority of

[25] In the event they were detained because of potential involvement in criminal activity
[26] LB Sutton IMR

all parties was to seize the current client list of Carefirst24 and make it known to the relevant local authority. Thereby privately funded service users could be identified and offered support, advice, information and alternative options for service provision.

By midday on 15th January Mrs Foster's name and details appeared on the lists seized in the raid and she was identified by Surrey ASC as being known to them (the AIS reference number is specified). Surrey ASC issued a request to identify a named person and contact the group of people including Mrs Foster today and offer advice and provide a list of alternative providers[27]. Just after 5:30pm Emergency Duty were advised appropriately.

The Surrey ASC information system (AIS) records indicate that a telephone call was made to Mrs Foster on the 16th. The record says there was no reply. The entry was made on the 25th January and there is no indication of why the call was left to the 16th rather than being made on the 15th as requested. (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 across a three week period including 14th – 16th January 2013. Mrs Foster's phone did not have an answer-phone facility but the police have confirmed there were no incoming calls from any relevant party. The SCR panel have made a recommendation about this and concluded it should be the subject of further Surrey County Council investigations.)

The records are extensive from all agencies around these dates but, as there appears to be no disputing the key facts, the detail becomes unnecessary.

In summary:

- The raid on Carefirst24 was planned with all relevant agencies participating, including Surrey Adult Social Care
- Clients, where it was known that Surrey was paying, were identified in advance and their needs met.
- The raid was planned with the priority of protecting service users to the forefront. A list of privately funding Surrey residents was made available to ASC around midday on the day of the raid. Mrs Foster's name and contact details were on that list and a request to offer support, advice, information and alternative provision that day was made.
- In Surrey those arrangements were successfully implemented for everybody other than Mrs Foster.

[27] Surrey ASC IMR chronology reference 114 and 115

- All parties believed that all service users' needs had been cared for until 24th January when Mrs Foster was discovered by a district nurse calling to undertake an INR test.

Ms Penston visited Mrs Foster deliberately on the 17th January as it was a day the care workers bought food. She had previously been on the 10th when she had seen that freezer was clogging up. She describes the scene she encountered as ordinary. She collected and opened the mail, noting that Mrs Foster had missed a hospital appointment – something she followed up with an email to the care manager at Carefirst24. She noted it being warm, an empty microwave meal container on the draining board, a light on the washing machine and that Mrs Foster was not in her chair in the lounge. She went into the bedroom to see if Mrs Foster was okay. She was on the bed turned away on her side. Ann asked her if she was okay and Mrs Foster grunted back which was taken to mean – yes. This was not untypical and assumed to be ordinary and okay.[28]

On 22nd January, the GP attempted to make a planned drop-in[29] visit to discuss Mrs Foster coming off Warfarin, a dementia review and diabetic check. He did not receive a response and did not have the key safe number. He requested the surgery receptionist check with district nursing whether there were any concerns or hospital admissions. She made the checks and rang him back later advising him of the key safe number, that she had got no replies from telephone calls to Mrs Foster and the care agency and with the information that district nursing had visited on 10th (no concerns) and were due to visit on 24th. By this time the GP was away from the property and as there were no pressing concerns – he did not know that the carers were not visiting any longer - he decided to wait until 24th.

On 23rd January LB Sutton convened a Safeguarding meeting that was poorly attended. It was advised that all clients had been catered for. The Surrey ASC representative sent her apologies with the message: Update from Surrey is that we have transferred care for all those people we knew about and have not being (sic) contacted by anyone else following Police intervention with agency.

On 24th January, shortly after 10:00am, Mrs Foster was discovered by a district nurse on a routine visit having gained entry via the key safe number. She was admitted to A&E in the manner and condition described above.

[28] Notes of meeting with Ms Penston and Mrs Grant 16th July 2013

[29] This is the phrase used in the Independent GP's report, it is described as an *opportunistic* visit in the Central Surrey Health IMR

The records are extensive across and between agencies. They include Surrey ASC realising that the client file record (AIS) said they had made an unanswered telephone call[30] to Mrs Foster and the implications. On 25th January the senior operational lead (locality team) in Surrey recorded:
T/C was made to Mrs Foster on 16.1.13, no reply. "Unfortunately I did not put this note on AIS[31] at the time I rang as I was busy setting up emergency care for other service users who had the same care agency. I did ring this lady but there was no reply. I assumed which I probably should not have done that as a self-funder she was able to arrange her own care, in hindsight this lady should have been visited, this was an error on my part"

On 28th the senior operational lead for Surrey at Epsom Hospital visited Mrs Foster. She was said to be improving but with grade 2 sores[32]

On 30th the senior manager for safeguarding convened a strategy meeting that determined there should be an independently led SCR. It also resulted in a further check; one had already been undertaken following the reporting of Mrs Foster's admission to hospital, that all other self-funders affected by the raid had new service providers. Surrey Police did not attend this meeting as they considered the circumstances of the case did not meet the criminal threshold for Wilful Neglect/Ill-treatment.

February Mrs Foster appeared to have rallied briefly on 1st February – sufficient to receive preliminary assessments for a possible return home – but then the team manager at the hospital recorded that Mrs Foster transferred to another ward due to possible stroke - not medically fit and very confused

Mrs Foster died at 7:45am on 4th February.

[30] Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.
[31] Adults Integrated Solution (AIS), which is a product of the software company Northgate.
[32] Grade 2: Partial-thickness skin loss or damage involving epidermis and/or dermis. The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater http://www.judy-waterlow.co.uk/pressure-sore-symptoms.htm accessed 7th July 2013

Analysis of the IMRs

32. IMRs contain detailed scrutiny of events and actions in an effort to understand the causes of failure and prevent re-occurrence. Additionally they can indicate what has happened that is positive. With Mrs Foster some IMRs have a more direct bearing on understanding why she did not receive care and support for nine days than others. The analysis will focus on:
    - Whether Mrs Foster was receiving appropriate care and support prior to the 15th January 2013. (It is possible that she should have had a care and support plan with additional or different elements to those provided by Carefirst24)
    - The management of the actions that lead to Carefirst24 ceasing to trade
    - How it came to pass that Mrs Foster did not receive advice, information and alternative care and support when Carefirst24 ceased to trade

Fulfilment of agency and professional roles and responsibilities

33. Surrey ASC did not have any contractual arrangement with Carefirst24 in respect of Mrs Foster. The main role and responsibility was that of assessment, care planning and review. When the initial referral was made in April 2007 they assisted Mrs Foster to specify her needs and supported her in securing a privately funded care agency (Carefirst24).
34. In 2008 three reviews were held, in January, March and May. At the latter the care manager advised, without explanation of the frequency, that there would be quarterly reviews[33]. Then there appeared to have been no involvement by Adult Social Care until August 2009 when a further review was held. This recorded some improvement in Mrs Foster's general condition and set a date for the next review of 30th July 2010. There were then no further records until March 2011 when an entry says the review was very overdue. This resulted in a review being undertaken on 8th March 2011 and a further review scheduled for the same date in 2012. There is no record of the scheduled March 2012 review having taken place.
35. The Surrey ASC IMR indicates that from late 2009 there was some confusion about whether Mrs Foster's case was open or closed and of which 'In Touch' team she was a client. The records are sparse with no actions other than the March 2011 review. The panel were advised that Mrs Foster was a client of the In Touch service, which was hosted within the Long Term Team from January 2011, and that in June 2012 the service was transferred to each of the Locality Teams.
36. Surrey ASC did not undertake annual reviews[34] in respect of Mrs Foster. Whilst it is recognised good practice, there is no statutory duty to undertake such reviews. It was not clear to the panel whether Surrey policy is to undertake reviews to such a

[33] It is possible that the reference was to the intention of the service, at the time, to make quarterly contacts – three by phone and a 'review'.
[34] In relation to reviews, section 47 of the NHS and Community Care Act 1990 imposes a specific statutory duty on the local social services authority in regards to undertaking assessments of need and this is supported by DH Guidance. The primary legislation makes no reference to "reviews" but, the DH Guidance addresses the local authorities' responsibilities in regards to reviews. The review guidance does not distinguish between "self - funders" and others in receipt of services. Rather, flexibility of approach is emphasised with particular attention being paid to those who lack capacity.

specific minimum annual frequency and if so for which cohort of their customers[35]. What emerges from the chronology and Surrey IMR is that practitioners and their managers had created an expectation[36] that annual reviews take place for Mrs Foster. Her changing health and care needs justified multi-disciplinary review and responses.

37. At the point when it was definitively known that the anticipated raid on Carefirst24 would have an impact on Mrs Foster's care package - this was midday on 15th January 2013 at the latest – 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. Professionally, the worker involved seems negligent in not following up the telephone call[37] she recorded several days later as being made on the 16th. 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. The answer to a simple question – did you speak to Mrs Foster? – would have prompted a follow up.
38. The other agencies involved in the care and support of Mrs Foster fulfilled their roles and responsibilities much as expected. There were some short-comings and/or queries as follows:
    - The GP could have followed up his unanswered visit on 22nd January but having sought assurances and ascertained that Mrs Foster was due a nurse visit on 24th, judged not to do so. The practice receptionist did try to call Mrs Foster and Carefirst24 on the telephone but was unsuccessful. It would improve practice if all visiting professionals ensured the documentation they take on visits keeps them informed of key safe codes
    - Mrs Foster's two admissions to hospital in October 2012 (2 days) and December 2012 (24 hours) for UTI after the lengthy stay for pulmonary embolus from 11th December 2011 to 23rd January 2012 ought to have prompted a multi-agency reassessment and/or an assessment for Continuing Health Care or for the Virtual Ward. As a minimum the situation merited at least a check with Adult Social Care and/or referral. In the event

[35] See paragraphs 83 and 84 below in Lessons Learned for clarification of Surrey ASC policy on 'reviews' and its future intentions to offer further clarity.

[36] The revised Surrey IMR 2nd 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.*

[37] Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.

she was discharged back to the same care package[38] - missing opportunities for more formal review. It has to be said that although the care package was deemed successful by all parties there was an absence of care coordination between professionals and agencies which dated from the review in August 2009

- The CMHT discharged Mrs Foster in March 2009 which meant she no longer had the regular visits of a community support worker. One of the roles of the community support worker was to seek to reduce isolation (hence the day centre referral) and to engage Mrs Foster in activities – they listened to music together in the home. 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.
- Surrey Police initially determined that Mrs Foster's case, although a serious mistake, did not meet the criminal threshold for Wilful Neglect/Ill-treatment. This was not seen as an intentional or deliberate act. They therefore decided there was no necessity to attend the safeguarding meeting of 30th January or to investigate. Following the death of Mrs Foster, on the instigation of the Coroner, further enquiries were undertaken by Surrey/Sussex Major Crime Team to determine whether the failure to transfer Mrs Foster to alternative care provision constituted gross breach of a duty of care amounting to a criminal offence. 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[39].

39. The agencies engaged with the enforcement of immigration law in respect of Carefirst24 should not be faulted. The Home Office, Metropolitan Police, LB Sutton and CQC worked well together involving Surrey ASC in planning and taking appropriate action, clearly conscious of the priority to identify and ensure the safety of potentially vulnerable people from the outset.
40. London Borough of Sutton held a safeguarding meeting on 8th February 2013 to review the operation, amongst other matters. It is to be hoped that the lessons learned can be documented and shared rather than being overshadowed by the death of Mrs Foster. Available good practice in collectively taking enforcement action that closes a social care service provider is valuable. That it did not work for Mrs Foster is not the fault of the enforcement agencies. The arrangements Surrey

[38] This is in line with policy at Epsom and St Helier University Hospitals NHS Trust where for short stays (24-48 hours) unless circumstances have changed or health has declined, the current community care package is re-commenced on discharge.

[39] *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.*

ASC put in place should have worked and even though Surrey now have a specific protocol to manage such circumstances, it still requires people to follow the protocol.

41. With hindsight there were some warning signs about Carefirst24:
    - They did not pass the Surrey ASC procurement quality standard to be on their framework contract in 2012. Arguably, Mrs Foster and her attorneys should have been advised of this. Although as private funders they had the right to whatever service they chose. Surrey ASC, itself, decided not to disrupt existing arrangements for the people it was funding directly.
    - 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 first of a subsequent cluster of four. These were referred to LB Sutton (3) and Surrey ASC (1). None of these were substantiated.
    - The issues with migrant workers were beginning to emerge in late 2012 through a whistle-blower (themselves transpiring to be an 'overstayer') but concrete evidence was not forthcoming. The Immigration Service gave the licensee/employer firm advice before resorting to the raid.
    - 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. There is always a need for safeguarding meeting chairs to ensure that right people attend meetings, at the right time and that the right actions are clearly recorded.
    - 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. The Care Quality Commission advised that it is currently taking legal advice and action to cancel the registrations for the registered provider, Carefirst24 Limited, and the owner/registered manager Mr. Mahen Causseyram.

Adequacy of assessments, decision-making and planning

42. Mrs Foster's initial assessment, care planning and reviews processes worked well. The resultant care package was deemed successful and was supplemented until April 2009 by a community support worker from the CMHT. It was around this time that scheduled annual reviews did not take place as intended and re-evaluations of Mrs Foster's needs were not undertaken in line with her changing condition or at the frequency best practice and professionals appeared to expect. The review in August 2009 indicated that all was going as planned. There was a further review in March 2011 and after that the key care management processes were absent as far as Surrey ASC were concerned. At the time of her death Mrs Foster had not had a review for 22 months.

43. The GP kept oversight of the health care assessment, decision-making and planning. There were health focussed reviews and Mrs Foster benefited from monitoring by district nurses with 36 visits taking place between 24th January 2012 and 24th January 2013. 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.
44. There were three opportunities to trigger a multi-agency/professional re-assessment of needs in 2012. The first was on discharge from Leatherhead Hospital at the end of January. Then there were two admissions to Epsom Hospital A&E for UTIs in October and December. If multi-professional re-assessment or referral to Adult Social Care had happened on any one of these three occasions then Mrs Foster may not have been in the situation where she became a victim of her care agency ceasing to trade and the subsequent failure to arrange an alternative. After the latter two admissions it was largely confidence in the existing care package (and perhaps because Mrs Foster was quiet and cooperative[40] and would do as she was told when around authoritative figures such as Doctors[41].) that appeared to facilitate speedy returns home.
45. Mrs Foster's complex mental health and physical needs, plus the fact she had attorneys for financial matters, were surely a strong indicator that mental capacity was a major consideration. Only Central Surrey Health documents an approach to assessment of capacity. Their IMR indicates that the healthcare professionals that visited her deemed her as having capacity and was able to make her own choices. They also observed that she understood and communicated with the care workers. Recordings are positive about the care workers in terms of the quality of their work and their interactions.
46. It is noted that she exercised her choice in not wanting residential respite, day care or to have a urinary catheter. She was involved in her choice of footwear. She clearly preferred not to have visitors or to answer the phone. She did not always engage with professionals. She probably would not have had the alarm if it had not been for Ms Penston. In the event she did not make use of the alarm when left without care for nine days. It was in working order[42] and found on the bedside table next to her bed[43].
47. Turning to the assessment, decision-making and planning, once it was known that the raid would be likely to impact on Mrs Foster's care package, the processes were clearly inadequate. Although there were gaps in the reviews and only intermittent contact after 2008, a basic look at the file (her file AIS file reference number was known on 15th January) before attempting to contact Mrs Foster would have revealed her history of dementia, anxiety and depression with a number of physical

[40] Central Surrey Health IMR says: *Throughout this review Mrs Foster has been described as quiet and cooperative, someone who chose to communicate by using a few words. This may be a significant factor that in view of the fact she was perceived as someone with a quiet personality her vulnerability and needs due to her dementia were not fully met.*

[41] Notes of meeting with Ms Penston and Mrs Grant 16th July 2013

[42] The Forensic Examiner who tested all the electrics and the personal alarm system on 8th February 2013 states that he tested the alarm and it 'operated every time' from different locations in and out of the flat. He has taken various photos to be seen in conjunction with his statement and these show the pendant on the bedside table in the bedroom next to where Mrs Foster was found.

[43] Ms Penston said it was there when she went into the flat after Mrs Foster's death and Surrey Police confirmed this is where it was found.

health problems. It would also have revealed the names of her two friends who had power of attorney (Mrs Grant and Ms Penston) who could have been contacted when Mrs Foster did not reply to the senior operational lead's telephone call[44]. On the face of it this is not professionally defensible.

48. The assessment, decision-making and planning of the agencies engaged in enforcement of the immigration laws was adequate.

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

49. 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. Regular support input from the CMHT ceased in 2009 once Mrs Foster's mental health and medication had stabilised. District nursing provided a regular at home support service after Mrs Foster was discharged from a lengthy hospital stay and rehabilitation in late January 2012. This included INR testing, continence services and wound (pressure sore) management. Throughout and until 15th January 2013 Carefirst24 provided four visits a day and Mrs Foster's attorneys contributed to the overall package of support that enabled her to remain at home.
50. Mrs Foster appears to have developed type 2 diabetes and this is noted on the review in March 2011. The outcome of that review is largely positive suggesting that the package was working well at that point. All in all Mrs Foster's care and support constituted a good example of what can be provided in a person's own home. It is of note that at one stage the professionals were considering the possibility of residential care – an option that Mrs Foster refused.
51. Surrey ASC knew[45] 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.
52. Given Mrs Foster's complex needs in terms of physical health, mental health and care requirements it was essential that an alternative care provider was in place straight away when Carefirst24 ceased to operate. This need was not met by Surrey ASC either through provision of information and advice or, given the short notice, arrangement of an alternative.

[44] Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.
[45] Surrey ASC IMR chronology entry 63

Effectiveness of information sharing

53. 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 the withdrawal of the CMHT and the move to the 'In Touch' team. After March 2011 information sharing became ineffective and, as far as Surrey ASC was concerned, ceased. The 'In Touch' team provided no practical benefit[46] to Mrs Foster.
54. In the last year of her life Mrs Foster's service revolved around the GP, the district nursing service and Carefirst24. There is no reason why this should not have continued successfully despite the absence of the aforementioned reviews. Information was not shared about the hospital admissions in late 2012. Whether this information would have prompted ASC to review is not known. Best practice would have been to share the information and undertake a review. Thereby care coordination could have been improved, possibly because of Continuing Health Care funding being agreed and/or consideration of Mrs Foster for the Virtual Ward[47]. This might have meant either a different response to the cessation of Carefirst24 and/or a more rapid realisation of the service failure.
55. Central Surrey Health IMR illustrates information sharing - both effective and ineffective. They concluded that they were unable to provide the care coordination and a more holistic approach to review and care planning which they might have wished to see in place. They describe their work thus: Many people choose to be cared for at home which has resulted in an increase in patient acuity[48] and the requirement for the service to manage more patients with complex long term conditions. All the district nurses interviewed expressed the view that this has reduced their capacity to undertake pro-active case management.[49]
56. The communications in Surrey ASC of their part in ensuring continuity of service to Carefirst24 service users were extensive and thorough. Everyone knew what was supposed to happen 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 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.
57. Information sharing and communication of the success in finding alternatives for all the service users was principally effective with the single exception of Mrs Foster. Whilst all other clients were contacted, for whatever reason, the manager of the worker making the unanswered call[50] to Mrs Foster thought (or assumed) that the

[46] Surrey ASC issued revised guidance regarding the In Touch teams on 18th March 2013
[47] Central Surrey Health is funded by Surrey ASC and Surrey Downs Clinical Commissioning Group to provide a virtual ward in the community. This is a model of Community Matrons case managing people with long term conditions. Mrs Foster appears to have met the criteria for this service, although it was in the early stages of implementation in January 2012.
[48] Acuity or Acuteness – the level of severity of an illness
[49] The Independent GP report makes a similar observation about the nature of the patients passing through a typical GP surgery.
[50] Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.

call had been made and that Mrs Foster had been spoken to. This remained the case until 24th January.

58. The information sharing by the agencies undertaking enforcement action of immigration laws was largely effective. It is accepted by both LB Sutton and Surrey ASC that involvement from the outset of an NHS lead may have added to known intelligence.
59. There remain some discussions about what the list of Carefirst24 clients shared at the 11th 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[51]. 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 address and fuller details were on the lists[52] that she was working from. She says it was not until the 15th, when she was supplied with a list after the raid, that the details were apparent. It is important to properly track what happened to client lists from start to finish for Surrey ASC and its residents. It is clear from the Surrey IMR that the initial 13 residents were followed up after they were identified on the 9th. The SCR panel puts forward a recommendation in this respect.
60. As the list had 49 names with 24 already recognised by LB Sutton and 13 by Surrey ASC, it does not seem unreasonable for both authorities to have run a search by name of the remaining dozen clients. This could have lead to Mrs Foster's vulnerability to the closure of Carefirst24 being picked up 2 or 3 days before the actual raid rather than waiting for sharing of the more definitive list on the day.

Impact of organisational capacity and culture

61. Mrs Foster was one of 40,000 self-funding older people living in Surrey. Having created an expectation[53] it is apparent that Adult Social Care did not have the capacity to provide the best practice of care coordination – constituting as a minimum an annual review - for Mrs Foster from 2009 onwards. Whether this was a matter of policy, workload, systems or management is beyond the remit of this review. However, the 'In Touch' team did not serve Mrs Foster's needs.
62. 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[54].
63. 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

[51] In a clarifying letter of 24th 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 15th January 2013*

[52] Surrey ASC IMR

[53] Revised Surrey IMR 2nd August 2013

[54] Central Surrey Health IMR

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. Questions like: was she able to drink enough or mobile enough to get herself a drink could have been asked. The care and support plan could have been revised and fresh guidance supplied to care workers and attorneys.

64. The cessation of Carefirst24 services created a spike in work for Surrey ASC, but it was known this was going to happen. On the day of the raid there were eight additional service users with needs to accommodate – four to the Epsom office and four to the Reigate and Banstead office where Mrs Foster's name appeared. Epsom dealt with its four people and Reigate dealt with three, but not Mrs Foster. The worker acknowledged that she had not followed up an unanswered telephone call[55] to Mrs Foster in a file entry made on 25th January. 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.
65. That Mrs Foster's file was not consulted, even on a cursory basis, prior to attempting any telephone contact, is a basic omission alien to good social work practice. The management request was that such contact be made today - the 15th January 2013 – yet the worker recorded (on the 25th January) that she made the call[56] on the 16th without any explanation for the delay. She did record that there was no reply[57] but once again omitted to consult the file. A third omission was not to follow up by either a call to those with power of attorney (the contacts were on file) or by a home visit. It appears that the practitioner then compounded the omissions by not making it abundantly clear to her manager that she had not made any contact with Mrs Foster.
66. The worker in question appears to have acknowledged, after the event in her file note, what she had not done and could yet have mitigating factors to share.
67. She then goes on to make a relevant point saying that she assumed that 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.
68. 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[58] and it recommends mechanisms for monitoring and controlling workloads.

[55] Further enquiries have since established that neither Surrey County Council nor Mrs Foster's telephone systems contain records of such a call being made.
[56] Ibid
[57] Surrey ASC IMR chronology entry 123
[58] It was noted by the panel that the other areas in Surrey ASC did not delegate the task from Team Manager

69. 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[59] as Surrey are doing could ensure this.
70. The SCR panel suggests that the organisational health checks[60], it was advised Surrey ASC had recently put in place, are used to secure this assurance. These contain four relevant themes – a healthy workplace, using feedback to improve services, effective workload management and having the tools to do my job.
71. Furthermore, the evidence is that law enforcement professionals did their job with due care and prioritised the care of people over the criminal process
72. Nor, in the case of Mrs Foster, was Surrey contracting out services as a saving to agencies with only profit in mind. The funding of Mrs Foster's care was private. Home care employers in London and the South East continually strive to recruit and retain a competent workforce[61]. The income from the public purse is said to be barely adequate to cover the local pay rates. However, it is unusual, in the experience of the SCR panel that a registered home care provider, like Carefirst24, should turn to unlawful migrants – potentially putting their customers at unknown risks of harm. It is not known what Mrs Foster was paying for her care but it is probable that it was more than if she had been publically funded.

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

73. The multi-agency policies and procedures for adult safeguarding appear to have been followed at all times.
74. Surrey ASC has a revised Provider Failure Protocol in place as a result of the failings with Mrs Foster. This now includes domiciliary care as well as residential care. Like the 'large scale investigation' procedures there would be merit in this being a multi-agency protocol. If the lead safeguarding nurse for NHS Surrey had known about the enforcement action appertaining to Carefirst24 in advance, as Surrey ASC did, then it is likely that Central Surrey Health would have been informed. They in turn could have alerted district nursing thereby possibly averting the suffering endured by Mrs Foster.

Lessons

75. There are lessons spelled out in most of the agency IMRs. This SCR invites the Surrey SAB collectively to consider lessons on:

[59] 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

[60] The organisational health check emanated from the national social work task force and in Surrey ASC is being implemented jointly with trades unions.

[61] Skills for Care, Regional Reports 2012 www.skillsforcare.org.uk accessed on 18th July 2013

- **Communication, data and information**

76. The lesson is that 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.
77. In adult safeguarding one of the challenges is spotting and using data and information that indicate that things are starting to go wrong and then are going seriously wrong. This is something that can be aided by systems, but requires human interactions to share worries and concerns.
78. With Carefirst24 there were early indications that things were going awry, but not all the pieces came together in one place. The SCR panel considered the minutes and actions from the meetings in LB Sutton were not always sufficiently clear to conclusively determine what actions were expected. Once it was obvious that action was required, the data and information were communicated according to plan. That it was not acted on in the case of Mrs Foster was neither due to absence of communication nor lack of data and information.
79. With Mrs Foster there were also early indications that her care plan was probably not meeting all her physical, mental health and care needs in the most effective way. 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**

80. Closing any social care service, particularly in crisis, requires planning across agencies. There are a number of guides and studies in respect of residential care[62] but little in respect of home care. As recently as 3rd July 2013[63] the Minister for Care was speculating about whether there was a pending crisis in home care and how it might be avoided and/or managed. 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.
81. Carefirst24 has other lessons to reveal about the financing, regulation, leadership, management and workforce in home care but these are not the subjects of this SCR. In them rests the probable causes of the calamity at Carefirst24 which, according to all reports, provided a good service for Mrs Foster from 2007 onwards.
82. Surrey ASC now has a revised Provider Failure Protocol which has a chapter on the closure (with little notification) of a community services provider, drafted in the light of the mistakes made with Mrs Foster. As observations:

[62] See references
[63] "Tell us how we can improve home care" Guardian Society 3rd July 2013

- 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 that spells out the ASC and health roles. 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[64]**

83. The lesson here is a simple one – make use of the coordination mechanism you have. 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 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 through an annual review process. Initially reviews took place, then they were sporadic and then ceased. An annual review could have led to improved outcomes for Mrs Foster. Up until 2009 the CMHT CSW plugged the gap and from early 2012 district nurses undertook the task.
84. 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 circle of support – not least her GP and in the case of Mrs Foster those with Power of Attorney. This was not the sole responsibility of Surrey ASC but it was their responsibility to check that coordination and review were taking place in the multi-agency context.
85. In clarifying its position on reviews to the SCR panel 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. They went on to say actions such as 'reviews' are carried out in many different ways, including face to face, telephone, meetings etc. Therefore the fact that a 'review' was or was not carried out may not indicate that a particular type of contact was made. Surrey ASC IMR has a recommendation in this respect as does this SCR covering the multi-agency aspects of care coordination.
86. 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. Improving care coordination for the 'frail elderly' and for those with

[64] 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

long term conditions is receiving national policy consideration by the Department of Health at present. The lessons from this SCR can contribute to a developing multi-agency approach.

- **Use of assisted living technology**

87. 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.
88. A review involving those closest might have discussed the possibility of additional technology in the interests of safety and 'peace of mind'. For example, considered use of movement sensors would have alerted when the carers failed to attend and when Mrs Foster ceased to be mobile. Information and advice about what is available and at what cost would have enabled Mrs Foster and her attorneys to consider the options.

- **Access to people's homes**

89. The 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 which does not jeopardise their privacy or safety.
90. As more and more people with increasingly complex conditions receive their health and social care in their own homes the challenge will increase. It is one that can be met with the right mix of the dignity of keeping your own front door, the personalised care plan, judicious use of technology and effective systems of communication and care coordination.

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

91. Mrs Foster funded her care package privately. The SCR is only privy to the information that care was provided four times daily from Carefirst24. The IMRs and other records do not show how many carers attended, for how long or how much she was paying.
92. Again, a review involving those closest, could have considered the pattern of care and support plus the value for money. Perhaps some visits could have been longer to enable activities – such as listening to music which Mrs Foster enjoyed and which the CMHT community support worker had facilitated – others could be shorter as a pop-in safety check or medications prompt only.
93. 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

94. 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.

95. The lesson, as the Care Bill becomes an Act, is that 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.
96. The Surrey ASC IMR reports that the council is in the process of producing a self-funders' strategy[65]. This is to include greater clarity on the role of the "In Touch" service in respect of this group of service users. The lesson is being learned, in practice, as the council successfully makes the shift, as a public service, from dependency relationships imposed on service users to offering both market facilitation and consumer protection roles - at one and the same time. Or put simply: choices of service that are safe are encouraged.

Social work

97. 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 circumstance culminated in a series of professional social work practice omissions.
98. This SCR has amongst its terms of reference questions of capacity, culture and how professionals work together. 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.
99. Surrey ASC, along with other local authority employers, is reshaping their social work service. They are drawing on the work of the Social Work Taskforce – particularly the organisational health check, the professional capabilities framework, the employer standard, and the social work leader's toolkit – to implant professional autonomy and application of the relationship-based skills of practitioners. 'Social Worker' is a protected job title in law – one with regulated standards of proficiency, conduct, performance and ethics. It is a title which should instil pride in practitioners for the roles and tasks they undertake.

• Conclusions

100. 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

[65] During the preparation of this SCR the LGiU published Independent Ageing 2013 – council support for care self-funders. This report has a series of useful recommendations that could inform Surrey ASC self-funders strategy.

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.

101. 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.

102. 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.

103. 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. It is important that Surrey Adult Social Care continue to work to ensure that there are no short-comings that contribute to or make mistakes more likely to happen.

104. 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[66].

105. 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.

[66] It has been confirmed that both the worker and manager involved are subjects of internal disciplinary action by Surrey County Council.

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.

   It is of note that there are a number of IMR recommendations that duplicate or overlap. In particular the Surrey SAB should seek to clarify who is accountable for what actions in an agreed timescale.

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.

   The SCR panel received conflicting information. It is important to understand what happened to ensure that the arrangements for potential service provider failures are as effective as possible and informed by experience.

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

   The SCR panel was troubled by some of the recording encountered whilst undertaking its work. In particular it would expect that all recording is a true and honest representation of the facts, like to emphasise the importance of recording file notes contemporaneously and that safeguarding meeting records should have clarity of actions and accountability

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.

   The SCR panel was keen to ensure NHS safeguarding leads have early involvement in service provider failures as quite often the most regular contact is via health workers and that chairs are clear in their minutes and able to insist on accountability for actions including across local authority boundaries where necessary.

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.

Mrs Foster's quality of life would likely to have been improved and she may have received a service which would not have left her a victim of events if this had been in place.

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.

   Opportunities were missed to share information and make referrals to adult social care that might have assisted improve care coordination for Mrs Foster.

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.

   This appears to be the type of service that could have benefited Mrs Foster.

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.

   It is possible that warning signs about Carefirst24 could have been picked up earlier and shared allowing problems to be averted.

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

   This is a thorough protocol which will benefit from further dialogue and agreement between SAB Partners. Among other things if the approach in the protocol had been applied in the Carefirst24 situation it would have: ensured full involvement of an NHS Safeguarding lead, identified the failure to meet Mrs Foster's needs within 24 hours, required quick follow up meetings, necessitated actions to be effectively logged and have made full arrangements to notify interested parties of the service closure (through telephone, email and internet response messages).

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

    Successful protocols are about people working collaboratively in practice. Professionals from across the disciplines can develop their leadership

capabilities by working together on scenarios such as the closure of a service provider.

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.

    The Surrey IMR recommends effective mechanisms for monitoring and controlling workload. Doing this presents a good opportunity for reinforcing organisational and professional messages. Using the organisational health check will provide a solid understanding of what is working well and what needs improvement.

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

    There was a notable lack of reference to mental capacity, best interests and advocacy in the IMR. On the one hand this may be indicative that these were not salient issues or that the arrangements in place were adequate but on the other it may warrant consideration of a check that training needs are being met across partner agencies.

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.

    Professionals will be able to gain access to people's accommodation when they are needed as a matter of planned routine and in emergencies.

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

    Planned use of technology can assist enhance a care and support plan in terms of monitoring, safety and opportunities for learning and inter-personal interaction

Appendix A: – Recommendations in IMRs

Care Quality Commission

The CQC IMR makes suggestions as follows:

a) The Review Case Conference at Sutton on 23/01/2013 was poorly attended and would have been a good point to evaluate what had taken place and identify any issues that needed be resolved.
b) Commissioners of agencies providing care could request that care providers provide lists of all of their service users including self funding clients. If this could be done, it would be a way of making contact with self funding people in situations where the provider might be closed down.
c) There should be a system of double checking of lists of names of service users affected by similar events.

Central Surrey Health

Along with and action plan the IMR identifies lessons and recommendations under the headings following:

Improve Inter agency communication

a) Improve inter agency communication on a regular basis and not just on a need to know, or ad hoc basis. To develop and implement a system where Community teams have the lead contact details for all care agencies they are working with and ensure this system is current and functional.
b) To communicate on a regular monthly basis and when there are any changes outside of this to operational practice or patient status and ensure that this information is shared with key partners.
c) To ensure that regular interagency communication is maintained and recorded as part of a formalised process. To consider the use of creative approaches to make sure this happens in practice such as conference calls and email updates.

That all information sharing decisions are based on the safety and wellbeing of the person and others who may be affected by their actions

d) To include the key safe access details on all community referrals and for named District nurses to update this and ensure that every GP Practice has a central list of patient access details following patient consent for this.
e) In the case of Mrs Foster had the opportunistic visit made by the GP enabled access to her, interventions would have taken place earlier and may have resulted in a positive outcome.
f) There is one reference to a community alarm for Mrs Foster but there is no clear indication that this was in use or was an integral part of her holistic plan of care and risk management.
g) To raise awareness of Community Alarm systems and include details of this on all community referrals and care plans in more detail. To include a section where Community Alarm systems are recorded as active and checked on discharge

home from hospital in agreement with service users, when they are fitted or reactivated.

Improve documentation so it is person centred, holistic and supports multiple patient pathways

h) The records reviewed did not fully demonstrate that the psychosocial and emotional needs for Mrs Foster were fully acknowledged.

i) The current care planning model in use does not ensure or promote continuity of care between services. The need to develop and implement a model which supports service users and promotes their welfare and transfers between services or where care is shared is essential. The care plans reviewed did not demonstrate that they considered all aspects of Mrs Foster's circumstances and focused on her immediate needs. Her longer term needs, preferences and choices were poorly recorded.

To improve awareness and understanding of caring for people with Dementia

j) More dementia training for Co-owners to maximise the support given to people who are living with a diagnosis of Dementia.

k) Provide greater opportunities for people to be involved in their care and that treatment and support options are explained to them. That families, significant others and advocates are invited to be part of this process following service user consent or if there is an identified need for advocacy.

l) In the case of Mrs Foster, who requested staff did not disturb, her there is no clear evidence as to any further actions that were considered which may have supported her in communicating her views and choices.

m) To promote a culture where patients work in partnership with services that they receive.

Epsom and St Helier NHS Trust

The Trust makes observations and recommendations as follows:

a) They should have established Mrs Foster next of kin and obtained confirmation and documentation of power of attorney for Mrs Foster during attendance at outpatients and recorded in the new healthcare records.

b) The medical team should receive feedback

c) Concerns should be raised as early as possible and information shared appropriately with social services and patient/client GP regarding their failure to attend outpatient appointments.

Home Office Crime Directorate Immigration Law Enforcement

None – the UKBA could not see any further safeguarding actions it could have taken. It suggested that local authorities could undertake closer scrutiny and robust supervision of follow-up actions to eliminate risks.

Independent GP Report

These points are extracted from a section headed 'lessons that can be learned' and paraphrased:

a) Establish how all visiting carers and clinicians have instant access to key safe numbers without the patient's protection and privacy being put at risk - a key safe policy
b) Review patients to make sure none on unnecessary atypical antipsychotics. Mrs Foster was on Olanzapine appropriately to keep her mentally well.
c) Record in more detail, and if possible, before an event like a planned drop-in visit.

London Borough of Sutton

Whilst not making any recommendations as such the LB Sutton IMR observes lessons that have pertinence to the Surrey SAB:

a) The development of effective relationships between organisations, such as that between Sutton Council and Sutton police, both members of the Safer Sutton Partnership, an arrangement in which the council and the police share a management culture and relationship with shared values on the need to safeguard vulnerable adults, leading to joint action taken immediately and effectively.
b) The social work led approach in Sutton meant that responsibility was taken to ensure that people who lived in Sutton but did not have services commissioned for them were safe.
c) There is a need to ensure that information is shared quickly, as shown by the sharing of the client list received on 9th January and the updated client list on 15th January 2013.
d) During the raid on Carefirst24, the UKBA and the police used powers to demand information pertinent to the safeguarding of vulnerable adults. As 'phone calls were received by the Carefirst24 office, the UKBA and the police officers questioned Carefirst24 staff about the calls in order to assure themselves that no one was being put at risk as the organisation was being closed down. The first priority of the UKBA and the police was to obtain a list of all the clients of Carefirst24 so that this could be given to London Borough of Sutton and Surrey County Council as quickly as possible.
e) The sharing of information is necessary but not sufficient in itself for the safeguarding of vulnerable adults. Whilst protocols for information sharing could be established between local authorities, the requirement to share information already exists in safeguarding policies and procedures and duplication is unnecessary and could cause confusion. Information was shared in the case of CareFirst 24
f) Action, followed by checking to make sure it has been carried out, is essential to ensure the safety of vulnerable adults. Assurance was provided by the Surrey County Council representative at safeguarding meetings that action had been taken to arrange alternative care packages for its clients. Action must be assured by each local authority for its own clients and residents.

Metropolitan Police

a) Good joint working did deliver good planning and coordination across the agencies, the planning should have prevented any client from being missed. There were agreements in the Confidential Minutes held by London Borough of Sutton that all the agencies agreed to, including actions.
b) From the police perspective, if another case similar was reported the action would be the same, to contact the partners at the right level in the Borough of Sutton, to join a multi agency planning meeting and ensure that the group identifies what the primary objective is.
c) In this case police/UKBA evidence was secondary to safeguarding

Mole Valley District Council, Community Alarms

None

South East Coast Ambulance Service (SECAmb)

Recommended that:

a) SECAmb must continue to facilitate front-line practitioners attending strategy and planning meetings involving cases referred by the Trust. To give the greatest chance of this being accommodated, meeting organisers must ensure invitations are sent as early as possible and do not over-look the important information which SECAmb may be able to offer.
b) Any wider learning points identified from the serious case review will be disseminated throughout the Trust and staff will be reminded of their responsibilities to promote and safeguard the welfare of all vulnerable adults.

Surrey Borders and Partnership NHS Foundation Trust

No recommendations aside from affirming the Trust's commitment to multi-agency working. There was no involvement for the last 4 years of Mrs Foster's life.

Surrey County Council, Adult Social Care

a) That consideration should be given to informing all service users of providers that cease to be part of Framework Agreement following a round of tendering, that the agency's status has changed. This would ensure that all service users are able to make an informed choice about whether to continue to use the service or consider changing to a provider that is part of the Framework. This should include service users who are directly funded by Surrey, those using direct payments and self-funders.
b) That the County Council should ensure that it has a clear policy on its responsibility towards people who are self-funding packages of care, particularly those where the council has been involved in helping to facilitate the arrangements.
c) That where the County Council has a duty to carry out annual reviews of packages of care provided for service users that there are robust systems to ensure that these occur at the right time and include all relevant people.

d) That the role of the “in Touch” team should be considered to make it clear to what extent it operates on a reactive or proactive basis and that people understand what being open to this service actually means in practice.
e) That the County Council should include in its provider failure protocol a requirement that would ensure that someone reads the case notes for all service users who are not open cases before making contact with them.
f) That the County Council should ensure that the provider failure protocol is used in all cases including those where the provider operates outside of Surrey or is not part of the Surrey Provider Framework.
g) That Surrey County Council should consider including in their Provider Failure Protocol a statement on communication between staff to the effect that this should principally be between the responsible senior manager and those who are required to provide information or take actions. As a general rule people should not be copied into emails unless there is a specific need to do so.
h) If not already in place Surrey Adult Social Care may want to consider whether mechanisms for monitoring and controlling workloads are in place and are operating effectively to ensure that the service is as safe as possible.

Surrey Police

None

Appendix B: References – Legislation, Policy and Guidance Context

Care Quality Commission, Enforcement Policy, May 2013

Crown Prosecution Service, Legal Guidance, http://www.cps.gov.uk/legal/p_to_r/prosecuting_crimes_against_older_people/ accessed 3rd July 2013

Developing Markets for Quality and Choice, http://ipc.brookes.ac.uk/dcmqc.html accessed 3rd July 2013

Diabetes – blood sugar levels www.diabetes.co.uk/diabetes_care/blood-sugar-level-ranges.html accessed 22nd July 2013

Duty of Care, http://www.scie.org.uk/workforce/induction/standards/cis05_dutyofcare.asp accessed 3rd July 2013

Effective Deployment of Social Workers, ADASS/Skills for Care Advice Note, http://www.cpea.co.uk/FSWM2_index.html accessed 3rd July 2013

Equality and Human Rights Commission, Your home care and human rights, August 2012

Home Office Border and Immigration Agency, Prevention of Illegal Working – summary guidance for employers February 2008

Health and Care Professions Council, Standards, http://www.hpc-uk.org/aboutregistration/standards/ accessed 3rd July 2013

Jon Glasby, Suzanne Robinson, Kerry Allan (2012), 'Achieving Closure – good practice in supporting older people during residential care closures'

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

LGiU, Independent Ageing 2013 – council funding of care self-funders

Local Government Association, Employers Standard, Social Work, http://www.local.gov.uk/web/guest/workforce/-/journal_content/56/10171/3511605/ARTICLE-TEMPLATE accessed 3rd July 2013

Mental Capacity Act, http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act accessed 3rd July 2013

Migration Advisory Committee, Skilled Shortage Sensible, February 2013

NHS Choices; How will my eligibility for NHS continuing healthcare be assessed? http://www.nhs.uk/chq/Pages/eligibility-assessment-for-nhs-continuing-healthcare.aspx accessed 3rd July 2013
Office of the Public Guardian, Powers of Attorney, http://www.justice.gov.uk/forms/opg accessed 3rd July 2013

Ray, Mo and Phillips, Judith; Social Work with Older People, Palgrave (2012 fifth edition)

Skills for Care, Social Work Leaders Toolkit, http://www.skillsforcare.org.uk/socialwork/swlt_toolkit/Social_work_leadership_toolkit.aspx accessed 3rd July 2013

Social Work Reform Board (DCFS, DH and BIS 2010): Building a safe and confident future – implementing the recommendations of the social work taskforce

Rogowski, Steve; Social Work – the rise and fall of a profession (The Policy Press, Bristol 2010)

Self-funders http://www.thinklocalactpersonal.org.uk/Browse/Self-funders/ accessed 3rd July 2013

Surrey Adult Social Care, Draft Community and Care Home Provider Closure Protocol, 1st May 2013

Surrey Adult Social Care, How do I access adult social care services? http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/how-to-access-adult-social-care-services accessed 3rd July 2013

Surrey Adult Social Care, In Touch – guideline for practice, March 2013

Surrey Adult Social Care, Select Committee Review Topic: AIS Business Process Review, November 2012

Surrey County Council, Adult Social Care Workforce, 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 22nd July 2013

Surrey Safeguarding Adults' Board, Executive Summary, Serious Case Review In Respect of 0002 (2009)[67]

[67] Among other things recommendations were made here about assessment care planning and review, supervisory oversight, the mental capacity act as well as integration between social care and health

The College of Social Work, Professional Capabilities Framework, http://www.hpc-uk.org/aboutregistration/standards/ accessed 3rd July 2013

The changing roles and tasks of social work - A literature informed discussion paper, James Blewett, Janet Lewis and Jane Tunstill, January 2007 http://www.scie.org.uk/news/files/roles.pdf

Appendix C: Independent Serious Case Review - Panel Members

Simon Turpitt	Independent Chair
Helen Blunden	Designated Nurse for Safeguarding Vulnerable Adults, NHS Surrey
Julie Fisher	Strategic Director, Business Services, Surrey County Council
Rachel Hennessy	Medical Director, Surrey and Borders Partnership Foundation Trust
Becky Molyneux	Detective Inspector, Public Protection Investigation Unit, Surrey Police
Wendy Newnham	Deputy Chief Nurse, Virgin Care
Louise Stead	Director of Nursing, Royal Surrey County Hospital

SCR Support

Support was provided to the Review Panel from the Senior Lawyer at Surrey County Council, the ASC Senior Manager at Surrey County Council and the Surrey Safeguarding Adults Board Project Officer.

The panel were advised that Adi Cooper, the Director of Adult Social Services of the London Borough of Sutton, was invited to be a panel member. She declined.

Report Author

Vic Citarella

Appendix D: Key to Acronyms

A & E	Accident and Emergency
ASC	Adult Social Care
AIS	Adults Integrated Solution
CMHT	Community Mental Health Team
CSW	Community Support Worker
CPS	Crown Prosecution Service
CT	Computerised Tomography
CQC	Care Quality Commission
DH	Department of Health
DNAR	Do not attempt cardiopulmonary resuscitation
ECG	Electrocardiography
FT	Foundation Trust
GP	General Practitioner
IMR	Internal Management Review
INR	International Normalised Ratio
LB	London Borough
NHS	National Health Service
POA	Power of Attorney
SECAmb	South East Coast Ambulance Service
SCR	Serious Case Review
SSAB	Surrey Safeguarding Adults Board
TIA	Transient Ischaemic Attack
UK	United Kingdom
UTI	Urinary Tract Infection