PRIVATE AND CONFIDENTIAL
Caroline Topping
HM Assistant Coroner
HM Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

Leadership Office
County Hall
Penrhyn Road
Kingston Upon Thames
Surrey
KT1 2DN

12 February 2018

Dear HM Coroner

Regulation 28 Report regarding Ronald Arthur Farrington

I write in response to your Regulation 28 report of 22 December 2017.

The issue you raised in your report for Surrey County Council to address is that "as at the date of the resumed inquest no adequate s42 report had been written. The family have not been invited to take part in the review. No adequate enquiry had been made".

It is clear that the concerns reported to Surrey County Council regarding Mr Farrington met the threshold in s42 of the Care Act 2014, so the Council was under a duty to make, or cause to be made, whatever enquiries it thought necessary to enable it to decide whether any action should be taken and, if so, what and by whom.

The Care and Support statutory guidance says, in regards to adult safeguarding enquiries under s42 of the Care Act 2014 that relate to regulated providers, that

> "It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by employees or in a regulated setting, such as a care home, hospital, or college. The first responsibility to act must be with the employing organisation as provider of the service … However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and, if not, to undertake any enquiry of its own and any appropriate follow up action"
>
> (Care and Support Statutory Guidance, 14.68 – 14.69)

At the meeting held on 30 June 2016 to plan the adult safeguarding enquiry into the concerns regarding possible abuse or neglect of Mr Farrington an action plan was produced that said that once the Police had concluded their investigation, Nuffield Care were to complete the enquiry under s42 of the Care Act. This planned action was in line with the expectations set out in the statutory guidance.

However, we did not adequately follow through to ensure this action was completed. It is evident from our records that we did not give the guidance or support to Nuffield Care in how to complete the s42 Care Act enquiry. As a consequence Nuffield Care produced a chronology of events which did not demonstrate or inform the safeguarding process, nor did it detail the care Mr Farrington received during the last few weeks of his life. At the meetings which followed we did not address the lack of a proper s42 Care Act adult safeguarding enquiry, and we did not address the lack of family involvement.

Our review of this matter has identified the following issues:

- There was inconsistent management oversight. No one person consistently managed the process throughout and as a consequence actions were not followed through in a timely, meaningful way
- Our adult safeguarding policies and procedures do not set out well enough what can be expected when we require others to make enquiries for the purposes of s42 of the Care Act 2014
- Our systems were not effective in identifying and rectifying where adult safeguarding enquiries were taking too long

Following the Inquest, Surrey County Council Adult Social Care services have worked with Nuffield Care and the family to complete a meaningful adult safeguarding enquiry that meets the requirements of s42 of the Care Act and the associated statutory guidance. Mr Farrington's family will be invited to an outcomes meeting with Nuffield Care and Adult Social Care in February where the family will be able to express their views and concerns.

We have improved our systems to identify long running adult safeguarding enquiries and take actions to bring them to a satisfactory conclusion. In December 2016 15% of our adult safeguarding enquiries had been in progress for over 12 months. By December 2017 we had reduced this to 4%, despite the number of adult safeguarding enquiries we are undertaking having more than doubled over that period. We are confident we can sustain this improved performance.

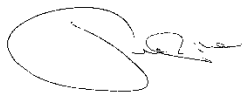
We have also put in place a revised quality assurance auditing programme of our adult safeguarding work so that we can more readily identify when our adult safeguarding work is falling short of expectations and take action to address this.

We are in the process of revising our adult safeguarding policies and procedures, and working with our colleagues on Surrey Safeguarding Adults Board to improve the Board's policies and procedures, so that

- they set clearer expectations of how adult safeguarding enquiries should be planned so that they involved the adult with care and support needs and their family; and
- they support better practice by Adult Social Care staff in setting expectations for contributions required from other organisations to s42 Care Act enquiries
- Clearly identify for each adult safeguarding enquiry who has the responsibility for ensuring that enquiry is timely and effective and to monitor the actions required

We expect these policies and procedures to be in place by April 2018, when they will be followed by a learning and development programme to support our staff to understand and be able to meet the expectations on them. We will also review our systems to ensure they are able to support the practice we expect and produce better management information to help oversee the work. We expect this work to be completed by October 2018.

Yours sincerely



Julie Fisher
Acting Chief Executive