


Southwark Coroners Court

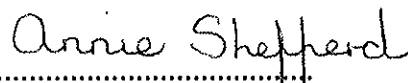
Rule 43 which is pursuant to The Coroners (Amendment) Rules 2008

Assessment into the circumstances surrounding the death of Mrs E. Lambert

This report was prepared by Prof. Derek Gardiner on behalf of Annie Shepperd, Chief Executive, London Borough of Southwark



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Prof. Derek Gardiner



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Annie Shepperd
Chief Executive

Date: Tuesday 27th January 2009

Background

1. This report sets out the findings of an independent investigation into the circumstances surrounding the death of Mrs Engelina Lambert in July 2008. The investigation was undertaken by Professor Derek Gardiner, who has no previous links with the staff or elected politicians of Southwark.
2. On 26 November 2008 the inquest into Mrs Lambert's death was held by the South East London Coroner's Court. The Coroner issued under Rule 43 of the Coroners Rules (as amended in 2008) a requirement that the Chief Executive of Southwark Council produce a report which addressed the specific concerns raised by the Coroner. The purpose of such reports is to draw to the attention of relevant authorities circumstances where the coroner believes that "action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held".
3. The Chief Executive agreed with the Coroner arrangements that ensured that her report was produced independently thereby ensuring that all relevant circumstances were investigated and reported to the Coroner.
4. Although this investigation has been conducted solely by Professor Derek Gardiner it is the Chief Executive that is responsible for the report and accountable to the Coroner and agrees the content of the report and, for this reason, both Professor Gardiner and the Chief Executive have agreed and signed this report.

Core Facts surrounding the death of Mrs E Lambert

5. This section of the report sets out briefly the facts of the case. They are drawn from an investigation of a large number of documents (including evidence available to the Coroner) and drawn from interviews with key staff employed by the Council in the integrated adult social services and health function. The investigation also reviewed national policy developments of eligibility and assessment for adult social services published recently to confirm what is currently considered to be good professional practice.
6. The core facts are not in dispute. Mrs Lambert, who was born on 15 May 1924, first came to the attention of Southwark Social Services as the sole carer for her husband who was receiving social care services until his death in December 2005. Mr and Mrs

Lambert did not have children. At that time Mrs Lambert had been assessed as a carer, but she did not request and was not assessed in relation to her own social care needs. Following her husband's death Mrs Lambert took over the tenancy of the property they lived in and housing records show that she was able to summon help with the property when required. On two occasions in June 08 Mrs Lambert contacted housing services about the boiler and heating system in her property which were not working properly. She received a prompt service and on two occasions relevant staff called to the home. Adequate heating was important in June 08 because it was an unseasonably cool English summer.

7. Relevant background here is that Mrs. Lambert had a long history of hypothyroidism, a condition which, especially in the elderly, makes people feel cold even when it is warm to others. She had few contacts with her GP in recent years and was last seen on 6 Nov 2007, some 9 months before she died. Mrs Lambert's GP had recorded that Mrs Lambert was not fully compliant with her medication and that she was always very reluctant to accept medical care. Mrs Lambert had also been offered treatment for her heart condition and a flu vaccination, both of which she had refused. She was a regular smoker. This investigation was unable to confirm whether she was still taking her medication and picking up repeat prescriptions.
8. Kindly neighbours offered support to Mrs Lambert, but grew concerned when they had not seen her for some time. On the 21 July the police and the ambulance service were called by a neighbour and Mrs Lambert was found to be at home. She was reported as having a degree of deafness which made it difficult for her to hear people knocking at the front door, especially because the television was on in the flat. During this call ambulance staff carried out basic health checks, though there is no record of them checking for pre-existing conditions or whether there was medication in the flat. Apart from lowered blood sugar levels they did not find her in need of medical care. They offered Mrs. Lambert the chance of a check up at the hospital but this was declined. After being given sugared drinks and glucose, Mrs Lambert's blood sugar quickly returned to normal levels. It was noted that the property seemed well cared for, and Mrs Lambert was clean and tidy. Mrs Lambert herself was not thought by the London Ambulance Service staff to have been eating enough, though she was fully hydrated.
9. At this point, on the evening of 21 July, Mrs Lambert had been seen by ambulance staff and neighbours, was mentally competent and capable of looking after her property. All her contacts with Housing Services showed she was capable of managing her financial

affairs and reporting concerns about her heating. She had a home telephone. The last people to see Mrs Lambert appear to have been the London Ambulance Service staff who attended on 21 July.

10. The ambulance service told neighbours they would refer the case to social services. The London Ambulance Service faxed Southwark's Older People (North) Team two days later in the early afternoon of 23 July. It is understood that in urgent cases London Ambulance Service referrals might be made, or followed up, by telephone. The referral included the information "is leaving gas hob in the kitchen on all the time, causing potential fire risk". There was no reference to her long-term medical condition, nor to any medication in the flat. This referral was less detailed than the report later supplied to the Coroner.
11. Her neighbour had rung the Older People's Team (North) earlier on 23 July, reporting the events of 21 July, saying that she had called the GP, police and Ambulance Service on 21 July, and that the Ambulance Service would be referring the case. The call was handled by an Executive Officer, who is not a qualified social worker, as was normal in the Duty Team at that time. None of the three Executive Officers in July 2008 was a permanent member of staff, reflecting recruitment and retention problems at that time. Information was recorded and passed to a qualified member of staff for decision and again this is usual practice in the team.
12. The Duty Manager at Social Services Older People's Team (North) evaluated the 23 July referral and did not consider it to be urgent and in need of an emergency visit by the Duty Team. However the decision and the reasons for this are not recorded clearly in the case file.
13. The same neighbour rang the Duty Team again on 24 July to say she had been trying to make contact with Mrs Lambert, without success. She was told that a decision would be made that day about when an assessment visit would be undertaken. The neighbour also notified another local health care professional on 24 July of her concerns and asked that her concerns should be passed on. They were, but not until further prompting by the neighbour on 28 July. Also on 28 July, the neighbour rang the Duty Team for a third time, and indicated she had also contacted the GP surgery. The Duty Manager decided to seek further evidence and requested a home visit by the GP. Later that day, reviewing all the available information, the Duty Manager decided that a Duty Social Worker should visit and a visit was scheduled for 4 August.

14. On 29 July the GP telephoned social services to say he had tried to visit Mrs Lambert but got no reply, and that he would be calling the police that day. He confirmed later in the day that he had done so and would inform the social services of the outcome. The social services file does not record any re-evaluation of the urgency in the light of these further contacts and concerns.
15. The following day, in the early hours of 30 July the police, responding to the GP's call the previous day, attended the property and forced entry. Mrs Lambert's body was found in the flat. There is no record about medication in the flat at that time. The Forensic Medical Examiner attended and signed a death certificate at 3.15 am, although he thought that Mrs Lambert had been dead for a few days prior to this. The Social Worker tried on 30 July to contact Mrs Lambert to set up a meeting, but was unsuccessful and rang the neighbour to ask her to ask Mrs Lambert to contact the team. She discovered Mrs Lambert had been found dead.
16. A post mortem was carried out the following day but the time and cause of death could not easily be established because of deterioration in the condition of the body since and death is presumed to have occurred some time earlier. The cause of death could not be ascertained and this prompted the involvement of the Coroner. An inquest was carried out on 17 November 2008 where an Open verdict was recorded, and the Coroner's direction that a request for a report under Rule 43 was sent to the Council's Chief Executive on 26 November. Derek Gardiner was invited after interview in December 2008 to conduct the independent investigation on behalf of the Chief Executive.

The independent investigation by Prof Derek Gardiner

17. Prior to the start of the investigation, the Chief Executive froze all Council files in respect of Mrs Lambert and called for all files (from social care and housing, Council tax and Housing benefit) to be given to her and they were brought together for the first time. Had they been brought together at an earlier point they could have provided the basis of a fuller report to the Coroner when the inquest was held in November 08. An outline sequence of events was prepared and all the files and timeline were made available for the investigation.
18. The investigation was carried out over twelve working days from just before Christmas 2008 until mid-January 2009. It consisted of a critical review of case files and related

records together with interviews with key professionals and others concerned with events. The investigation draws on the author's experience of managing adult social care services in a number of local authorities. It has also encompassed current national policy documents about assessment and eligibility for adult social care services and current national publications about good practice and how to develop adult social services.

19. The investigation has taken as its starting point the report from the Coroner which drew to the attention of the Chief Executive the circumstances surrounding the death of Mrs E Lambert and the concerns of the coroner in respect of Mrs Lambert. The main action points to address apparent deficiencies were:

- (i) Further training on what the eligibility criteria mean
- (ii) Better communication of the objective means by which a decision is reached
- (iii) Better investigation and enquiry into circumstances where information is lacking
- (iv) Clearer investigation into and responses into issues raised by external agencies and individuals
- (v) A clearer distinction between social work decisions and medical responses

Section 1: The five points raised by the Coroner

(i) Further training on what the eligibility criteria mean

20. The Coroner suggests that "further training on what the eligibility criteria mean and where the gap is between 'critical' and 'life-threatening' circumstances including clearer examples of what circumstances meet the criteria in each level and a clearer indication that such lists are neither exhaustive nor definitive".
21. Southwark has, in keeping with most other local councils, been reviewing their eligibility criteria for adult social care. At present all Councils are governed by the statutory guidance "Fairer Access to Care Services (FACS)" which sets out four categories of risk – critical, substantial, moderate and low. Until recently Southwark provided services to the top three categories; but after recent public consultation decided to target services on those with critical and substantial needs. Most Councils now provide services to people in these two top categories only and many have now consulted on tighter targeting.
22. At the time of Mrs Lamberts referral adult care services were being provided to older people in the three top categories and staff interviewed in this investigation agree that the decisions being made by the duty team staff in July 2008 were about the speed of response required (*urgency*) and not about the *eligibility* for a service. It seems agreed that Mrs Lambert would have been eligible for assessment and following that full assessment of her needs is likely to have service provision based on her needs and the eligibility criteria . The right to an assessment was included in the FACS Guidance but in many Councils those not eligible for services are steered or re-directed to other resources in the community including other council services and the voluntary sector.
23. It is clear from the Coroner that there was some confusion in the Court about the clear but important distinction between urgency of assessment of need and the eligibility criteria for services. This confusion was not helped by the limited record keeping on the case file, and the lack of availability at the Coroner's Court of the day of the Inquest of the Duty Manager directly involved in this case. This investigation found that training plans do include training for all frontline staff on the use of the FACS criteria and it is important that this continues. The recommendation focuses on the assessment of urgency.

Recommendation 1:

- *Training of all staff (including temporary or agency staff) should involve how to assess the urgency of a case as well as eligibility for services*

(ii) Better communication of the objective means by which a decision is reached

24. The Coroner asks for action on “better communication of the objective means by which a decision is reached.- The Coroner appears to make this statement based on the fact that the duty manager not available to give evidence before the Coroner at the Inquest but the member of staff who did give evidence was not able to discern why certain decisions had been made.

25. For most frontline staff attending the Coroner's Court as a witness happens rarely and can be a challenging experience. Staff have little opportunity to build up experience and expertise. Guidance on the kinds of reports required by the Coroners Court is likely to help that process. Experienced senior managers and Council lawyers have the opportunity to support staff by preparing proper guidance on how to produce reports for the Coroner's Court. This would be beneficial.

26. Managers of frontline staff appearing in the Coroners Court may also have limited experience. This can make the Coroner's job more difficult especially when dealing with professional judgements about managing risk. It is clear that the Coroner could have been better briefed to understand how decisions about urgency and eligibility are made in adult social care, and specifically how decisions were made in this case.

Recommendation 2:

- *there should be clear procedures setting out action to be taken by staff in cases involving the Coroners Court and guidance in preparing written reports for Inquests so that staff provide the reports needed to support the Court in its work. A pre-case review by the Coroner would help to identify what preparatory work needed to be done by the Council.*

Recommendation 3:

- *consideration should be given to designating a senior manager who will review cases to ensure all information about an individual is brought together prior to an Inquest Hearing*

(iii) Better investigation and enquiry into circumstances where information is lacking

27. The Coroner asks for "better investigation and enquiry into circumstances where information is lacking - one of the key characteristics of this case was that Mrs. Lambert had not been seen for some days and therefore crucial information as to the extent of any risk was not there and was not sought."
28. All social care work requires clear and accurate record keeping. Records are not kept just for those who make them, they are for others including the client who may need to know the case details and, crucially, to show the basis of decision making. In the case of Mrs Lambert the file does not make it clear why decisions had been made and therefore the reasons for considering the case not to be urgent are not given.
29. The adult care services had begun an internal review prior to Professor Gardiner's appointment, which had drawn out lessons and the service had begun to implement changes to procedures. For example, there was not a pre-existing protocol in the guidance for social services staff setting out how to respond in cases where older people living alone had not have been seen for a period of time. Since the death of Mrs Lambert, material on how to deal with such cases has been incorporated into current social care guidance on what to do if a person receiving services is not seen when a service provider arrives at their home.
30. This has been considered further and the conclusion has been reached that separating these different circumstances is preferable and there should be guidance in a separate protocol on how to handle new referrals where one of the presenting concerns is that an older person living alone has not been seen for a period of time. Such a protocol should set out how to determine the urgency of making an assessment and making or arranging a visit in such cases. The contents of such a protocol need to be discussed and agreed with partners in other agencies but at a minimum should indicate that multiple or repeated concerns about the same individual should increase the urgency of response even when no new evidence of risk has been provided. Other agencies might also be in receipt of concerns about an older person's wellbeing and there is a need to ensure good inter-agency sharing of information about risks and concerns.
31. In the case of Mrs Lambert, the initial referrals on the same day were essentially the same referral and at that point Mrs Lambert had been seen recently by police and ambulance staff. In those circumstances the decision that this was not a case requiring an immediate visit seems reasonable. However, the receipt of further concerns from the neighbour that again Mrs Lambert had gone some days without being seen should,

under a new protocol, trigger staff consideration of a more urgent response. In such cases, a visit may be made to check on the individual where there have been multiple expressions of concern and that someone living alone has not been seen for a number of days. This could involve the police because right of entry is with them not with social care agencies.

32. This investigation into Mrs Lambert's circumstances shows that she lived less than a mile from the duty team office. A visit from a member of staff in the duty team or another professional in the office, who was visiting nearby, could have been undertaken when the second call from the neighbour was received on 24 July. However given that the neighbour could not get in touch with Mrs Lambert, access to the home would have required a referral to the police.
33. The investigation looked at the likely workload consequences of such a proposal. On the best estimates available it was expected that there would be an extra 2 or 3 visits per month needed in the North area to deal with such circumstances. This does not seem an unreasonable additional improvement to service delivery but such individuals should automatically be referred to the Council's SMART telephone service which provides twenty four hour support to older people in their own home and enables individuals to raise immediate concerns through a monitoring service. This preventative service supports people to live in their own homes.

Recommendation 4:

- *a protocol should be drawn up setting out how to deal with cases of older people living alone who have not been seen for a period; the protocol should include indications of how multiple expressions of concern for someone's wellbeing increase the urgency of a case even where no other new evidence is available, and that a visit to the client's home is the appropriate response in such situations. The protocol should be agreed with other local agencies and the referral to the SMART service made to introduce a secure support service and to reduce future call outs.*

(iv) Clearer investigation into and responses to issues raised by external agencies or individuals

34. The Coroner states there should be "clearer investigation into and responses to issues raised by external agencies or individuals".

35. There needs to be a systematic way of responding to referrals from external agencies and individuals. This should include acknowledgement of the receipt of information and an indication of the action which will follow. In the case of Mrs Lambert there is no indication on file that the referral from the London Ambulance Service was acknowledged nor that the neighbour was told about how the duty team were going to respond to her concerns.

Recommendation 5:

- *new procedures need to ensure the proper receipt and acknowledgement of referrals from other agencies and individuals; within the framework of client confidentiality the referrer should get an indication of the actions to be taken*

(v) A clearer distinction between social work decisions and medical responses

36. The Coroner proposes “a clearer distinction between medical decisions and social work responses. It appears both from the criteria and the actions in Mrs. Lambert’s case that, despite providing services that are quite distinct from those provided by the medical profession some of the criteria for care are based on medical needs and, in this particular case, a decision was made to contact Mrs. Lambert’s GP rather than to visit her. This suggests a reliance on clinicians to deal with social needs or using clinical needs to define social care needs. The two are distinctly different and, whilst one might inform the other, they cannot be confused as a means of assessing any individual’s need for social care.”

37. This investigation considered the decisions made in respect of Mrs Lambert’s circumstances. An internal review concluded that the decision to request a GP visit on 28 July instead of a social care assessment visit was an error of judgement. Mrs Lambert had healthcare needs as well as social care needs, and a referral to a GP would be a normal part of professional practice in such circumstances. This would not be to seek a medical view of social care needs, but to meet the healthcare needs of the individual.

38. However, a visit from the GP should not be seen as an alternative to a social care visit or assessment. This does not appear to be an area requiring specific changes but why a referral is made to a GP has to be recorded in casework files.

Conclusions

39. This investigation has looked at the circumstances surrounding the death of Mrs Engelina Lambert in July 2008. Because her body was not found until some time after her death, a post mortem was unable to establish a cause of death and the case was referred to the local Coroner. The Coroner issued a Report under Rule 43 of the Coroner's Rules to promote action to prevent the recurrence of fatalities similar to that of Mrs Lambert. The Report was addressed to the Chief Executive of Southwark Council even though a number of agencies had been involved in the case.

40. The Chief Executive appointed an independent person to undertake an investigation into the circumstances surrounding the death. The facts in this case are not in dispute. In summary, there is no evidence to determine the cause of death, nor the time of death, so it is not possible to speculate whether a visit by a social worker would have made any difference. It is not clear whether Mrs Lambert's health status contributed to her death. Equally it is not evident that she would have accepted social care services if they had been offered. It is not unusual for older people to choose to die at home, rather than in hospital. As an 84 year old smoker with long-standing health problems her death might have happened even if a social care visit had been made.

41. Nevertheless, this investigation and report sets out clear recommendations to address the issues identified by the Coroner. It is proposed that an action plan is prepared which addresses each of the recommendations and presents a timetable for implementation, naming the lead officer responsible for each recommendation to try to reduce the likelihood of an older person living alone not being visited promptly after a referral reflecting concerns about their wellbeing and where they have not been seen for a period of time.

Section 2: Specific Recommendations to the Local Authority

42. The previous section of this investigation deals with the specific concerns raised by the Coroner and makes recommendations to address those concerns.
43. During this investigation there were other additional service issues which could benefit from further attention. This section of the report makes specific recommendations to the Council about the duty system.

The Duty System

44. This investigation looked carefully at the responsibilities of the duty team and how the team carries out its work. Current arrangements were implemented only a few months ago on a trial basis and that trial is likely to be reviewed soon. At present the team carries a wide range of work, not all of which is about new referrals and urgent cases. This may distract from a core responsibility of a duty team to focus on managing the risks in new referrals. This duty team carry out work which in other places might be carried in a brokerage function, in commissioning, or in the management of external contracts. The review of the duty system should look carefully at how the duty team resources are being used and how they can be best used in future.
45. The investigation also looked at working practices in the duty system. In general, calls to the team are handled by executive officers who ask for and record information. For cases requiring social care, this record is passed to a senior social work practitioner who makes decisions based on the information collected and criteria for services.
46. The present working arrangements can be problematic. The executive officers at the time of Mrs Lambert's referral were all temporary agency staff, reflecting recruitment and retention problems and this is an ongoing problem in social care generally and London specifically. This service is the front line interface with older people and is the way crucial information is collected and decisions made about eligibility and urgency. The Council is currently reliant on the skills and abilities of temporary unqualified staff to do this work. On average four new social care referrals are made each working day to the duty team. The majority of referrals are by telephone as in Mrs Lambert's case and a review would be an opportunity to look at which staff should be covering data collection and which staff should be making key social care decisions. There may be lessons to learn from how others arrange their intake systems.

Recommendation LA - 1:

- a review of operational arrangements for the duty team should take place