City and Hackney
Safeguarding Adults Board

Safeguarding Adults Review of the circumstances concerning Mr BC

Overview Report

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Overview report writer

April 2016

CITY & HACKNEY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW OF THE CIRCUMSTANCES CONCERNING MR BC

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April 2016

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1. INTRODUCTION

1.1. Brief overview of the circumstances that led to this review

1.1.1. Mr BC, aged 72, died in a fire at his home on 7th November 2014. He lived as an assured tenant in a flat in sheltered housing, receiving housing-related support from staff at the scheme. He also received a personal care and support package of 14 hours per week from a care agency commissioned by London Borough of Hackney Adult Social Care. His adult sons and daughters were actively involved in supporting him; one of his daughters managed his finances and paperwork and bought his food. Mr BC was a heavy smoker who also routinely drank large amounts of alcohol. He had a number of complex health problems including high blood pressure and strokes, arthritis, a hip replacement, diabetes, sickle cell anaemia, and cataracts; his condition resulted in poor mobility and balance and incontinence, and he neglected his diet, personal hygiene and home conditions. Emergency services were alerted on a number of occasions: the police to deal with repeated verbal and physical abuse of Mr BC by a neighbour, and theft from Mr BC by visitors to the building; the ambulance service when he had falls; the fire brigade when smoke alarms were activated. On a number of occasions safeguarding referrals were made.

1.1.2. Early on the morning of 7th November 2014, fire broke out in Mr BC's flat, the seat of the fire being on his bed. All emergency services attended, and ambulance personnel treated Mr BC, but he was pronounced dead at the scene. At a post-mortem on 10th November 2014 the cause of his death was identified as smoke inhalation. The Coroner's Court completed an inquest on 30th April 2015. The verdict was of accidental death with a Prevention of Future Deaths Report submitted to London Borough of Hackney.

1.2. Statutory duty to conduct a Safeguarding Adults Review

1.2.1. The City & Hackney Safeguarding Adults Board (CHSAB) has a statutory duty under s.44 of the Care Act 2014 to arrange a Safeguarding Adults Review (SAR):

- Where an adult with care and support needs has died and the Board knows or suspects that the death resulted from abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

1.2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work together to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

1.3. City and Hackney SAB decision to conduct a review

1.3.1. The SAR sub-group of the City & Hackney SAB determined at its meeting on 9th July 2015 that the circumstances of Mr BC's death met the criteria for undertaking a SAR. The SAB therefore set up a SAR Panel to conduct a review that would help the Board meet its objectives:

- To be provided with a report that analyses and makes recommendations that will contribute to improving safeguarding outcomes for adults at risk of abuse or neglect;
- To review the effectiveness of both single agency and multi-agency procedures in securing safeguarding of adults at risk of abuse or neglect;
- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together;
- To inform and improve single and inter-agency practice for safeguarding adults at risk of abuse or neglect;
- To contribute to the accountability to service users, the general public and relevant government departments and regulatory bodies of the agencies in City & Hackney responsible for safeguarding adults at risk of abuse or neglect.

1.3.2. The membership of the SAR Panel was as follows:

- Chair of the Panel: Chris Pelham, Assistant Director People, Department of Community & Children's Services, City of London;
- Lead reviewer and overview report writer: Suzy Braye, independent consultant;
- Circle Housing Group: Michael Pughsley (Property Programme Manager)
- City & Hackney Clinical Commissioning Group: Dr Charlotte Morgan (Safeguarding Adults Lead) / Teresa Gorczynska (Interim Designated Adult Safeguarding Manager);
- London Ambulance Service: Alison Blakely (Quality, Governance & Assurance Manager (East Central London);
- London Borough of Hackney Adult Social Care: Rob Blackstone/Adrienne Stathakis (Assistant Director);
- London Fire Brigade: Rod Vitalis (Station Commander Shoreditch Fire Station).

1.3.3. The Panel was supported by:

- City & Hackney Safeguarding Adults Board Manager: Paul Griffiths;
- City & Hackney Safeguarding Adults Board Business Support Officer (Minutes): Jayde Maynard.

2. TERMS OF REFERENCE

2.1. The SAR Panel

The role of the SAR Panel is set out in the CHSAB SAR Protocol: *"The role of the Panel is to commission evidence from all relevant agencies involved in the case under review, to assess and analyse that evidence and make judgements about the lessons learnt."* The Panel must work in a way that:

- Recognises the complex circumstances in which professionals work together to safeguard adults at risk of abuse or neglect;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

2.2. Terms of reference for this SAR Panel

The Panel's full terms of reference may be found at Appendix 1. The specific questions it was asked to address were:

i. What were the key points of assessment and decision making for Mr BC while he was being supported by health and social care services, and what can we learn from how these were carried out?
ii. What was the professional understanding of Mr BC's risk and vulnerability at these key decision-making points and how was this shared by the agencies involved?
iii. What implications does this review have for multi-agency work with service users where there is an identified risk of fire?
iv. Are there any issues of particular importance that the SAR Panel would like the CHSAB to consider in advance of completion of the report?
v. Where can we identify good practice in this case?
vi. How can the City and Hackney Safeguarding Adults Board make sure the learning from this review leads to lasting service improvements?
vii. What can the City and Hackney Safeguarding Adults Board do to hold agencies to account to improve the quality of services to service users where there is an identified risk of fire?

3. THE REVIEW METHODOLOGY

3.1. The review model

The approach chosen by the SAR Sub-Group was a review model that involved:

- Appointment of a SAR panel, with an independent chair and core senior level membership from a range of agencies;

- Individual Management Reports commissioned by the Panel from each agency that had involvement with Mr BC before his death, setting out the nature of their involvement, its progress over time, the reasons for actions taken or not taken, and reflection on their learning;
- Appointment of an independent reviewer and author to work with the Panel, and provide an overview report and summary report containing analysis, lessons learnt and recommendations;
- Formal reporting to the Safeguarding Adults Board, development of an action plan, and monitoring of implementation across partnerships.

3.2. Internal management reviews (IMRs)

3.2.1. The panel requested IMRs from the following agencies, with (in some cases revised) reports requested and clarification sought through interview or correspondence:

Agency	Nature of involvement with Mr BC
Centra Care and Support, Circle Housing Group (revised IMR + clarifications through verbal and written submission)	Centra Care and Support was commissioned by London Borough of Hackney Housing Department to provide sheltered housing to Mr BC. It is part of Circle Housing Group who, as the housing association owning the property, was his landlord, working through a Specialist Housing Management Team.
First Choice Homecare (revised IMR + clarifications through verbal and written submission)	First Choice was the agency providing personal and domestic care and support to Mr BC, commissioned by Adult Social Care.
Heron GP Practice (revised IMR)	This was Mr BC's GP practice.
London Ambulance Service (revised IMR + clarifications through written submission)	The Ambulance Service was involved in emergency response visits to Mr BC when called to attend to emergency health needs.
London Borough of Hackney Adult Social Care (revised IMR + clarifications through verbal and written submission)	Adult Social Care was the local authority department responsible for assessing and meeting Mr BC's care and support needs.
London Fire Brigade (revised IMR + clarifications through verbal and written submission)	The Fire Brigade was involved in emergency response visits to Mr BC when called to attend to fires, and also provided fire safety advice to him and to the landlord.

Metropolitan Police (IMR + clarifications through written submission)	The Police were involved in emergency response visits to Mr BC when called to attend incidents of domestic abuse, assault and theft, and the fire in which he died.

3.2.2. The purposes of the IMRs were:

- To enable agencies to reflect on and evaluate their involvement with Mr BC, identifying both good practice and systems, processes or practices that could be improved;
- To contribute the individual agency perspective to the SAR Panel's overview of interagency practice in Mr BC's case;
- To identify recommendations for change, at either individual agency or interagency level.

3.2.3. IMR writers were asked to provide a narrative report explaining and evaluating their agency's involvement with Mr BC, and a detailed chronology of that involvement. The Panel provided templates containing standard headings. The period chosen for scrutiny was between the date of Mr BC's first involvement with Adult Social Care, 20th December 2007, and the date of his death, 7th November 2014. Some IMR writers focused more specifically on the period following his move, in June 2010, to the accommodation in which he was living at the time of his death. Some IMR writers also submitted supporting documentation in the form of case notes, assessments or care plans.

3.2.4. Following scrutiny of the submitted IMRs, some agencies were asked to submit revised IMRs. Others were invited to address specific points in further detail through written clarification. A sub-group of the SAR Panel then met with some IMR-writers to seek verbal clarification and further discussion of particular points. In some cases these meetings led to the submission of further written clarification and documentation.

3.3. Thematic analysis

3.3.1. From the agencies' chronologies, a consolidated chronology was produced, mapping the actions of each agency by date against the actions of others. From this cross-referencing emerged some significant episodes and key themes in how the agencies, singly and jointly, responded to Mr BC's situation and needs. The narrative reports and interviews with IMR writers allowed further exploration of key episodes and themes.

3.3.2. The SAR Panel met on 4 occasions for discussion and analysis, with two additional meetings at which some members met with IMR writers for discussion.

3.3.3. Based upon this review process, this overview report contains:

- A summary of the circumstances of Mr BC's case;

- A chronology detailing the key actions reported by the relevant agencies;
- A themed analysis of learning that emerges from the actions taken or not taken by individuals and agencies;
- A concluding evaluation of the ways in which Mr BC's circumstances were responded to;
- A set of recommendations for the CHSAB as a whole concerning the areas in which policy, procedure and practice need to be improved.

3.4. Family involvement

Mr BC's family declined the Panel's invitation to take part in this review. A suitable date for sharing its conclusions and recommendations with them is being sought.

4. MR BC: THE PERSON

4.1. Sources of information

Without direct involvement from family members, it has been possible to put together only outline details about Mr BC's life. The Panel has relied upon written documentation from agency records, and upon the comments of professional staff who knew him.

4.2. A pen picture

4.2.1. Mr BC was born in Guyana on 12th March 1942. The date he moved to England is not known, but he was married and had 4 children - two daughters and two sons. Prior to retiring from work, he had been employed as a West End store manager for 35 years. His religion was Church of England. Mr BC's wife June died of cardiac arrest in 2006. By 2007, when he was first referred to Adult Social Care, it appears he was neglectful of his own personal care and of his domestic environment, and members of his family were concerned about his use of alcohol and his smoking. By 2009, self-neglect was certainly established and noted on a referral from his daughter requesting that he be given help to look after himself.

4.2.2. Adult Social Care assessed his care and support needs as eligible for services, and he received personal care and support commissioned by them from an independent agency. The number of hours gradually increased to meet his changing needs. In 2010 he moved to the sheltered housing scheme in which he was living at the time of his death, where in addition to personal care from the care agency he received housing-related support from the housing scheme staff.

4.2.3. Mr BC was a heavy smoker who also routinely drank large amounts of alcohol. His health problems included high blood pressure and strokes, arthritis, a hip replacement, diabetes, sickle cell anaemia, and cataracts. He had poor mobility and balance, was incontinent, and neglected his diet,

personal hygiene and home conditions. Despite his deteriorating mobility and unstable balance, it was noted that he valued going out to the pub to meet his friends and he greatly valued visits from his family.

4.2.4. Emergency services were alerted on a number of occasions: the police to deal with repeated verbal and physical abuse of Mr BC by a neighbour, and theft from Mr BC by visitors to the building; the ambulance service when he had falls; the fire brigade when smoke alarms were activated. He was somewhat at risk from the attention of others, as when he was befriended by strangers who offered to carry his shopping home but then stole property from his flat. A neighbour in the housing scheme, who was his regular drinking companion, would on occasion become violent and abusive to him (and was eventually evicted by the landlord). Safeguarding referrals were made on a number of occasions by the housing scheme manager, covering risks Mr BC experienced from others, risks from his own self-neglect, and risks he posed to others as a result of his smoking and use of alcohol.

4.2.5. Mr BC did not always easily engage with all the services that sought to help and support him. He did not always attend routine appointments, and although after emergency calls he did sometimes agree to go to hospital, he sometimes refused this, against ambulance crew advice. Although he was offered specialist advice about smoking and drinking, he did not make use of the services that were offered. He received fire safety advice from his family, from professional staff and from the Fire Brigade, but it seems that his behaviour did not change in response, even though he appeared to acknowledge the risks. He would sometimes refuse personal care from his care staff, and he could at times be aggressive towards them, although he would usually accept the support of the housing scheme manager. On the occasions when his mental capacity was referred to, it was to confirm that he had capacity to make decisions and his apparent wishes were respected. The picture conveyed is of a man who, despite being somewhat challenging to care for, enjoyed the affection of those who knew him, even if that was sometimes tempered with frustration at his continued self-neglect.

5. CASE CHRONOLOGY

5.1. Introduction to the chronology

5.1.1. The history of Mr BC's involvement with health and social care agencies is taken from the combined chronologies submitted by the agencies that completed IMRs, along with additional information provided on request by those agencies, and the SAR Panel's interviews with IMR writers. A combined narrative of necessity involves some overlap or repetition; there is also occasional date inconsistency, any significant instances of which are commented upon in the narrative. The account also comments on the emergence of significant themes, with the commentary shown in emboldened italics for clarity.

5.1.2. For clarity, the history is set out by three significant time periods that emerged from the analysis: an initial period prior to Mr BC's move to the sheltered housing scheme; a mid-period during the early part of his residence there; and a final period in the 18 months before his death.

5.2. The period preceding Mr BC's move to his sheltered accommodation: December 2007 – May 2010

5.2.1. Summary

During this period Mr BC, who was living in a 6th floor council flat, became known to Adult Social Care, initially as a result of hospital admission for a stroke, and subsequently through referral by his family, who were providing significant amounts of care and support. A further hospital admission for confusion and urinary tract infection followed. Risks arising from his poor health due to a range of chronic conditions, together with his substantial consumption of alcohol, led to recognition that his independence was at substantial risk. From 2009 he received a care package that gradually increased from 3 to 7 hours per week, and included meals on wheels. There was occasional intervention from the Police when Mr BC became abusive to his adult children during arguments about his drinking, resulting on each occasion in no further action.

5.2.2. Detail by date

5.2.2.1. On **20th December 2007** Mr BC was referred to Adult Social Care. At that time he lived with his adult son in a 6th floor council flat, but was in Homerton Hospital following a stroke. In a social work assessment on 23rd January 2008[1], Mr BC was noted as having a long history of alcohol misuse, but being 'in denial' of this, and mobility problems and poor balance, which made him prone to falls. It was noted that his wife had died in 2006, and that he was finding it difficult to deal with his loss. His family were providing a 'significant amount of care and support'[2], with daily visits from his two daughters (providing shopping, housework, supervision of medication and financial management) and regular visits from a second son. They were reported as keen for him to undertake detox treatment. One daughter, who was present at the assessment, declined a carer's assessment.

5.2.2.2. The assessment records additionally that a CT scan conducted in the hospital showed small infarcts of unknown age; an occupational therapy assessment concluded that he was able to attend independently to his own personal care; and a capacity assessment undertaken by a doctor on 10th January 2008 stated he 'has capacity

[1] FACE rapid assessment form 23/1/2008
[2] ASC IMR

to make decisions', though there is no mention of which decisions. The assessment form later shows the '*capacity assessment required*' question ticked yes, but no further detail is available. The assessment identified moderate risks related to his use of alcohol: becoming confused due to the level of alcohol consumed; risk of falling; risk of setting fires from smoking; risk of deteriorating physical health if he did not 'seek help with his addiction'[3]. His needs were identified as supervision with taking medication, support with daily living tasks, and prompting with personal care. The outcome of the assessment appears to have been information and advice, and a recommendation that he be referred to Crossroads for assessment for detox treatment. (It is not clear whether this referral was actually made.)

5.2.2.3. This is the first mention of mental capacity, which will emerge as a significant theme: the recording is imprecise, and it is not clear how the identified need for further assessment was to be pursued. It is clear too that the risks from Mr BC's lifestyle are already established and recognised.

5.2.2.4. In **April and May 2008**, the Police responded to two domestic incidents involving verbal arguments between Mr BC and the son who lived with him[4]. These seemed to stem from his son's attempts to moderate Mr BC's drinking. On the second of these Mr BC had threated to burn the house down, but this was not pursued as his son did not wish to substantiate the criminal allegation. Mr BC declined a Police offer to refer him to social services and to the GP. Standard risk assessments were recorded on both occasions, and on the second (6th May 2008) a Merlin alert was sent to CAIT (the Police's Child Abuse Investigation Team) and YOT (Youth Offending Team) due to the presence of Mr BC's 11-year old grandson.

5.2.2.5. On **1st January 2009**, Police attended following a further domestic incident[5] in which Mr BC's son became locked out, but could hear Mr BC distressed inside. He had forced entry, found Mr BC drunk and an argument had ensued. A standard risk assessment was completed and no further action taken.

5.2.2.6. On **23rd April 2009**, Mr BC's daughter Ms AT made a direct referral to Adult Social care[6]. Mr BC, by then described as living alone, was said to have 'let himself go' since the death of his wife. A range of health issues were noted: strokes, hip replacement, high blood pressure, diabetes, sickle cell disease, arthritis, cataracts. He was described as prone to falls due to poor mobility and high alcohol consumption, doubly incontinent when drinking, neglecting his diet

[3] FACE rapid assessment form 23/1/2008
[4] Met Police IMR: (a) CRIS 4611092/08 & CAD 3989; (b) CRIS 4612247/08, MERLIN 08CTN041776 & CAD10554
[5] Police IMR: CRIS 4600016/09, CAD 2160
[6] ASC Background Information and Contact Assessment

and personal hygiene, and presenting fire risk from pans left on the stove and security risk from leaving his door ajar in case of losing keys. His reliance upon his family was causing considerable stress, and carers' assessments were requested, along with community care assessment for Mr BC, an occupational therapy assessment and referral to Crossroads.

5.2.2.7. The resultant Overview Assessment of Mr BC, dated **29th May 2009**, with his two daughters present, provided further detail consistent with the above, noting also that Mr BC was sometimes depressed and irritable, lacked energy and did not sleep sufficiently. It recorded his needs as giving rise to substantial risk to independence, and deemed them eligible for community care provision. Mr BC's wishes were to have a carer's visit 3 times a week to help with his personal care, to go to a day centre for social interaction, and to move to sheltered accommodation. The form also mentioned a need for podiatry, review by an optician, referral to a befriending scheme and Telecare assessment.

5.2.2.8. The entries above demonstrate the close involvement of Mr BC's family and their concerns about his alcohol consumption as well as the risks from his health and pattern of daily living. His needs are recognised as eligible, demonstrating recognition of the risks to his independence from this early stage.

5.2.2.9. The Statement of Need and Care plan, also dated **29th May 2009**, specified 1 hour of care, three times a week, for the purposes of taking a shower, dressing, having breakfast and general tidying. A referral was to be made to the GP for psychogeriatric assessment, in the light of information from Mr BC's daughter about him forgetting pans on the stove, smoking in bed, and setting bed linen on fire. Referrals for Telecare, to a day centre and to the Fire Brigade for smoke alarms were also listed as necessary. It was noted that Mr BC had not complied with two previous referrals to Crossroads for detoxification assessment.

5.2.2.10. On **16th October 2009**, the hospital social work team at Homerton Hospital carried out a further assessment following Mr BC's admission with confusion and a urinary tract infection. His daughter Ms CC was present. In addition to the established picture of complex health needs, alcohol consumption and self-neglect (now described as severe), the assessment notes he had been drinking excessively, urinating in bottles and eating off the floor. He was aggressive when denied alcohol or the funds to buy it, and had threated to jump from his 6th floor flat if not rehoused. A CT scan showed small Infarcts of unknown age, and confirmed that there might have been long-term damage to his brain due to two previous strokes and possibly from a long history of alcohol misuse. A multidisciplinary case discussion had recommended that a psychogeriatric assessment take place. His needs were again assessed

as giving rise to substantial risk to independence, and eligible for a 'low level care package to assist with personal hygiene and nutritional needs'[7]. Mr BC was open to receiving personal care at home but declined referral for Crossroads or the Substance Misuse Team.

5.2.2.11. The possibility of long-term brain damage due to strokes and alcohol use is made more explicit here. Also becoming more apparent is Mr BC's reluctance to engage with reduction of his intake. The need for psychogeriatric assessment is recognised but the impact of possible brain damage on his decision-making capacity is not mentioned.

5.2.2.12. The care package, then at 7 hours per week, was reviewed on **15th December 2009**. In addition to his known needs, the review document indicates he had been referred to occupational therapy for aids and for physiotherapy to improve mobility. There is mention too of anti-depressant medication prescribed for the last 2 years by the GP. It appears meals on wheels were provided daily, and that the family had engaged a private cleaner to visit once a week. His mood is noted as bright and alert, and the family no longer had concerns about suicidal ideation.

5.2.2.13. On **16th May 2010**, the Police were called to a further domestic abuse incident[8] – a verbal argument over a key, during which Mr BC became abusive to his son and his daughter. No offences were alleged or apparent, and the Police recorded a standard risk assessment.

5.3. The initial phase of Mr BC's residence in sheltered accommodation: July 2010 – September 2013

5.3.1. Summary

During this first phase of his residence in the sheltered housing scheme, Mr BC repeatedly came to the attention of the emergency services for a number of reasons: acute health episodes, fire safety issues and incidents involving abuse of him, sometimes by strangers but more commonly by a neighbour who was a drinking companion (and who was eventually evicted on 1st September 2013). Mr BC himself was also sometimes aggressive to care staff, on occasions declining personal care. While a primary focus was on the risks posed to Mr BC by third parties (strangers and his neighbour), housing scheme staff became increasingly concerned about fire risks from his drinking and smoking, both to Mr BC himself and to others in the building.

5.3.2. Detail by date

[7] FACE Rapid Assessment 16/10/2009
[8] Met Police: CRIS 4612759/10 & CAD5425

5.3.2.1. On **10th June 2010** London Borough of Hackney Housing Department referred Mr BC to Circle Housing Group on grounds of his housing need, noting his care and support needs related to self-neglect, health issues and isolation. On **28th June 2010** he started his tenancy at a sheltered housing scheme, with housing-related support provided by Centre Care and Support (also part of Circle Housing Group).

5.3.2.2. It is significant that at this point, although the risks from Mr BC's use of alcohol and smoking were established and recognised, no mention was made of them in the housing application. The allocation of his tenancy was therefore made without the opportunity for consideration of the full extent of his needs.

5.3.2.3. His care and support package commissioned by Adult Social Care was on-going, and from **16th August 2010** was provided by First Choice at 10.5 hours per week (3 calls per day). From **19th August 2010** this was increased to 12 hours per week. A phone survey conducted on **17th February 2011** by First Choice indicated that Mr BC wished to continue with their service.

5.3.2.4. On the **28th February 2011** the London Fire Brigade made the first of a number of Home Fire Safety Visits, this one as a result of targeted calls on households in areas of high risk (P1 postcodes) – areas where a combination of factors make residents more likely to experience, or be a casualty of, accidental dwelling fires.

5.3.2.5. Home Fire Safety Visits are a key element in fire risk reduction strategies, and Mr BC received a number of such visits during his tenancy at the housing scheme, some triggered through routine postcode targeting, and other in response to requests from the housing scheme staff. The adequacy of fire safety measures, both in the building and in Mr BC's flat, emerges as a key theme from this review.

5.3.2.6. By the **22nd March 2011**, housing scheme staff were concerned about risks posed to the security of the building by Mr BC's visitors, said to include drug users and sex workers. In response to a warning letter (which was sent to all tenants on 23rd March), Mr BC stated he could bring whoever he liked to his flat.

5.3.2.7. On **28th March 2011** Mr BC became a victim of theft. A woman approached him offering to help with his shopping, accompanied him home and stole his mobile phone. The Police attended but the CCTV was not working on the day and the suspect was not identified. The Police closed the case and informed the Victim Support Service (on 10th April 2011), though there is no mention of any subsequent contact from that agency.

5.3.2.8. On **10th May 2011**, Mr BC's phone number was found in the phone of a known drug dealer, but this information cannot be confirmed as correct[9].

5.3.2.9. On **12th July 2011**, the housing scheme manager requested a review of Mr BC's case and, the same day, passed on to the duty social worker a request from Mr BC that he be allocated a social worker.

5.3.2.10. On **18th July 2011**, the London Fire Brigade responded to a 999 call by the alarm monitoring company in response to alarm activation. Burnt toast in Mr BC's kitchen had set off the alarm, resulting in light smoke, ventilated by the fire crew.

5.3.2.11. Small or moderate fires at Mr BC's home, attended by the Fire Brigade, become an emerging theme during this period, with mounting evidence of risks.

5.3.2.12. On **21st October 2011** there was communication between First Choice and the housing scheme when Mr BC threatened his carer with a bread knife because she refused to buy alcohol for him. This incident is noted in both agencies' IMRs, with Circle's report implying that this was not an uncommon occurrence: "*violent incidents of this kind usually occurred when staff would not buy alcohol and cigarettes for him*"[10]. While there is a case note, there is no incident record on Circle's file. First Choice put the service on hold and informed duty social services.

5.3.2.13. A meeting took place on **24th October 2011** between Mr BC, the housing scheme manager, a social worker and a representative of the domiciliary care agency. Adult Social Care appointed a new provider; this is noted on the Circle chronology, with the comment that Mr BC was not happy about the change. First Choice confirmed they ceased provision from this point (until 25th March 2012). No matching record has been identified by Adult Social Care and it is not clear which provider was involved in the interim.

5.3.2.14. On **15th November 2011** came the first noted disturbance involving Mr BC's neighbour and drinking companion, Mr KL. The housing scheme manager called the Police as Mr KL was in Mr BC's flat being verbally abusive to Mr BC and racially abusive to the scheme manager's husband. When the Police attended Mr KL apologised and returned to his own flat; it was noted that staff did not want to assist in pursuing prosecution[11].

5.3.2.15. Mr BC's relationship with his friend and neighbour from within the scheme, Mr KL, becomes a cause for concern from this point

[9] Met Police IMR: Crimint NIRT00405492
[10] Circle IMR
[11] Met Police IMR

onwards. Mr KL's treatment of Mr BC is progressively seen as abusive; equally it becomes clear that although Mr BC is fearful, he does not himself avoid the contact that places him at risk. The same pattern is evident in his inability to protect himself from risks from others, with repeat instances of theft by people who befriended him.

5.3.2.16. Mr BC himself continued to be abusive to staff. On **18th November 2011** he was verbally abusive to the housing scheme manager, who sent an incident report to the Police and to Circle's specialising housing management team. This entry in the IMR also notes that all kitchen hob rings were alight, posing a fire risk.

5.3.2.17. On **9th January 2012**, Mr BC was again a victim of theft; this incident is described as robbery in the Circle IMR, but there is no corresponding Police report. The scheme manager made a safeguarding referral, but received no feedback on the outcome.

5.3.2.18. Lack of feedback to the referrer on safeguarding referrals made about risks to and from Mr BC becomes an emerging theme.

5.3.2.19. On **13th January 2012**, the GP's chronology logs a home visit, a routine appointment initiated by the practice, as Mr BC was a new patient. Mr BC was not at home, but the GP returned for a further visit on the 18th January 2012. A health check was carried out, including discussion of smoking and drinking; Mr BC refused examination. The GP sought information from the former GP and this was received by the practice on 26th January 2012, as a result of which the GP initiated a review of bladder problems and discussed medication with medical colleagues. But on 23rd February 2012 Mr BC did not attend an appointment made for him, and missed a further appointment on 13th March 2012.

5.3.2.20. This shows an emerging pattern of proactive follow up on health issues by Mr BC's GP, and demonstrates Mr BC's reluctance to engage.

5.3.2.21. A further burglary took place on **22nd January 2012**. A woman (described by the Circle IMR as a sex worker/drug user) offered to take Mr BC's shopping home. Mr BC and the woman went to another flat in the complex and while they were gone a man entered and took a television from the property. Housing scheme staff notified the duty manager, the police, Mr BC's family, and his social worker. Both suspects (identified through CCTV and forensics) were arrested, interviewed and bailed. However, the forensic paperwork was lost at Forensic Science Service and Mr BC did not attend for an "Achieving Best Evidence" Interview. The Police closed the case and informed Victim Support Services (on 23/01/12). The Circle IMR notes that Mr BC was shaken and upset, and that he received advice on his personal

safety. A safeguarding referral was raised (but is not noted on the Adult Social Care chronology).

5.3.2.22. The mismatch between different agency records on safeguarding referrals is of concern, and illustrates an emerging theme of incomplete or missing documentation.

5.3.2.23. On **27th January 2012**, the Police attended in response to Mr BC pulling his emergency cord, stating there was a man in his flat. His neighbour Mr KL was drunk and in the flat, but left with the Police, who concluded no further action was needed[12]. Further problems arose on 11th February 2012, when the domiciliary care worker informed the housing scheme manager (and her own manager) that Mr KL had threated her while she was giving care to Mr BC. Mr BC is reported as stating he did not want his neighbour in his flat[13].

5.3.2.24. Further concerns arose about fire risk on **24th February 2012**, when Mr BC burnt toast. The housing scheme manager removed Mr BC's toaster in order to reduce risk, and raised an incident report, informing their line manager and Circle's specialist housing management team. Mr BC's family were also alerted. Mr BC was said not to be happy at the removal of the toaster as he did not see the fire risk.

5.3.2.25. On **27th February 2012**, Mr BC's daughter queried with the housing scheme manager why her father had dried blood on him. Mr BC said he had fallen. The GP was called and attended the following day.

5.3.2.26. On the **29th February 2012**, the Fire Brigade once again attended following a 999 call by the monitoring company in response to alarm activation[14]. There was a small fire in Mr BC's kitchen caused by cooking left on the stove; the crew dealt with the fire.

5.3.2.27. On **13th March 2012**, the Circle IMR notes there was a meeting between the housing scheme manager and the social worker to discuss Mr BC's safety, given concerns about him leaving his flat door open, letting people into his property. There is no Adult Social Care record about this meeting, and the outcome is unclear.

5.3.2.28. From **25th March 2012**, the care and support package was once again provided by First Choice, at 10.5 hours per week (2 calls per day).

5.3.2.29. On **28th March 2012**, the GP IMR records a doctor's visit, called for by the housing scheme manager because Mr BC had fallen and hit

[12] Met Police IMR: CAD 310
[13] Circle IMR
[14] Fire Brigade IMR

his head. He refused to attend A&E for a head laceration. He declined advice about smoking and drinking, but agreed that he would allow personal care for washing. The doctor's assessment was that Mr BC was vulnerable and at risk, and should be referred to a psychogeriatrician. A discussion with the social services duty team also took place. The following day the GP requested a capacity review from a consultant psychiatrist and advised that this had been done[15].

5.3.2.30. This is the third mention of referral to a psychogeriatrician, but at no point is there evidence of any interagency sharing of outcomes that could have informed overall risk management strategies. Again mental capacity is mentioned in passing, without detail of the decisions for which his capacity was being assessed, or of the outcome.

5.3.2.31. On **5th April 2012**, the housing scheme manager made a safeguarding referral about Mr BC's refusal of care, and a violent incident with another service user[16]. It is not clear what incident this refers to, as it is not mentioned in any other agency's submission. Mr BC's social worker and his family were informed and a key guard was fitted to enable Mr BC to keep his flat door locked while allowing access for care staff. A mental capacity assessment was also requested but the housing scheme records do not show whether this was carried out. The scheme manager did not receive any follow up from Adult Social Care regarding this incident.

5.3.2.32. On **17th April 2012**, Mr BC's neighbour and drinking companion Mr KL threatened Mr BC's daughter and refused to leave the flat. The Circle IMR notes that although Mr BC stated he did not want Mr KL in his flat, he repeatedly instigated contact with him. The Police were called and removed Mr KL. The Police IMR[17] describes the incident as a common assault –Mr KL having shaken Mr BC's neck after a dispute over beer and kicked Mr BC's carer. Mr KL was arrested and charged with two counts of common assault and remanded in custody to court.

5.3.2.33. This incident demonstrates the escalation of risks to Mr BC from Mr KL. It also shows a lack of clarity on whether or how incidents were advised to safeguarding or to adult social care.

5.3.2.34. On **23rd April 2012**, Mr BC fell and was admitted to hospital, possibly twice. The Circle IMR notes that a fall took place at 3.15 a.m. and that signs of self-neglect were observed; Mr BC was covered in faeces. An ambulance was called and Mr BC was taken to hospital, his daughter being informed. He was discharged the same day and referred to physiotherapy. The Ambulance Service log records a call at 14.06, from a health care professional reporting that Mr BC had a

[15] GP IMR
[16] Circle IMR
[17] Police IMR: CRIS 4610265/12 & CAD 4962

fractured femur. The injury was said to date from an incident 3 days previously, in which he had fallen from a bus onto the pavement and injured his leg. He was conveyed to hospital and admitted at 15.45. This account is consistent with an entry from the GP the same day, logging a home visit during which a possible fracture had been identified and an ambulance called.

5.3.2.35. Mr BC's increasing frailty can be observed from incidents such as this. His mobility, already impaired by his health conditions, is further compromised by his alcohol consumption.

5.3.2.36. A further GP entry the same day records that Mr BC had seen a consultant psychiatrist, who had assessed him as having mental capacity, although the decision for which his capacity was being assessed is not recorded.

5.3.2.37. By **25th May 2012**, there are again problems relating to the behaviour of Mr BC's neighbour Mr KL, reported on the Circle IMR as behaving aggressively to care workers and stopping them delivering care to Mr BC. The Police were called and arrested Mr KL, who was under bail conditions not to enter Mr BC's flat[18]. The housing scheme manager made a safeguarding referral (the outcome of which was not advised to her), and also informed the social worker and Mr BC's family.

5.3.2.38. On **30th May 2012**, Mr BC again missed a medical appointment, this one for eye screening at the hospital.

5.3.2.39. On **19th June 2012**, the Circle, Police and Ambulance Service IMRs identify that Mr BC activated the emergency cord in his flat. The housing scheme manager also believed the neighbour, Mr KL, was breaking bail conditions by going in Mr BC's flat. It transpired that a friend had pulled the cord in error while cleaning a flooded toilet. The Ambulance crew attended but found they were not needed. The Police IMR[19] notes that no bail conditions were identified on the national database, and that the ban on entry to Mr BC's flat was a housing scheme rule only; no further action was taken.

5.3.2.40. On **21st June 2012**, the housing scheme manager emailed the social worker asking for a discussion about risks posed by Mr BC to other tenants. The response is not recorded, and there is no matching record from Adult Social Care. The same day, the physiotherapist called the doctor indicating that Mr BC was sitting in urine, refusing to have his incontinence pads changed. The surgery alerted the social worker and the incontinence service.

[18] Police IMR: CAD 2460 & CAD 2988
[19] Police IMR: CAD 1199 7 CAD 2121

5.3.2.41. This is an explicit mention of the risks posed to others by Mr BC's behaviour. This becomes an increasing focus as time moves on, but proves to be a challenge in terms of identifying risk management strategies.

5.3.2.42. The emergency cord was activated again on **1st July 2012**; the housing scheme manager called the Police after hearing shouting in the background. The Police attended and found no offences or reference to another person; no further action was deemed necessary[20].

5.3.2.43. On **3rd July 2012**, the Circle IMR notes a call to the housing scheme manager from the GP surgery, requesting a reminder for Mr BC about his appointment for alcohol misuse treatment. Mr BC refused to attend but requested sleeping tablets and a new appointment was made.

5.3.2.44. On the **4th July 2012** the GP IMR notes that Mr BC was seen by the Grove Alcohol Project; he was deemed to have capacity to understand 'alcohol issues'[21] and declined help. He subsequently missed another appointment with his GP on **9th July 2012**. The GP followed this up the following day but received no reply so called the housing scheme manager and requested she check his wellbeing. The manager advised there was a meeting with social services and the family that day to discuss needs and plans; the GP also called social services and the family about the missed appointment. A subsequent home visit on **24th July 2012** enabled blood tests to be carried out.

5.3.2.45. Again, there is insufficient detail here about the capacity assessment to indicate what specific decisions were being considered when the assessment was carried out, or what information was taken into account.

5.3.2.46. The emergency calls relating to the neighbour's behaviour continued. On **2nd August 2012**, the Police attended [22] when the emergency cord was activated because Mr KL was in Mr BC's flat refusing to leave. Mr KL racially abused the police and scratched one of the officers; he was arrested and charged with two counts of assault on police and a racially aggravated public order offence. Again on the **5th August 2012** the housing scheme manager called the Police stating a male was causing trouble at Mr BC's flat. The Police found Mr BC and another man watching TV, with no evidence of a disturbance, and concluded there was no cause for police action[23]. The following day the housing scheme manager called the Police when the emergency cord was again activated. A male voice was heard in the background asking for money. The Police found both men drunk, and in an

[20] Police IMR: CAD 9031
[21] GP IMR
[22] Police IMR: CRIS 4620792/12 & CAD 8861
[23] Police IMR: CAD 3758

argument over money for vodka. No further action was taken[24]. The GP undertook a home visit health check the same day, though this appears unconnected to the earlier incident. It emerged the following day that Mr BC's keys had been stolen during the incident; they were replaced[25].

5.3.2.47. On the **19th August 2012**, Mr BC was found drunk in his flat. An ambulance was called and he was taken to hospital; his family were informed. While this incident is mentioned on the Circle IMR, there is no corresponding entry from the Ambulance Service.

5.3.2.48. The Ambulance Service were involved on **6th September 2012**, when a 999 call reported that Mr BC was experiencing slurred speech and had had previous strokes. On attending, the ambulance crew found that Mr BC had locked himself out of his flat and Careline had requested an ambulance, deemed by the crew not to be needed[26].

5.3.2.49. On **19th September 2012**, a Police intelligence report indicated that Mr BC was begging in the street. The Police spoke to his family and emailed his social worker. There is no matching documentation from Adult Social Care.

5.3.2.50. On **11th October 2012**, the Circle IMR notes a call from the social worker indicating that a review was to take place on the **24th October 2012**. The meeting involved the housing scheme manager, the social worker, Mr BC and his daughter. The outcome recorded by Circle was that Mr BC was to keep his door locked at all times and his daughter was to seek funding for additional items that he required. It is noted that Mr BC stated he did not want to move from his current accommodation. There is no matching Adult Social Care documentation for this meeting.

5.3.2.51. This is the first mention of the possibility of a change of accommodation for Mr BC, but in the absence of documentation it is not clear how this suggestion arose, and whether it was in response to risks from his neighbour or (as on subsequent occasions) from his own behaviour.

5.3.2.52. Further emergency Police alerts continued. On **2nd November 2012**, the housing scheme manager again called the Police after emergency cord activation[27]. Mr BC was found intoxicated. The Police IMR comments that the Ambulance Service attended but no treatment was deemed necessary. The Ambulance Service records indicate that the original call was made by a neighbour, concerned about noise; the Ambulance Service was not required and left the scene.

[24] Police IMR: CAD 8028
[25] Circle IMR
[26] Ambulance Service IMR
[27] Police IMR: CAD 355

5.3.2.53. On **5th November 2012**, the warden called the Police when Mr BC was the victim of an alleged assault by his neighbour. The Police found that the two men had argued over a shopping trolley. No further action was deemed necessary[28].

5.3.2.54. The Circle IMR notes that the housing scheme manager the same day made a safeguarding referral because another neighbour, Ms YZ, had witnessed Mr KL assaulting Mr BC. She informed social services and Mr BC's daughter about the incident, and a strategy meeting was arranged. A safeguarding strategy meeting followed on **13th November 2012** (noted in the IMRs from both Circle and Adult Social Care) attended by Mr BC, his daughters Ms CC and Ms DC, the neighbour Ms YZ, the social worker and a manager from Adult Social Care, two members of Circle's specialist housing management team and the housing scheme manager. The minutes note that Ms YZ, had witnessed Mr BC being hit by Mr KL; alcohol appeared to be a factor. Mr KL had hit her too, when she tried to intervene, and she, another neighbour and Mr BC had escaped into the lift. When Mr BC was able to access his flat he locked himself in, and Ms YZ activated the emergency cord. The Police were called, and took Mr KL back to his flat. The minutes also state that Mr BC wanted to press charges but thought the Police would not be interested as they "*would consider both him and KL too old and with poor mental health capacity*"[29]. Mr BC reported several other incidents at this meeting; it was noted too that carers reported feeling fearful of Mr KL, and that he prevented carers accessing Mr BC's flat. The safeguarding plan was that the Circle specialist housing management team would seek legal advice, and would write to Mr KL about his behaviour, and the housing scheme staff would try to keep the two men apart. A key chain would be provided so that Mr BC could wear his key, enabling him to lock his door and have his key available at all times. A chain would also be fitted to the door. The care staff would do his laundry to minimise his chance of meeting Mr KL. Further liaison would take place with the Police about the support they could provide, and mental health services would be notified.

5.3.2.55. On **18th November 2012**, Circle's specialist housing management team sent a letter to Mr BC and Mr KL warning them about anti-social behaviour that took place in the communal area of the building. All residents were asked to complete logs on anti-social behaviour; such logs may be used by a landlord in seeking possession of a property on grounds of anti-social behaviour.

5.3.2.56. On **17th December 2012** Mr BC did not attend a further hospital appointment for eye screening[30]. The GP practice records that he

[28] Police IMR: CAD 6962

[29] ASC IMR: Strategy Meeting Minutes 13th November 2012

[30] GP IMR

declined support for drinking and smoking; a nurse had a full discussion with him, and considered that he understood the health implications of not changing his behaviour.

5.3.2.57. A follow up safeguarding case conference was held on **18th December 2012.** Mr BC is not listed as attending, but a mental health social worker is listed as his representative; his two daughters were present, along with the social worker, an Adult Social Care manager, the housing scheme manager and Circle's specialist housing management team members. The Police and the care agency sent apologies. The minutes note that Mr BC and Mr KL remain friends and continue to meet. Safeguarding action was identified as not possible in these circumstances. It was believed that the Police were not intending to prosecute Mr KL. Circle's specialist housing management team reported that the evidence for Mr KL being in breach of his tenancy was insufficient to support eviction. The emphasis was placed upon the family getting Mr BC to protect himself better; without his cooperation the only options available were either eviction for one or both men, or criminal action. There was discussion of the need to identify whether alternative housing was available for Mr BC, in case he should change his mind about moving. This is linked in the minutes to a comment about mental capacity: one of Mr BC's daughters "*reported that she has noticed alcohol and dementia problems in Mr BC. (The social worker) reported that it would mean we would have to go into capacity of Mr BC; it could be that Mr BC just made an unwise decision*"[31]. No further action on this is logged.

5.3.2.58. Although the safeguarding strategy meeting and case conference are well documented, they illustrate the rather limited focus on concern upon risks from Mr KL, representing a missed opportunity to give wider consideration to the overall risks inherent in Mr BC's situation.

5.3.2.59. On the **20th December 2012**, the GP made a further home visit and undertook a full assessment, finding Mr BC's mood to be low. He again declined referral for alcohol treatment but agreed to a trial of anti-depressant medication. The GP IMR notes that he had "*capacity to weigh up decisions; aware of risks*"[32].

5.3.2.60. It is helpful to see capacity addressed here; however, the assessment appears unrelated to the safeguarding case conference discussion two days earlier, despite the mention in those minutes of the need for fuller consideration of capacity, and this assessment by the GP does not appear to have been discussed with anyone else. This demonstrates an emerging theme of the

[31] ASC IMR: Safeguarding Case Conference Minutes 18th December 2012
[32] GP IMR

failure to convene a full professional system to consider Mr BC's needs.

5.3.2.61. On **14th January 2013**, the GP undertook a further home visit in response to a call from the housing scheme manager. Mr BC had fallen. No on-going concerns were noted in the records[33].

5.3.2.62. On **21st January 2013**, the Ambulance Service responded to a 999 reporting that Mr BC had been unable to move or eat for 3 days. He complained of lower back pain since a fall 2 weeks previously and had been sitting on the sofa for a few days, not eating, continuing to drink, and not getting up to urinate. He had developed bed sores that were bleeding. His GP was said to have prescribed medication for a urinary tract infection a few days previously. The Ambulance crew took Mr BC to Homerton Hospital. The same day, his GP referred him to community nursing services.

5.3.2.63. It is not clear whether Mr BC remained in hospital. The only record over the following few days is from the Adult Social Care IMR, and refers to emails between the "*service delivery manager*" and the social worker regarding the suitability of Mr BC returning to the provider, but it is not clear whether this is the care and support provider or the housing provider. There is an internal note by the social worker expressing concern about the provider's decision and suggesting that housing with care be explored. The IMR writer was unable to ascertain the basis for this.

5.3.2.64. By **28th January 2013** Mr BC was at home. His GP visited to offer support and help with washing, but he declined, and refused counselling. The GP record mentions referral to the community matron as being "*good for hard to reach patients*"[34]. On the **11th February** a home visit took blood samples for a possible urinary tract infection.

5.3.2.65. Again there is evidence of a disconnect between health and social care needs. It is not clear whether the GP, in seeking Mr BC's agreement to support and help, was aware of the care and support being provided by Adult Social Care, or considered it relevant to liaise about their concerns.

5.3.2.66. On **22nd February 2013** a paid carer called the Police to a further violent incident, with Mr KL aggressive towards Mr BC and his care workers, who were advised not to enter the flat if Mr KL was present. The Police log[35] notes that Mr BC was said to be armed with a knife, that neither party wished to substantiate any allegation and that no offences were alleged or apparent so no further action was taken. A

[33] GP IMR
[34] GP IMR
[35] Police IMR: CAD 7360

Police log the same day[36] notes that the Police held a meeting with staff over the on-going problems between Mr BC and Mr KL, and that the housing association intended to serve both with "Acceptable Behaviour Contracts". Police records do not disclose whether the ABC plan was put into practice.

5.3.2.67. The housing scheme manager made a safeguarding referral, though Adult Social Care records refer only to an incident report being received, noting that Circle's specialist housing management team placed conditions on Mr KL.

5.3.2.68. The Circle IMR refers to a call to the housing scheme manager from the Police on the **26th February 2013** informing about a violent incident between Mr BC and Mr KL. It is not clear whether this was an additional incident (there is no matching Police record).

5.3.2.69. On **2nd March 2013** at 07.17 the Ambulance Service received a 999 call reporting that Mr BC had been found outside on the floor, and was now at home in bed; a passer-by had found him asleep on the pavement, and a housing worker had helped him inside. The ambulance crew found him intoxicated; his observations were within normal parameters, he was not experiencing chest pain or difficulty in breathing and had no obvious injuries. He was conveyed to Whittington Hospital (and must have returned home the same day – see below).

5.3.2.70. The same day, the Circle IMR reports that Mr BC set fire to himself on a bus due to putting a lit cigarette in his pocket; he was reported to be drunk at the time. The line manager, contracts officer, Police and next of kin were informed about the incident and the Circle risk assessment was reviewed. The IMR writer comments that a safeguarding referral was not made following this incident, but should have been.

5.3.2.71. At 18.04 the same day a second 999 call reported that Mr BC had fallen twice in an hour and was still on the floor. When the ambulance arrived the carer told how they had witnessed Mr BC trying to sit on the sofa but he had slipped. On examination Mr BC had no apparent injuries, but was slightly tachycardic and pyrexic; he was assisted up and was able to self-mobilise slowly. He declined conveyance to hospital and confirmed he would pull his alarm if he fell again. Ambulance staff made a falls referral via the Emergency Bed Service to the GP in accordance with procedures[37].

5.3.2.72. On **4th March 2013** the Circle IMR records a call from Mr BC's paid carer reporting that Mr BC had been found on the floor, having fallen

[36] Police IMR: CAD 4880
[37] Ambulance Service IMR

while intoxicated. The record states that an ambulance attended but Mr BC refused to attend hospital. (There is no matching record from the Ambulance Service.) The IMR writer comments that an incident report should have been completed but wasn't. The GP was notified; the record states that a check-up took place and he was diagnosed with anaemia (it is not clear that this was the same day). A later GP record (6th March) notes that Mr BC's blood results were abnormal and his daughter was informed[38]. Further blood tests were taken on the 19th March.

5.3.2.73. On **6th March 2013**, the housing association sent Mr BC notice of its intent to seek possession due to him brandishing a weapon and threatening others. The IMR writer comments that it is not clear which incident is being referred to, but possibly the one that took place on the 22nd February 2013. Notice of intent to seek possession was also served on Mr KL, in relation to various incidents of anti-social behaviour towards Mr BC. On **11th March 2013** the housing scheme manager advised Mr BC's daughter that he was still letting Mr KL into his flat, despite a ban on him doing so. The Adult Social Care IMR identifies that on **14th March 2013** a care worker reported a further incident to the Police, but it is not clear which incident was being referred to, and there is no matching Police record.

5.3.2.74. From **16th March 2013**, the care package delivered by First Choice was increased to 14 hours per week (3 calls per day).

5.3.2.75. The Adult Social Care IMR refers to an internal note on **21st March 2013**, indicating a meeting had been called with the housing scheme and the police were invited to attend. The IMR writer found no indication of the subject or outcome. There is no matching record from the Police.

5.3.2.76. On **22nd March 2013** an Adult Social Care record indicates that Mr BC had people drinking in his flat, but the IMR writer found no indication of what the purpose of this notification was, or of any action in response.

5.3.2.77. On the **26th March 2013** the GP record shows a telephone conversation with a consultant urologist about Mr BC's abnormal blood test results. A referral was made and the next of kin informed.

5.3.2.78. On the **27th March 2013**, the Adult Social Care IMR records a home visit to Mr BC, noting that this appeared to be a service review. Mr BC was noted to be intoxicated at 9.10 a.m. The Circle IMR provides more detail: the visit involved the social worker and the housing scheme manager, and was for the purpose of discussing Mr BC's falls. The social worker advised the scheme manager that he would have

[38] GP IMR

difficulty moving Mr BC anywhere else as there was no suitable place that would accept him.

5.3.2.79. The mounting concern about Mr BC's safety seems to have triggered this joint visit, and it is clear that the possibility of Mr BC moving to a more supported environment was being raised by the housing scheme. In the absence of supporting documentation from Adult Social Care it is not clear whether any overall plan was in place, and whether alternative suitable accommodation had been actively pursued at this stage.

5.3.2.80. The same day, the Police record indicates that Mr BC's daughter called them having been told by a care worker that her father had been threatened with a knife. The Police found Mr BC and Mr KL to be drunk and one (the record does not state which) had a fork; both were removed to their own rooms and no further action taken.

5.3.2.81. On the **28th March 2013**, a partially completed carer's assessment form was "*sent to carer*"[39] by Adult Social Care, but no further detail is available about who the carer was or what had triggered this action. The First Choice IMR records that the same day Mr BC was found intoxicated and unable to receive care and support; duty social services were informed.

5.3.2.82. On **31st March 2013**, housing scheme staff called the Police to a disturbance, again involving Mr KL, who was in Mr BC's flat and was said to have pushed and prodded Mr BC's care worker[40]. The carer did not wish to make allegations or assist Police in a prosecution; the Police escorted Mr KL back to his own flat and advice was given to the housing scheme (the Police IMR does not specify what that advice was). The Adult Social Care IMR notes that an incident report was received from the housing scheme on this incident, which the IMR writer believes was for information only.

5.3.2.83. The following day, **2nd April 2013**, the First Choice IMR reports that Mr BC was intoxicated and attacked his care worker; the Police were again contacted, and duty social services and Careline were informed. There is no matching Police record of this incident, but the Police IMR records a different incident[41], in which a PCSO visiting the housing scheme witnessed Mr BC being slapped round the face by Mr KL, both men being drunk. Mr KL was arrested and charged with common assault and a Merlin (Adult Come to Notice) report relating to Mr BC was sent to Social Services. Adult Social Care the following day also received a notification from the housing scheme about the arrest[42].

[39] ASC IMR
[40] Police IMR: CADs 2495, 2540, 2548, 2591, 2911, 2932, 5454
[41] Police IMR: CRIS 4607842/13, MERLIN 13PAC043194
[42] ASC IMR

5.3.2.84. On **4th April 2013** the Adult Social Care IMR records an internal note from a senior practitioner outlining actions requested of other staff: a protection plan for Mr BC and mental health team involvement. The IMR writer was unable to find details of actions taken in response. The same day, the GP diagnosed that Mr BC had a urinary tract infection, informed his daughter, and left a prescription for her to collect.

5.3.2.85. On **5th April 2013**, the Circle IMR identifies that the housing scheme manager undertook a risk assessment review, identifying risks from fire and self-neglect. The IMR writer does not comment on what was done with or in response to this revised assessment.

5.3.2.86. Police were called by housing scheme staff to a further disturbance on **9th April 2013**[43]; Mr BC and Mr KL were fighting in Mr BC's flat, with Mr KL in breach of bail conditions. The Police arrested Mr KL for breach of bail. The housing scheme manager reported this to Adult Social Care the following day[44].

5.3.2.87. Again on the **11th April 2013**, housing scheme staff called the Police reporting that Mr KL was again breaking his bail conditions by being in Mr BC's flat. The Police attended and instead found Mr BC in Mr KL's flat, thus without any breach of bail conditions. The Adult Social Care IMR records a call from the social worker to Mr BC's daughter informing her of the incident, and referring to a meeting that would take place. It records too that an email was received from Circle the following day, indicating that senior managers were meeting, but without further detail. There is no matching record from Circle.

5.3.2.88. The Adult Social Care IMR also records that on **15th April 2013** a Merlin report from the Police identified Mr BC being at risk of harm as a victim of crime from Mr KL, disclosing a number of police interactions with Mr BC for the period 2008 to the time of the latest incident. The IMR writer comments that the number and causation of the incidents are all "*out of Social Services control*"[45].

5.3.2.89. On **17th April 2013** the housing scheme manager called the GP to say that MR BC's urinary tract infection symptoms were still present and no appointment had been received from the urologist[46]. The GP discussed this with Mr BC's daughter the following day, and the record indicates the daughter's support for the urology appointment[47].

[43] Police IMR: CAD 2230, CAD 2305
[44] ASC IMR
[45] ASC IMR
[46] GP IMR
[47] GP IMR

5.3.2.90. On the **18th April 2013**, Mr BC was again the victim of assault by Mr KL, who pushed and shoved him and verbally abused a housing scheme staff member, who called the Police. The Police arrested and charged Mr KL with common assault[48]. The Circle IMR reports that a safeguarding referral was completed, recording that Mr KL was arrested with bail conditions not to return to the sheltered housing scheme. The IMR writer notes there is no internal incident form relating to this incident. The Adult Social Care IMR records that Vulnerable Adult information from the Police was forwarded to the social worker and to Adults Duty by the Adult Protection Team; it is not clear whether this is the Merlin referred to on the 15th April, or a further alert relating to the incident on the 18th April. An internal note records that the social worker attended a meeting at the housing scheme, but the IMR writer found no record of the topic or outcome. The Circle IMR does not refer to a meeting.

5.3.2.91. The Circle IMR notes that on **22nd April 2013** Mr BC's daughter asked why Mr KL was still living at the housing scheme. The manager informed her that a process was taking place and the case being looked at on an on-going basis.

5.3.2.92. On **1st May 2013** the GP tried to visit following a call from Mr BC's daughter to say he was unwell. Mr BC was out at the pub when the GP called.

5.3.2.93. On the **7th May 2013**, First Choice advised the family and social services that they had received no response from Mr BC's flat when they called to provide care.

5.3.2.94. On the **8th May 2013**, the housing scheme manager undertook a further risk assessment review, again identifying risks from fire and self-neglect. The IMR writer does not comment on what was done with or in response to this revised assessment.

5.3.2.95. On the **5th June 2013** the Police IMR notes an Intelligence Report giving information that Mr BC when travelling on a bus had a lit cigarette in his pocket. It appears (though is not stated) that the Police liaised with housing scheme staff, who are reported as informing the Police that "*he is a constant problem with similar problems*"[49]. The Police IMR comments that a Merlin report was not submitted.

5.3.2.96. On **6th June 2013** the Ambulance Service responded to a 999 call reporting that Mr BC had activated his alarm but there had been no voice contact. The ambulance crew found Mr BC's front door open, with Mr BC conscious and alert on the sofa; he denied activating his alarm and it was deemed that an ambulance was not required[50].

[48] Police IMR: CRIS 4609124/13, CAD 5813

[49] Police IMR: Crimint GDRT00428681, CAD 5414

[50] Ambulance Service IMR

5.3.2.97. On **7th June 2013**, the Adult Social Care IMR records a home visit to Mr BC by the social worker and the housing scheme manager, but no further details are available.

5.3.2.98. On **14th June 2013**, the housing scheme manager advised the GP that Mr BC's urinary tract infection was still present; a further prescription was issued[51], and medication subsequently adjusted.

5.3.2.99. The Circle IMR notes that on the **25th June 2013**, the housing scheme manager picked up an internal fire alert from a smoke detector, caused by Mr BC burning food. The IMR writer comments that an internal incident report should have been completed. In response to this incident, the scheme manager requested a home fire safety visit by the fire brigade.

5.3.2.100. On **2nd July 2013**, Mr BC's daughter complained to First Choice because Mr BC's soiled bedding had not been changed[52]; First Choice advised social services. Their IMR records a spot check the following day, as part of "*routine quality monitoring*"[53], during which Mr BC advised that he wished to cancel his evening visits. The following day Mr BC refused care; First Choice advised his daughter, who agreed to talk to her father, and social services.

5.3.2.101. **On 12th July 2013** the Fire Brigade undertook a home fire safety visit (logged in the IMR as arising from station generated targeting of P1 postcodes, although a visit had been requested by Circle after the 25th June incident). The Circle IMR reports a Fire Brigade recommendation for a door mechanism on Mr BC's front door to reduce the risk of fire spreading from the flat into communal areas. The mechanism was fitted on 17th July, with Mr BC reported as not being happy, as he liked to keep his door open.

5.3.2.102. Circle made a safeguarding referral about the Fire Brigade's concerns about fire risk[54]. The referral records that the fire officer noticed burn marks on flooring, sofa and mobile chair, and stated that it was a case of when rather than if there would be a potential fire; there was serious concern for Mr BC's safety and that of others given his potential to fall asleep while smoking and drinking, and his habit of leaving his door open. The family had been asked to talk to Mr BC about his smoking and drinking, and to purchase fire retardant sofa and flooring; the scheme manager and community police were to undertake frequent visits. Circle requested an emergency review, with a view to increasing Mr BC's care package pending a move to more supervised accommodation. The form records the social

[51] GP IMR
[52] First Choice IMR
[53] First Choice IMR
[54] Circle IMR

worker's decision that this should not be dealt with through the safeguarding process as the risks were on-going and had been discussed with both Mr BC and his family and measures were in place. The IMR writer comments on the absence of signature to record who else was involved in this decision (despite the form clearly stating that 'it is expected that managers will be involved in this decision-making').

5.3.2.103. The IMR writer also refers to an email chain on **15th July 2013** relating to the referral, and questions the view expressed that the issue did not look like safeguarding, when it clearly identifies risk to others. He notes also that the Head of Adult Safeguarding asked the social worker on 15th July 2013 to undertake a care management review, but this didn't take place until the 18th August 2013, and the concerns outlined in the safeguarding referral are not recorded as having been considered.

5.3.2.104. Two key themes emerge here:

- ***the disconnect between adult social care and safeguarding processes: it seems that the case being open to adult social care is a rationale for not proceeding with safeguarding processes; yet the safeguarding concerns are not addressed through the assessment and care management process;***
- ***it seems that decisions on how safeguarding referrals are dealt with have not been made with management scrutiny or, if they have, no clear audit trail of that scrutiny exists.***

5.3.2.105. On **7th August 2013**, the GP made a home visit; Mr BC was requesting painkillers for abdominal pain; on examination all was normal. The doctor also reviewed the home situation with the housing scheme manager, noting that Mr BC goes out to buy alcohol. Mr BC declined further help.

5.3.2.106. On **8th August 2013**, First Choice again reported no response from Mr BC and were reassured by his daughter that he was alright[55].

5.3.2.107. On **16th August 2013** the Adult Social Care IMR notes a meeting held between the social worker, the housing scheme, Mr BC and his daughter to discuss Mr BC's smoking and the Fire Brigade report[56]. The Circle IMR notes that the family was asked to remove a sofa because of fire risk. Two days later a reassessment was completed by the social worker[57], noting that the current care package of 10.5 hours per week met Mr BC's needs. Housing was identified as suitable/satisfactory, but physical health issues and emotional wellbeing/mental health were rated as 'severe' (grade 3 on a scale of 0-4). He was seen as prone to self-neglect due to alcohol use, with high support needs for care/nutrition. Behaviour affecting self and others

[55] First Choice IMR

[56] Assumed to be that of the 12th July 2013

[57] ASC IMR

was rated as 'very severe' (4 on a 0-4 scale – '*continuous or near continuous observation required to minimise behaviour or its impact'*). Although difficulty with planning and decision-making was rated as 'severe' (grade 3 on a 0-4 – '*severe difficulties in making any but simple everyday decisions or plans, even with assistance*'), mental capacity was logged as not needing further consideration. Problems with uninvited visitors and safeguarding issues from another scheme resident were described as now resolved, but a number of other risks were logged as 'undermanaged' (grade 4 on a 0-5 scale – '*current arrangements are inadequate or unsustainable; action required to reduce risk/put alternative arrangements in place*'). The Adult Social Care IMR writer observes that the assessment does not refer to what triggered it (which was the 15th July request by the Head of Adult Safeguarding) or to the potential fire risks. There is no indication that any changes to the care plan were envisaged.

5.3.2.108. This provides further evidence of the emerging theme that a structured multiagency risk management strategy was sorely needed, and that ongoing actions did not adequately or proactively address the risks identified.

5.3.2.109. On **30th August 2013**, the GP IMR notes that Mr BC did not attend a hospital appointment for eye screening.

5.3.2.110. On the **1st September 2013**, Mr BC's neighbour Mr KL was evicted from the housing scheme.

5.4. The final phase of Mr BC's residence in sheltered accommodation: July 2010 – September 2013

5.4.1. Summary

Mr BC's health was deteriorating and his care and support needs increasing. He continued to smoke and drink, and emergency services were regularly called when he had falls or fires in his flat. The focus of interagency concern became the fire risk. Five months before his eventual death, he suffered smoke inhalation during a moderate fire in his flat, triggering reassessment of his care and support needs. While a move to alternative, more supported accommodation was discussed with him, he consistently refused to consider this. Despite a stated wish to reduce his smoking, his motivation for this did not seem strong, and his drinking continued. He was judged to have capacity to make decisions about his own welfare. Mr BC died in a fire at his flat on 7th November 2014.

5.4.2. Detail by date

5.4.2.1. On **12th September 2013** the Adult Social Care IMR records an application to the funding panel for an increase of 30 minutes daily to Mr BC's care package. While not stated as such, it is possible that this

arose as a result of the reassessment in August. The IMR writer comments that the application makes no reference to the risks that Mr BC posed to himself or to others, or to the fact that the housing provider had raised serious concerns, and states that this suggests a missed opportunity to escalate the concerns to senior managers. The IMR writer comments that a note on the file suggests the increase was agreed, but that an internal note on the **20th September 2013** indicates that the increase was not agreed. It appears it was not, as there was no change to the hours provided by First Choice.

5.4.2.2. This is an example of an emerging theme of failure to escalate serious concerns about safety to senior management.

5.4.2.3. On **7th October 2013**, both the First Choice and the Adult Social Care IMRs record the care agency's concerns about Mr BC being intoxicated and refusing care. On **21st October 2013** he did not attend a GP appointment.

5.4.2.4. On **30th October 2013**, the Ambulance Service responded to a 999 call indicating that Mr BC had fallen, was a diabetic and had a heavy drink problem[58]. It was found that Mr BC had been drinking strong cider all day and was slurring his speech. His daughter, who was present, stated he was an alcoholic. He had been having groin pain for 2 days but had no obvious injury or wound; he had not fallen and the area was not painful to touch. Mr BC declined conveyance to hospital and confirmed he would visit his GP. He was given paracetomol. The Ambulance Service submitted a safeguarding referral to the local authority.

5.4.2.5. On **31st October 2013**, First Choice advised Mr BC's daughter and social services that he was not eating. His daughter agreed to talk to him.

5.4.2.6. On **5th November 2013**, an internal note in Adult Social Care indicates that an Outcome Focused Support Plan had been agreed (but the details are not available). The IMR writer comments that it is unclear whether an increase in care had already been made.

5.4.2.7. On **9th November 2013**, the Fire Brigade responded to a 999 call from the monitoring company following alarm activation. Cooking left on the stove had caused a small fire, which was dealt with.

5.4.2.8. On **13th November 2013** the Circle IMR record that the housing scheme manager undertook a risk assessment review and that risks from fire and self-neglect were noted. The IMR writer does not comment on what was done with or in response to this revised assessment.

[58] Ambulance Service IMR

5.4.2.9. On **16th November 2013**, the Circle IMR reports a Police visit to Mr BC, followed by a feedback session with the housing scheme manager to discuss sex workers' visits to the building. The Police advised they be contacted if sex workers were seen in the building. The IMR writer comments there is no internal incident report on file to provide further detail.

5.4.2.10. On **16th December 2013**, First Choice again notified social services that Mr BC declined care.

5.4.2.11. On **27th January 2014** the GP undertook a home visit following a call from Mr BC's daughter that her father was in pain. It was noted that Mr BC was still drinking. The need for an annual health review was discussed, and the housing scheme manager agreed to help ensure Mr BC would attend. The following day the GP IMR indicates that a phone call to the daughter identified that an appointment was no longer necessary.

5.4.2.12. From the **5th February 2014**, concerns escalated about Mr BC smoking in communal areas. The housing scheme sent a warning letter to him, and the housing scheme manager asked his daughter to limit his supply of cigarettes and alcohol. It is reported that she agreed, but that there were no subsequent changes to his consumption[59].

5.4.2.13. On **17th, 18th and 20th February 2014**, First Choice liaised with Mr BC's daughter, having been unable to provide care, either because of refusal or because he did not answer the door. He missed a GP home visit for blood tests also on the **20th February**, although an annual health review took place by home visit on the **24th February 2014**.

5.4.2.14. The Circle IMR reports that on **26th February 2014** the external fire risk assessment contractor completed a routine fire risk assessment. The IMR writer comments that this does not mention either the general risks for the resident client group or specific risks from individuals, although it does mention concerns regarding the mobility of residents.

5.4.2.15. Again this links to the emerging theme of the adequacy of fire safety measures, here raising questions about the contractor's assessment and questions about how proactively the concerns it did raise have been addressed.

5.4.2.16. On **28th February 2014**, the housing scheme manager raised a safeguarding referral relating to fire risks from Mr BC's smoking[60]. Mr

[59] Circle IMR

[60] It should be noted that this referral is dated 12th July 2013 on page 1, and 28th February 2014 on page 3. Because it contains (on page 2) detail of events happening n February 2014, it has been placed here in this chronology. The date error illustrates the unreliable nature of some of the records in this case.

BC had been reported by various tenants as smoking and drinking in the lobby of the building (during periods when no staff are on site), resulting in chairs and carpets becoming messed and burn marks in the lobby, and raising serious concern about fire risk. He would also leave his front door open when smoking in his flat, allowing smoke to escape into communal areas, and although a letter had been sent to Mr BC (on 5th February) pointing out he was in breach of his tenancy, his behaviour had not improved. The family had been alerted to speak to him about smoking and drinking, and the housing scheme manager and community police were visiting frequently. A Fire Brigade visit had been requested. Emergency review of his care package was requested, with a view to increasing hours while suitable supervised accommodation was found. The scheme manager stated she received no feedback or follow up regarding this referral[61].

5.4.2.17. The Adult Social Care IMR notes too that a safeguarding referral was received, but finds no indication of who viewed it within the safeguarding team. The safeguarding referral appears to have been closed on 2nd April; the Adult Social Care IMR writer identifies a safeguarding closure summary, but notes that while it states adult social care services are aware, it makes no reference to who is doing what in relation to the issues identified.

5.4.2.18. The Adult Social Care IMR indicates that the same day an email from the housing scheme manager requesting a new assessment of Mr BC was marked for no further action. It is not clear how this relates to the safeguarding referral, but in any event there is no indication of what was done in response either to the referral or to the housing scheme manager's email request.

5.4.2.19. This reinforces the theme of lack of feedback on safeguarding processes. A related issue is the extent to which referrers see it as their responsibility to follow up and escalate the concern if it is not clear what is being done. Such efforts, if they take place, do not appear to be routinely logged.

5.4.2.20. On **28th February 2014** the Fire Brigade carried out the requested home fire safety visit[62], but no further detail of the outcome is given from their documentation.

5.4.2.21. On **4th March 2014** the GP IMR records a home visit for a health check, and notes that Mr BC was requesting painkillers. A review of his medication took place the following day.

[61] Circle IMR
[62] Fire Brigade IMR

5.4.2.22. On **5th March 2014**, the Circle IMR notes a visit from the Fire Brigade to advise Mr BC on careless smoking and other fire risks. There is no matching Fire Brigade record.

5.4.2.23. On **6th March 2014**, the Circle IMR reports that an Acceptable Behaviour Contract was put in place with Mr BC regarding visitors to the building and his threats to staff. Recent trigger events for this are not identified.

5.4.2.24. On **20th and 26th March 2014**, First Choice notified Mr BC's daughter and social services that he had refused care and had behaved aggressively[63].

5.4.2.25. Again on the **14th/15th April 2014, and 15th/21st May 2014**, First Choice notified social services that Mr BC was refusing care, behaving aggressively and not eating.

5.4.2.26. On **2nd May 2014**, the housing scheme manager notified Mr BC's family about Fire Brigade strike action, with the family undertaking to monitor fire risk very closely.

5.4.2.27. On **19th May 2014**, the Circle IMR notes that the housing scheme manager undertook a risk assessment review, identifying risks from fire and self-neglect. The same day the Fire Brigade made a home fire safety visit as a result of station generated targeting of P1 postcodes[64]. The Circle IMR indicates that housing scheme staff again raised concerns about Mr BC's fire risks with the Fire Brigade and were advised to check on him 3 times a day, emptying ashtrays.

5.4.2.28. On **21st May 2014** the GP practice issued a prescription in response to the housing scheme manager notifying them that Mr BC had pain on urinating.

5.4.2.29. Concerns about Mr BC's verbal abuse of his care staff were recorded by Adult Social Care on **27th May 2014**, the IMR writer commenting on an absence of clarity in the records about any follow up action.

5.4.2.30. Major concern about risks arose in the early hours of **16th June 2014**, when all 7 IMRs record a significant fire-related episode in Mr BC's flat. The Fire Brigade and the Ambulance Service responded to a 999 call from the monitoring company in response to alarm activation. The Ambulance Service IMR records that Mr BC was found sitting on a sofa, alert. He had fallen asleep while smoking and drinking in bed, and a towel caught alight. He had extinguished the fire, and experienced approximately 3-5 minutes of smoke inhalation. Mr BC declined

[63] First Choice IMR
[64] Fire Brigade IMR

conveyance to hospital, although advised by the Ambulance Service that he had an unsafe amount of carbon monoxide in his blood. He was deemed to have capacity and to understand the ambulance staff advice and once again declined conveyance to hospital. Housing scheme staff were to stay with him for a while to monitor him, and he was advised to ring 999 again if he developed breathing difficulties. The Fire Brigade IMR notes that having dealt with the fire the fire crew called the Fire Investigation Team, who generated a report that was sent to the Fire Brigade's Borough Management. It was noted that Mr BC did not readily engage with fire crew and wanted them to leave him alone.

5.4.2.31. The Fire Brigade notified the Police that they were attending a fire[65]. The Police IMR records that the Fire Brigade had found Mr BC collapsed, but that there were no suspicious circumstances and the casualty was ok. The CAD message was marked "Police not required" and the message was closed without any police unit being assigned to attend.

5.4.2.32. The GP IMR notes that the GP was notified about the fire by housing scheme staff, and made a home visit. The GP discussed Mr BC's smoking and drinking with him, and while he declined any help with drinking he seemed keen to give up smoking. The GP's record notes that it was not safe for Mr BC to live in the housing scheme long term. A joint review by a doctor and the practice care manager[66] took place and Mr BC was noted to have capacity. The care manager did another social services referral.

5.4.2.33. The Circle IMR records that housing scheme manager raised a safeguarding referral. The Adult Social Care IMR records the incident and the safeguarding referral, which again notes the Fire Brigade as having said it was a question of when, rather than if, a fire would occur. The referral also mentions that the Fire Brigade took photographs demonstrating the fire risks in the flat, and that an emergency review was requested to increase care package hours and consider a move to more supervised accommodation. Section 2 of form was not completed, and no outcome of the referral is recorded on the form. The IMR writer states that he cannot find at the point of closure any evidence to show that attention was paid to the following extracts from the referral: "*The Fire Brigade notice various burn marks…it is a case of when rather than if there will be a potential fire*"; "*Request an emergency review with the possibility of increasing his care package until suitable accommodation with a supervision facilities is found*"; "*GP will order an x-ray for his lungs*"; "*The evidence that he is a high risk and that he needs to be in a more supervised environment*". He comments that the safeguarding referral appears to be closed without strategy discussion or the rationale behind closure being noted.

[65] Police IMR: Cad 864

[66] This appears to be a care manager within the GP practice rather than in Adult Social Care.

5.4.2.34. Again this provides evidence of the disconnect between safeguarding and adult social care, as a result of which serious concerns are not addressed through a concerted risk management strategy.

5.4.2.35. The First Choice IMR shows that the care agency was also aware of the fire having taken place.

5.4.2.36. The Fire Brigade IMR notes that the following day, **17th June 2014**, senior leaders of the Fire Brigade and Adult Social Care met and discussed this case among other issues. The photographs taken at Mr BC's flat were shown. No notes exist from this meeting, and it has been clarified by Adult Social Care senior management that it was held to discuss strategic level liaison rather than to escalate this particular case, which was used only as an example. No action in Mr BC's case was requested or followed directly from this meeting.

5.4.2.37. The incident on the 16th June 2014 represents a missed opportunity to convene multiagency involvement in devising an overall risk management strategy. An absence of leadership, combined with an absence of initiative from any party, produces a collective failure of joint action.

5.4.2.38. On **20th June 2014,** the Adult Social Care IMR notes receipt of a letter from the GP requesting a review of Mr BC's current accommodation, expressing concerns on his health and that of other residents in the accommodation.

5.4.2.39. On **12th July 2014** the Circle chronology notes an email from the housing scheme manager to Circle's specialist housing management team stating that in respect of the fire risks posed by Mr BC, the Fire Brigade had said they were happy with systems in the building"[67].

5.4.2.40. The Adult Social Care IMR reports that on **14th July 2014** a social worker completed a Community Review Form. The care package, noted as 14 hours per week, was meeting Mr BC's care needs adequately; his needs for support with personal care and daily living remained eligible. He was described as having deteriorating mobility and balance, and being prone to self-neglect due to alcohol use, but no psycho-social or cognitive issues were identified. His flat was well-equipped and his daughter managed his finances. The form notes the Fire Brigade's observations about burn marks following the fire on 16th June, and their comment that it was a matter of when rather than if a fire occurred. Despite this, in the section headed 'other issues' (including safeguarding and risk) none were identified.

[67] Circle IMR

5.4.2.41. The review resulted in an Outcome Focused Support Plan, which confirmed the 14 hours per week care package from First Choice. Mr BC's personal care and emotional wellbeing needs were identified as substantial. The IMR writer comments that despite again mentioning the fire on 16th June and the Fire Brigade's observations about risks, the documentation provides no evidence that any organisation is dealing with this potential threat to life.

5.4.2.42. This observation gives stark recognition to the emerging theme of inadequate attention to risk.

5.4.2.43. The Circle IMR records a call from the social work the same day, stating that he had spoken to Mr BC's family and there was currently "*no cause for concern*"[68].

5.4.2.44. The Circle IMR notes that on **21st July 2014** the housing scheme manager sent an email to the social worker in response to his request for details of people living in the scheme who were currently receiving a care package. The email listed all service users and highlights the date on which a review of Mr BC was thought to have taken place, though the housing scheme manager was not sure as she had not received notes.

5.4.2.45. On **23rd July 2014** a care worker raised concern to the housing scheme manager about Mr BC's weight loss[69]. The GP visited the same day but Mr BC was not at home. The GP had a discussion with Mr BC's daughter about her father's alcohol consumption, and subsequently ordered a chest X-Ray and weight monitoring[70]. The GP IMR notes although social services had visited a full assessment had not yet been done. The Circle IMR notes discussion with the GP about Mr BC's smoking, but Mr BC was not keen to attend smoking cessation clinic.

5.4.2.46. On **27th and 28th July 2014**, Mr BC refused care, with First Choice informing social services.

5.4.2.47. The GP continued investigations on the **8th August 2014**, discussing Mr BC's abnormal blood test result with medical colleagues. The GP had initiated a phone call to Mr BC's daughter, the IMR noting that a long discussion took place; the family were struggling with Mr BC's behaviour and the fact that he declined help with his alcohol consumption. He could not have his chest X-Ray as he was too drunk to travel. He had refused to be rehoused. The care workers and family members were going in and making sure ashtrays were empty to reduce fire risk. Over the subsequent few days, the GP ordered a DEXA scan, took blood tests and prescribed antibiotics, finding in two home

[68] Circle IMR
[69] Circle IMR
[70] GP IMR

visits that Mr BC was smoking less. It is not clear that the GP discussed the concerns with other agencies.

5.4.2.48. On the **31st August 2014** a care worker called 999 for an ambulance (though the First Choice IMR places this call on the 1st September). The Ambulance Service IMR records that Mr BC had fallen the previous night and hit the back of his head on a glass cupboard door, shattering the glass, but had got himself up and gone to bed. A small laceration to the back of his head was clean and scabbed; he had good skin colour and no difficulty in breathing, chest pain, nausea, visual disturbance or vomiting. He could self-mobilise and denied pain. He had old scabs on his back from previous falls. He declined conveyance to hospital against advice and was left at home in the care of his daughter. The GP IMR reports a home visit, during which Mr BC's wish to stop smoking was again discussed and he was given advice.

5.4.2.49. The Circle IMR records that a safeguarding referral was made due to his fall, and his self-neglect, and the Adult Social Care IMR records receipt of this referral. Section 2 (the Safeguarding Adult Manager section) of the form is not completed and no outcome is logged. The IMR writer comments that the Adult Social Care client recording sheet contains no reference to this referral, but that a later note on the case record indicates no further action. He again comments on the lack of reference to the rationale for closure, or who was involved in making the decision.

5.4.2.50. On **9th September 2014**, the Circle IMR records a call from the social worker to the housing scheme manager advising he had asked Mr BC's daughter to move a cabinet in the flat to reduce risk of injury should Mr BC fall.

5.4.2.51. The GP IMR records that on **11th September 2014**, on a home visit to support with the smoking reduction, Mr BC was found outside smoking, and was not interested in reducing his smoking further.

5.4.2.52. On **11th September 2014** smoke vent servicing was carried out at the housing scheme[71]. And on **18th September 2014**, a quarterly fire risk assessment found a broken smoke vent outside another flat, which was repaired as a result. There was no mention of issues relating to Mr BC's property[72].

5.4.2.53. The First Choice IMR records that on **18th September 2014** there was no response when the care worker called, and that the same day Mr BC fell and was taken to hospital. The hospital admission is also recorded on the GP's IMR, which indicates Mr BC had a urinary tract

[71] Circle IMR
[72] Circle IMR

infection. The GP IMR writer comments: "*nil on discharge summary re capacity – says alcoholic cerebellar degeneration syndrome*".

5.4.2.54. On **22nd September 2014**, the Adult Social Care IMR records an email request from the housing scheme manager for review of Mr BC's care package. The IMR writer comments it is unclear why, as no change in his situation is referred to.

5.4.2.55. The GP practice followed up the hospital discharge by phone to the housing scheme manager on **24th September 2014**, the IMR noting that the doctor and the scheme manager agreed Mr BC needed more secure accommodation, but he would not agree to move. He was known to decline help from the care workers who call 3 times a day, and to have declined help to stop drinking. The GP re-referred to social services for assessment of capacity and safeguarding issues. On 2nd October 2014 the GP also referred him to Adult Community Nursing to start vitamin B12 injections for anaemia.

5.4.2.56. On the **16th October 2014**, the social worker undertook a review of care and support arrangements, attended by the housing scheme manager and Mr BC's daughter Ms CC. A Community Review Form was completed, identifying risks as smoking and alcohol risk, refusal of medical care for smoke inhalation, and not recognising risks to others. Mr BC was advised he should move to a more supported environment, but refused.

5.4.2.57. The practitioner recorded a capacity assessment relating to Mr BC's ability to decide where to live and matters of welfare. His history as entered on the dedicated form refers to the possibility that he had long term brain damage due to previous strokes and to his long history of alcohol use, but this is not referred to at all in evaluating his capacity, which is reasoned as follows: "*Mr BC was clearly advised, informed and made fully aware regarding the possible consequences of smoking-related fire, alcohol abuse and of inviting undesirable people in his flat. He was also advised that he should move to a more supported environment, including 24-hour SLS or a residential care home. However, he clearly stated that he did not want to move anywhere, he had a tenancy agreement and he wanted to continue living there. He added that he has all the right to smoke, drink alcohol and invite his friends in his flat as other people. On basis of the above, I am in view that Mr BC has capacity to make decision regarding where he should live and his welfare*"[73].

5.4.2.58. The Community Review Form states that "*best interests assessment was considered, but not carried out because (1) he had mental capacity and he was able to make decisions in relation to his welfare and where he wanted to live, although he used to make unwise*

[73] ASC IMR: Mental Capacity Assessment Form

decisions, and (2) his liberty was not compromised and he always had free access to go into the community"[74]. The IMR writer comments: "*Mr BC's capacity created an inability for the local authority to have any powers of enforcement, citing quite rightly that the impact of his actions on others is through the route of the tenancy agreement*" [75]. The Outcome Focused Support Plan that follows this review appears to be a duplicate of the previous one of 14th July 2014. The Adult Social Care IMR writer comments that the review form is detailed and comprehensive on the issues of Mr BC's lifestyle and their impact.

5.4.2.59. The mental capacity assessment form referred to here is the only record of capacity assessment made available to the Panel. While it contains more information than other references to mental capacity elsewhere in the documentation, it is not convincing in demonstrating full application of the criteria or understanding of the relevance of best interests in the circumstances of the case.

5.4.2.60. On **17th October 2014** the GP IMR records concerns from the therapy at home service about Mr BC's medication, and his reduced capacity when drunk. A district nurse referral was made for further support to Mr BC. On **22nd October 2014** Mr BC's care was discussed at a multidisciplinary review meeting. The GP IMR does not record an outcome.

5.4.2.61. On **7th November 2014** Mr BC died in a fire at his home, as noted in all the IMRs (with the exception of the GP practice). A number of 999 calls brought a response by the Police (time logged as 05.24), the Fire Brigade (4 vehicles) and the Ambulance Service (several vehicles including the Helicopter Emergency Medical Service (HEMS): first call received 05.21, first vehicle arrived 05.34). The Fire Brigade IMR records that a "*moderate fire within flat with smoke spread to common areas*" was dealt with. Mr BC was rescued unconscious by the Fire Brigade Breathing Apparatus Team and CPR was commenced. The Ambulance Service IMR records that on arrival the fire brigade were performing CPR on Mr BC who was in cardiac arrest post smoke inhalation. The HEMS doctor carried out an assessment and treatment. BC was cannulated and intubated and a full drugs protocol administered. The HEMS doctor pronounced life extinct at 06:14.

5.4.2.62. The Circle IMR notes that the duty manager attended the fire, and the First Choice IMR notes Mr BC's death in the fire. The joint Police and Fire Brigade investigation at the scene found the seat of the fire to have been on Mr BC's bed. A senior leader of the Fire Brigade notified Adult Social Care, and requested details of interventions with Mr BC since the previous fire, to enable compilation of the Fire Brigade's

[74] ASC IMR: Community Review Form
[75] ASC IMR

internal standard procedure Fatal Fire Report, which was passed to the Coroner by the Fire Investigation Team.

5.4.2.63. The Coroner's inquest was completed on **30th April 2015**, the Coroner stating in court in inquest her verdict that Mr BC had died from inhalation of smoke, and that his death was the result of an accident. The Coroner indicated in court in inquest that the absence of smoke detector in Mr BC's bedroom was an important factor and that she intended to address a Prevention of Future Deaths Report[76] to the Chief Executive of London Borough of Hackney.

6. THEMED ANALYSIS OF LESSONS LEARNT

6.1. Introduction to the analysis

A number of common patterns and themes are apparent from the chronology, providing pointers to learning that emerges from the circumstances of Mr BC's death. A key focus in what follows is on how the various agencies involved worked together to help and protect him. Within each theme, both the strengths identified and the aspects needing improvement are explored.

6.2. How Mr BC's health care, social care and housing needs were met

6.2.1. Health care

6.2.1.1. It was well known by all involved that Mr BC had complex health problems; each assessment by Adult Social Care records his medical background in terms of physical conditions, and there is occasional mention also of his mental health and the possibility of long-term brain damage from previous strokes and high alcohol use. The GP surgery proactively pursued annual health check-ups, sought information from his former surgery on his history, and was vigilant about his day-to-day medical needs. Both the GP IMR and the Circle IMR provide evidence of good liaison between the GP, the housing scheme manager and Mr BC's daughter to ensure that he received prompt attention to problems such as urinary tract infection as they arose, referrals to specialists (urology and eye clinic) where appropriate, and advice on drinking and smoking.

6.2.1.2. Mr BC was not a compliant patient, however, and it is frequently noted that he did not attend hospital and GP appointments. The GP practice was proactive in visiting him at home, repeating visits until contact was made.

[76] Such reports are made under the Coroners and Justice Act 2009 and the Coroners (Investigations) Regulations 2013.

6.2.1.3. Mr BC's long-term alcohol use and smoking was well recognised. Early responses from the Police to domestic incidents indicate that they often stemmed from arguments with family members about his drinking. An early Adult Social Care assessment (23rd January 2008 at Homerton Hospital during an admission) records that his family was keen for him to detox, and he was referred to Crossroads for assessment. Mr BC did not keep this or a subsequent appointment and continued to decline intervention. Adult Social Care again during a community care assessment (16th October 2009) offered referral to the Community Substance Misuse Team, and the GP practice made repeated offers, all of which were refused. The GP was more successful in securing Mr BC's agreement to reduce his smoking habit during home visits during the summer of 2014, but it appears even there his motivation was not sustained.

6.2.1.4. Throughout, all the agencies involved worked on the assumption that Mr BC was able to make his own decisions on these matters, and as a result no alternatives to the 'under his own control' route were considered, even when the concern about his health moved into concern about his safety, and the safety of others. This report will later return to this question when considering questions of his mental capacity and of risk management strategies.

6.2.2. Social care

6.2.2.1. Adult social care undertook a number of assessments and reviews of Mr BC's needs for care and support, resulting in care plans that addressed his need for personal care through the commissioning of a care package from a domiciliary care agency, First Choice. Where reviews indicated a need for a higher level of support, this for the most part resulted in a modest increase of the hours commissioned.

6.2.2.2. While over several years the same social worker undertook these reviews, there is little evidence of on-going visits taking place between reviews other than when triggered by crisis of some kind. This may arise from the method of workflow used in Adult Social Care, with cases closed or dormant until a review becomes due or an event requires attention. What emerges is that the interaction with Mr BC was usually focused on practical matters over which he required support, rather than upon building a relationship that sought his perspective on the reasons for his behaviour and could provide the basis for change. Adult Social Care also confined its involvement to matters of care and support provision, and did not overtly take any coordination or leadership role in relation to an overall interagency risk management strategy. This report will return to this point later.

6.2.3. Housing

6.2.3.1. The local authority's housing department commissioned Mr BC's sheltered accommodation on the grounds of his housing need; he moved in in October 2010. The property is owned and managed by Circle Housing Group, the landlord, and is managed by their specialist housing management team. Centra Care and Support, also part of Circle Housing Group, provide day-to-day support and housing management services, consisting of an average of 2 hours per week of housing-related support and weekend wellbeing checks (with 5pm – 9am out of hours cover provided by another provider). The housing-related support may include practical advice with furnishing and decorating the property, routine home improvements and the use of equipment and appliances, encouragement to perform essential daily living domestic tasks, guidance and support on health and safety issues; assistance with benefit claims, help with budgeting, advice about local and specialist services, and opportunities to engage in activities outside the home, assistance in fulfilling tenancy conditions, and detention and prevention of crises, providing additional support when they occur and signposting to other appropriate agencies.

6.2.3.2. The Circle, Adult Social Care and GP IMRs all refer to the suitability of this accommodation for Mr BC being questioned. Circle note that the care and support needs presented at the time of referral related to self-neglect, health and isolation; there was no mention of dependency on alcohol or risks of accidental fire setting from careless smoking. "*On the basis of the information presented in the referral documentation, the landlord would have had no reason to refuse the referral*", which took place in the context of considerable pressure to accept allocations on the basis of housing need[77]. Mr BC's use of alcohol was well established at that time, though it is not clear what liaison took place between Hackney's Housing Department and Adult Social Care, and which of them might have been expected to provide information to Circle. The Circle IMR writer reflects that "*more stringent consideration of care and support needs and the associated risks at the point of referral by Social Services may have been prudent*." The Circle IMR also indicates that a fire risk assessment conducted by the company's external contractor on 26th February 2014 did find fault with a number of aspects of the building, including the evacuation procedure. The IMR writer concludes that, while not made specifically in relation to Mr BC, the assessor's observation does again call into question the fitness of purpose of this property for an extra-care or low mobility client such as Mr BC.

6.2.4. Family involvement

6.2.4.1. Mr BC's family, in particular his daughters, were closely involved in his daily care and support. Their input was recognised and relied upon by Circle, First Choice, Adult Social Care and the GP practice.

[77] Circle IMR

Frequent communication took place, particularly when Mr BC had experienced some adverse event, and one or sometimes both daughters were involved in all formal meetings and assessments.

6.2.4.2. There is some evidence too that the impact on them of providing care and support was recognised. An early contact assessment (23rd January 2008, at Homerton Hospital during an early admission of Mr BC) records that his daughter, Ms DC, declined a carer's assessment. A later referral by the family (23rd April 2009) requested carers' assessment for his other daughter (Ms CC) and one of his sons, and the ensuing community care assessment of Mr BC indeed does record consideration of his carers' needs, noting that a separate assessment was not necessary. Care planning at that point and subsequently clearly took account of the need to relieve some pressure on the family.

6.2.4.3. As time went on and risks intensified, family members frequently undertook to talk to their father about the risks he ran through his behaviour. In fact it could be said that the family were overly relied upon by Adult Social Care and Circle for risk management measures, in the light of what seemed to be a shared view that there were no options for intervention other than persuasion of Mr BC to change his behaviour, despite a well established pattern of him not doing so. Such measures (such as the purchase of fire retardant furniture) were clearly sensible and appropriate but in isolation unlikely to provide a robust solution.

6.2.4.4. It is significant that despite the frequent interaction with Mr BCs family, and the reliance on their involvement with and support to Mr BC, it is hard to discern from the documentation what they thought should happen. They clearly were concerned about the risks their father experienced, but it is not clear how much the professional network fully explored with them what they believed the options to be. It seems despite their support being recognised during assessment of Mr BC, a full carers' assessment was not undertaken at any point, nor was any in-depth discussion about how they saw their father's situation recorded. Their view can only be deduced from a comment made by Mr BC's daughter at the Coroner's inquest in court, stating that her father had in fact been willing to move to 24-hour supported accommodation, and had received an offer for the following February. This is a very different picture from that presented at the last review prior to his death, and cannot be substantiated from any other source.

6.3. Adequacy of fire measures

6.3.1. Given the circumstances in which Mr BC died, there has been an inevitable focus on fire safety measures, both in the building generally, and in relation to Mr BC's own flat. In relation to the building, the Circle IMR reports on the fire risk assessment dated 26th February 2014 – the last

such review prior to the fatal fire. The contractor was concerned about the evacuation procedure for low mobility residents. The IMR writer considers that this should have prompted a review of the suitability of this property for low mobility residents and those with extra care needs.

6.3.2. The IMR also reports that Circle's housing management support team conduct quarterly risk assessments of the communal areas of the building, the last before the fatal fire being on 18th September 2014. This mentions a broken smoke vent elsewhere in the building, later reported to maintenance, but no mention is made about the smoke vent outside Mr BC's flat, which was found by the Fire Brigade investigators to be turned off on the morning of the fatal fire in November. It was known to staff that residents could use the switch on the vent to provide ventilation in the summer or to prevent the vents opening with false fire alerts in the winter. Residents had been asked not to do this but the mechanisms were not changed. In addition, the mechanisms often broke down and were reported many times over a two-year period. The IMR writer concludes that repeated breakdown of a number of smoke vents in this building should have prompted a survey and planned programme of replacement, and that risk assessments must move beyond a tick-box exercise and must prompt careful examination of risk.

6.3.3. The Circle IMR, noting that after the fatal fire the Fire Brigade queried whether the landlord had considered retrofitting sprinkler systems, indicates that the housing association had mooted the installation of sprinklers more widely but this had not progressed to a feasibility analysis. The IMR writer comments that the retrofitting of sprinklers would clearly provide additional fire protection, although the cost of this may prove to be prohibitive.

6.3.4. Much attention has focused on fire safety measures inside Mr BC's flat. Even before his move to the sheltered housing scheme, Mr BC was known to runs fire risks from leaving pans on his kitchen stove, and from smoking in bed (Adult Social Care assessment 23rd January 2009) and Mr BC's daughter had been advised about contacting the Fire Brigade for smoke alarms. During his residence at the sheltered housing scheme, there were at least 10 incidents involving fire (for example, burnt toast, hob rings left alight, a towel catching fire in the bedroom), many of which were attended by the Fire Brigade. Circle stated in court in inquest that fire risk assessments at the current level or risk assessment for sheltered housing do not extend beyond front doors, with internal measures being the responsibility of tenants.

6.3.5. Under the Regulatory Reform (Fire Safety) Order 2005, landlords assumed the duty for assessing and mitigating fire risks in their properties. This includes a responsibility for producing a suitable and sufficient fire risk assessment for those properties. The suitability of this assessment depends on the nature of the property and the service provided in it. Currently Circle Housing Group, as the landlord, conducts a Type 1 risk

assessment in sheltered housing, which is non-invasive and (whilst it should take into account the general nature of the client group living there) does not go beyond the front door of a tenant's flat. It focuses on the common parts whilst often recommending that residents seek a home fire safety visit from the fire service for their own flats when encouraged to do by the scheme manager. The more invasive Type 4 assessments of the interiors of around 20% of flats in detail, as well as a destructive examination of the common parts, have not been introduced by the landlord for sheltered housing. The landlord and tenant both retain general responsibilities for the good repair of the property under the tenancy although no mention is made specifically of fire safety in that agreement[78].

6.3.6. Undertaking a higher level of assessment, while under active consideration, would have significant cost implications, although legal changes will introduce a requirement for a smoke detector in every room for new build and fire safety system upgrades.

6.3.7. The Circle and Fire Brigade IMRs show that fire safety measures and advice were provided for Mr BC. His flat already had smoke alarms in the hallway and sitting room, and a heat detector in the kitchen. The Fire Brigade provided fire safety advice on at least 6 occasions, sometimes initiated by the Fire Brigade's policy of targeting Home Fire Safety Visits in postcodes in which individuals at high risk were known to be living, sometimes undertaken in response to a request from Circle, or sometimes in response to an incident. Where the Fire Brigade gave advice, Circle acted upon it, for example installing a door closing mechanism to counteract Mr BC's habit of leaving his front door open, reinforcing advice on safe extinguishing of cigarettes, keeping ashtrays as empty as possible.

6.3.8. Given the seat of the fatal fire was known to be on Mr BC's bed, the Coroner in court in inquest placed much focus on the absence of a smoke alarm in Mr BC's bedroom, seeking to establish whose responsibility it might have been to install one. Circle has stated, and gave evidence in court in inquest to this effect, that they received no advice from the Fire Brigade about fitting a bedroom smoke detector. Their evidence specifically referred to the home safety visits conducted on 12th July 2013 and 4th Feb 2014. The Fire Brigade, however, has stated that on the 16th June 2014, the date of the moderate fire in Mr BC's flat, the Watch Manager returned to the property to give fire safety advice. In Mr BC's absence, the housing scheme manager gave access to Mr BC's flat so that photographs could be taken. The officer recommended to the scheme manager that a Fire Brigade smoke alarm should be fitted in Mr BC's bedroom; the scheme manager's response was that Mr BC would not be happy with a smoke alarm in his bedroom. The Fire Brigade note that they can only advise, not enforce advice in residential premises, but indicate that permission for installation could have been given by the resident or by the managing agent of premises. It

[78] Explanation provided by Circle Housing Group to assist the SAR Panel with the significance of the points made about fire safety measures.

has not proved possible for the SAR panel to see documentary evidence that confirms either of these two verbal accounts from the staff involved. The Fire Brigade home fire safety visit documentation is merely a tick-box form that does not record the substance of advice given.

6.3.9. It seems no agency saw it as their responsibility to ensure that a smoke alarm was installed in the bedroom; nor did Mr BC's family pursue this. The Coroner in court in inquest referred to the installation of a smoke alarm in the bedroom as an "*obvious and mundane*" measure. She referred to the fact Adult Social Care saw it as a housing issue, while the Housing Association saw its responsibility not extending beyond the front door of the flat, a "*system failure*". The Coroner on 30th April 2015 submitted a Prevention of Future Deaths Report to London Borough of Hackney's Chief Executive, raising the following matters of concern: *Whilst smoke and heat detectors were installed in (Mr BC's) hall and kitchen, there was no smoke detection system in his bedroom. He was known to be at significantly raised fire risk because of his smoking, drinking and immobility ... London Fire Brigade had been called to his home more than once in the past. However, his social workers never addressed their minds to the question of whether there was a smoke detector in his bedroom and, if not, whether that might be useful. This seems to be an area that would benefit from exploration for particularly high-risk service users.* The recipient of a Prevention of Future Deaths Report must respond within 56 days of the date of the report. It appears however that the report was not received; The Coroner's office has sent a duplicate and the local authority has 56 days from 11th February 2016 to respond.

6.4. The interface between individual agency actions and shared responsibility for safeguarding

6.4.1. There are two categories of safeguarding concerns: those arising from people entering Mr BC's flat, as a result of which he experienced theft, and verbal and physical abuse, and those relating to fire risks. The SAR Panel has found it difficult to identify the comprehensive pattern of referrals that were made. Adult Social Care records show 5 safeguarding referrals being received between January 2012 and June 2014; Circle say they made 9 referrals during this period. Some incidents might have been the subject of a safeguarding referral but were not. Examples include the theft of Mr BC's mobile phone by someone who had befriended him and accompanied him home, and the lit cigarette fires in Mr BC's pocket while travelling on buses. The Adult Social Care and Circle IMR writers both comment on the difficulty of identifying the patterns of referral.

6.4.2. The safeguarding forms available for the Panel to view are sometimes incomplete, with blank sections making it difficult to identify who makes what decisions, or sections meant for use by the safeguarding team erroneously completed by the referrer. Dates appear muddled, with some identical information appearing erroneously on different forms. The Adult Social Care IMR writer comments on the absence of an audit trail in the documentation, making it hard to ascertain the rationale leading to a

decision to close safeguarding referrals, or how key points raised were taken forward.

6.4.3. The two categories of concern rarely interlink in the discussions. The risks to Mr BC from visitors to the building and from his violent neighbour, Mr KL, seem to have been responded to in isolation from the fire risks posed by his smoking and drinking. The one safeguarding strategy meeting that is convened (13th November 2012), which is followed by a case conference (18th December 2012), considers the risks of violence from Mr KL but makes no mention of Mr BC's alcohol consumption and smoking, even though alcohol formed a key element in the interaction between the two men. The GP, who at the same time was attempting to engage Mr BC in alcohol treatment, is not listed as either attending or sending apologies. This seems a missed opportunity to engage a multidisciplinary network to consider the situation in the round.

6.4.4. In relation to the latter, there is mention of risk to other tenants and that the fire brigade said a fire would happen at some point. However, it cannot be seen how these points were followed up within the safeguarding process, nor do they always overtly join up with the on-going adult social care involvement. The on-going involvement seems sometimes to be the rationale for not pursuing a safeguarding process, yet the on-going involvement does not address the risks identified in the safeguarding referrals.

6.4.5. There appears to have been an absence of feedback to the referrer on the outcomes of referrals, contrary to expectations in the pan-London procedures, which state "*feedback should be given to the person who made the referral, taking into account confidentiality and data protection issues*" (p94).

6.4.6. Equally, referrers have not routinely followed up or escalated concerns when no response has been received. Both need to happen in order to ensure effective communications. One IMR makes the telling observation: "*people need to take responsibility until an outcome is achieved*". In some cases it has been claimed that follow up took place verbally, but because this is not recorded the quality of interagency communications about safeguarding actions and outcomes is in doubt.

6.5. Consideration of mental capacity

6.5.1. There is a marked lack of documented attention to mental capacity. Records sometimes identify that Mr BC had mental capacity without specifying the decision that this related to, or indicating whether capacity had been presumed (in line with the principle in the Mental Capacity Act 2005, section 1(2))[79] or fully assessed. Only in the GP IMR is mental capacity referred to at some key points in the narrative (for example when

[79] s1(2) MCA 2005: A person must be assumed to have capacity unless it is established that he lacks capacity.

Mr BC declined the GP's offer of support to reduce alcohol consumption). Elsewhere, consideration of mental capacity is for the most part conspicuous by its absence.

6.5.2. For example, in the first assessment undertaken by Adult Social Care (23rd January 2008) it was noted that a capacity assessment undertaken by a doctor on 10th January 2008 had concluded "*has capacity to make decisions*", though there is no mention of which decisions. The assessment form later shows the "*capacity assessment required?*" question ticked yes, but there is no evidence of such an assessment having been conducted. An Adult Social Care form completed 23rd April 2009 contains no prompt for capacity, or space to record any comment about capacity. The Care Plan dated 29th May 2009 mentions referral to the GP for a psychogeriatric assessment, due to leaving pans on the stove, and risks from smoking in bed. An assessment conducted on 16th October 2009, while recording that strokes had impacted upon Mr BC's cognitive as well as his physical functioning and the possibility of brain damage due to long term alcohol use, makes no link between this and the possibility of impaired capacity. The GP IMR recognises that while it was likely that at each doctor/nurse contact a capacity assessment should have been undertaken and documented, this was not clear from the records. The IMR does record that when Mr BC was discharged from hospital after admission for a fall on 18th September 2014, the discharge summary contains nothing about capacity, but does refer to Mr BC having "*alcoholic cerebellar degeneration syndrome*". This seems to have triggered the request to Adult Social Care for a capacity assessment, but apparently without consideration of whether this might need to involve a joint medical/social care approach.

6.5.3. The lack of focus on capacity is puzzling, given that respect for what was assumed to be Mr BC's lifestyle choice is a constant theme to emerge from the IMRs and their supporting documentation, and therefore mental capacity was implicitly crucial to how his situation was approached. Two key concerns arise:

- That a presumption of capacity overtook the need for proper assessment, when what was known about Mr BC's pattern of behaviour (acknowledging yet ignoring safety advice) and his brain damage from strokes and alcohol use should have raised questions about whether his executive brain function was impaired;
- That the ensuing conclusion that nothing could be done ignored the need for alternative approaches to secure his agreement to changes that would contain risk, or to consider whether imposed solutions were available in law.

6.5.4. If capacity assessment showed he had capacity over decisions about using alcohol and cigarettes, then a more strongly assertive relationship-based negotiation of key decisions about those aspects of his life and about levels of care and supervision could have been pursued. Equally, if capacity assessment showed he lacked capacity to make such decisions, best

interests intervention could have secured stronger risk management interventions.

6.5.5. Instead, the individual agencies involved were caught in the competing imperatives of respecting his autonomy versus promoting his welfare and dignity, and missing from the accounts given is a sense of how those options were systematically weighed and used in determining the way forward.

6.5.6. One formal capacity assessment exists on record, undertaken by the social worker who reviewed Mr BC's needs on 16th October 2014. The review comprehensively records the risks he faced, and gives an account of attempts to secure his agreement to move to a more supported environment or into residential care. The record of the assessment, and the mental capacity assessment form that accompanies it, provide no direct evidence to show how his ability to make this decision was assessed; it records only his continued assertion that he did not want to move and appears to use this as evidence of his capacity. There is no mention of the core determinative provision under Mental Capacity Act 2005[80], or of how the four key elements of decision-making[81] were evaluated. There is a puzzling reference to the fact that his living arrangements did not constitute deprivation of liberty.

6.5.7. Equally, given the complex picture presented by Mr BC's health and behaviour, and given the GP had raised concerns with Adult Social Care about whether it was safe for Mr BC to remain in the housing scheme and had requested they review his capacity to decide where he lived, it would have been appropriate for this to be a multidisciplinary capacity assessment, involving at least the GP and the social worker. In fact the GP practice's IMR queries whether they should in fact at this point have asked a consultant psychiatrist to see Mr BC again.

6.6. Developing a shared, interagency strategy on options for intervention based on an integrated picture of need and risk

6.6.1. All the agencies found it difficult to engage Mr BC in their efforts to keep him safe. His failures to attend appointments (for example to address his alcohol consumption and smoking over the period 2008-2010, to have specialist urology or eye-care assessment in 2014) were only one manifestation. He also declined personal care, either by not being at home

[80] s.2(2) MCA 2005: a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

[81] s.3(1) MCA 2005: a person is unable to make a decision for himself if he is unable: (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision.
s.3(4) MCA 2005: The information relevant to a decision includes information about the reasonably foreseeable consequences of (a) deciding one way or another, or (b) failing to make the decision.

when his carers called or by actively and sometimes aggressively rejecting them; he constantly re-engaged with his violent neighbour and drinking companion, despite being scared and shaken by Mr KL's violence; he sometimes refused hospital admission against advice; he did not respond to encouragements from practitioners or his family to change his smoking and drinking habits.

6.6.2. The reasons behind this do not emerge from the documentation this Panel has reviewed; if practitioners knew his perspective, they did not record it. It is clear, however, that the professional networks believed Mr BC to be exercising autonomous choice – that he was unwilling rather than unable to change. What is striking is that the fundamental picture does not change radically over time; the pattern of alcohol, falls, emergency services, hospital, fire risk, risk from others, repeats itself, with some intensification as health deteriorates, but essentially changed only by the removal of external risk factors (notably the eviction of his violent neighbour in September 2013).

6.6.3. There is evidence of active sharing of concerns on a day-to-day basis: frequent calls from First Choice to the housing scheme staff, social services and the family; communications from the housing scheme to social services, to the GP and to the family. But there are missing lines of communication also: to Circle about a full picture of Mr BC's needs at the point of referral for housing, and at key points such as some care and support reviews thereafter; between Adult Social Care and First Choice about management of Mr BC's behaviour; between the GP and Adult Social Care.

6.6.4. Three key features of effective case management are missing: a cumulative picture to inform risk appraisal and options for intervention; an overall, shared, interagency strategy; and appropriate escalation within and between agencies.

6.6.4.1. *The cumulative picture*: Consideration of the cumulative nature of the safeguarding referrals and other sources of concern, and reflection on the fact that interventions were not effective in mitigating risks, could have created a stronger impetus for consideration of alternative options. Instead each incident is dealt with in isolation; what was tried each time was 'more of the same', raising questions about whether the professional network collectively had become tolerant of, or desensitised to, the high levels of risk involved. The Adult Social Care IMR writer raises a particular concern that each safeguarding referral was responded to in isolation rather than as part of a cumulative picture, and that management oversight of decision-making on referrals was not apparent.

6.6.4.2. Engaging with the shared cumulative picture of concerns from all agencies might have led to 'something different' – either practice approaches such as motivational interviewing, which seek to enhance capacity for change and can be effective with people who self-neglect,

or overt consideration of legal options for more imposed measures. The Adult Social Care IMR comments that due to Mr BC having capacity and insight into his actions, the department had no legal process at their disposal. Yet even if the view that he had capacity ruled out best interests decisions or application to the Court of Protection, an alternative measure worthy at least of consideration could be the inherent jurisdiction of the High Court, now established as a route for seeking judicial involvement decisions where an individual does not fall within the jurisdiction of the Court of Protection (*DL v A Local Authority* [2012]).

6.6.4.3. There is no evidence that anyone other than Circle Housing Group took legal advice about the mounting concerns, and even here it is not clear that anything other than possession proceedings was considered. Although an acceptable behaviour contract (ABC) between Circle and Mr BC produced no change in his behaviour, this seemed to have no consequences. The Circle IMR comments it was unlikely that the landlord could have secured a possession order from a court, and there is no reason to believe this was not an accurate appraisal. But given the breached ABC, consideration of escalated measures on anti-social behaviour might have been consistent with the view that Mr BC had mental capacity and therefore had choice over how he behaved.

6.6.4.4. *Shared interagency strategy*: The second missing feature is a shared interagency strategy. It is striking that each agency did what it might have been expected to do, but often in isolation. The emergency services dealt efficiently with fires, falls, urgent health concerns, criminal activity towards Mr BC, and disturbances at the sheltered housing scheme. Adult Social Care conducted assessment and reviews of need for care and support, adjusting care plans as necessitated by Mr BC's needs for personal care. First Choice provided the care and support commissioned from them. The sheltered housing scheme provided high levels of housing-related support, and indeed mediated between Mr BC and a range of other agencies. The GP practice was proactive in addressing physical health needs.

6.6.4.5. Communication took place between key players on a day-to-day operational basis, but at no point did all those agencies gather together to share their experience of Mr BC, pool their knowledge and understanding about his needs, and devise collective strategies for managing the risks involved. As one IMR writer comments: "*as a result of agencies being sensitive to Mr BC's rights to continue with his nicotine use and substance misuse with disregard to either his or other's safety and wellbeing I read no evidence of coordinated action to deter him from either practice*". And another observes: "*there should be an active inter-agency risk management strategy meeting whenever a risk is identified or a service user at risk is identified*". Missing from discussions about safeguarding were the GP, the Police and the Fire

Brigade, all of whom had key contributions to make to an interagency strategy, along with First Choice staff who, along with the housing scheme staff, had the most contact with Mr BC.

6.6.4.6. Whether the appropriate route would have been safeguarding processes or some other forum matters less than the fact that the need and the route for pursuing it should have been clear. This is in part a matter of how procedures create space for interagency discussion in complex risk cases; equally it is a matter of practitioners involved in each case recognising the need for shared responsibility, and how their individual role contributes to a shared strategy.

6.6.4.7. Here, where work continued along parallel tracks, there was a clear need for coordination of the efforts being made by each agency and leadership of a shared approach. Given Adult Social Care's key role in assessing Mr BC's care and support needs and ensuring they were met, they would have been well placed to convene and lead interagency strategy discussion. Going forward, this responsibility is strengthened by the duties conferred on the local authority by the Care Act 2014[82] and by the Act's reciprocal duties of cooperation between all relevant partners (sections 6 and 7).

6.6.4.8. *Appropriate escalation*: The third missing feature is a failure to escalate concerns, both within and between agencies. The Adult Social Care IMR notes: "*There is no evidence of senior management being made aware of the need for leadership and guidance in response to the number of safeguarding concerns and level of risk, also the complexities of Mr BC's informed choices and the impact on himself and/or others. There is no evidence in the safeguarding documents of escalation of this case to more senior managers for leadership due to the number of safeguarding concerns and level of risk*". The IMR writer comments that the request to the resource panel for an increase in Mr BC's care package (12th September 2013) was a missed opportunity to bring the full scale of the risks he faced to the attention of senior management. The Circle IMR notes a number of missing incident reports that could have been made about events surrounding Mr BC, and also comments on a lack of communication back to staff from more senior managers: "*At the time of the incident it seemed common for staff reporting incidents to have no feedback from more senior staff and*

[82] Section 42(1) provides a duty on the local authority to make (or cause to be made) enquiries where an adult with care and support needs is experiencing (or is at risk of) abuse and neglect (including self-neglect) and as a result of their needs is unable to protect themselves. It is the local authority that must then decide what action should be taken and by whom (s.42(2)). Equally, the local authority's assessment duties under sections 9 and 10 may be carried out jointly with other agencies; the local authority must prepare and review a care and support plan on how needs will be met (s.24(1)). Statutory guidance (DH, 2014) requires that where a person has both health and social care needs, the local authority should work with other professionals to ensure that the person's health and care services are aligned (supported by common values and objectives at frontline level), and should link various care and support plans to set out a single, shared-care pathway – Care Programme Approach is given as an example, but the requirement is not restricted to that context.

communication of incidents to housing officers relied on the discretion of the support worker".

6.6.4.9. Equally, escalation between agencies was not common, despite concerns about lack of feedback. The Circle IMR comments on the lack of feedback from Adult Social Care on concerns raised, including safeguarding referrals, but it is not clear whether the absence of communication was raised higher in the organisation. Supervision notes from First Choice record a member of staff's concern that they were reporting Mr BC's smoking and risks to social services "*but they seem to do nothing"*. The agency comments that they would have expected, in the absence of responses from social services, to see escalation of the issues/concerns raised: "*If concerns were followed by coordinators or senior care managers and outcomes sought from social services, serious consequences like this one could have been averted*".

6.6.4.10. On one occasion, photographs of burn marks on furniture and bedding, taken in Mr BC's flat after the moderate fire on 16th June 2014, were used as an example of fire risks in a meeting of the senior leadership of the Fire Brigade and Hackney Adult Social Care. The Panel has been told, however, that this was not an escalation of an individual case, but a strategic level meeting to consider liaison over fire risks between the Fire Service and Adult Social Care. No action in relation to Mr BC himself ensued

6.7. Recording

6.7.1. Some of the IMR writers submitting reports to this SAR Panel have experienced difficulties in finding information from their own agency records, and comment that the quality of the records raises questions about practice. Email correspondence does not always make it through into case notes; phone calls are sometimes not recorded, or their content not noted. This makes it difficult to compile a complete narrative.

- "*The recording was of poor standard and at times hard to follow particularly when requests for a placement review were made and the subsequent review made no reference to the safeguarding concerns*"[83].
- "*Record keeping has been poor in some instances and it has not been possible to retrieve some data from archives … On several occasions internal procedures were not followed with regard to completing internal Accident/Incident Reporting Forms. This may have meant that patterns of risk could not be accurately identified in relation to the service user. It is regrettable that records do not accurately reflect the work of the Scheme Manager or the volume of communication which in reality we know took place*"[84].

[83] ASC IMR
[84] Circle IMR

6.7.2. The difficulty in constructing an audit trail of the safeguarding referrals, noted in an earlier section, seems to arise in part from erroneous recording of dates, possibly due to use of an electronic version of an earlier referral to record later concerns. Equally, there are reports by agencies of having made safeguarding referrals that are not noted by Adult Social Care (for example, the Ambulance Service on 30th October 2013, and some of the referrals raised by Circle), suggesting that recording systems at the time were not creating a systematic record.

6.7.3. The important link between recording and good practice is recognised: "*Our record keeping protocols need to be adjusted and improved. Good and elaborate record keeping enables care managers and subsequent managers/others to deduce and predict possible outcomes in some situations*".

6.8. Supervision, challenge and support

6.8.1. Working in circumstances such as those presented by Mr BC is challenging for the staff involved in a number of ways. Mr BC often behaved aggressively to care workers and housing scheme staff, raising the need for decisive management action in urgent situations and also active support mechanisms on-going. Equally, the frustration of attempting to provide care and support takes its toll on staff motivation and job satisfaction, and it is to the credit of the individuals involved that they remained concerned and committed to Mr BC's wellbeing over a long period of time. It is clear that those agencies whose staff were in the front line did indeed have staff support policies through which appropriate management responses to the pressures could be delivered.

6.8.2. What is less clear is how supervision was able to provide appropriate challenge to how practitioners thought about and approached their work with Mr BC. Certainly the GP practice provided evidence of consultation between colleagues, and with specialists, about Mr BC's health. But there is little mention in the Adult Social Care IMR, for example, of supervision discussions about Mr BC's case, or evidence that managers were able to challenge the assumption that all that could be done was being done.

6.8.3. Similarly, it is not evident that managers were involved in decisions about safeguarding referral closure, or were alerted to the links between safeguarding concerns and adult social care input relating to care and support needs and risk management around Mr BC's smoking and drinking. Appropriate challenge is an important element in casework of this nature, and is part of the checks and balances that need to be built into any system that comes under pressure.

7. CONCLUSIONS

7.1. Explanatory note on the conclusion and recommendations

7.1.1. The conclusions below are drawn from the themes emerging, as described above, from scrutiny of the evidence provided to the SAR Panel. Where those conclusions give rise to a recommendation, the recommendation is noted in italic type so that a clear link with a specific conclusion can be made. For ease of reference, the full list of recommendations follows in section 8.

7.1.2. Where research findings are mentioned, these are drawn from two sources:

- a research report commissioned by the Department of Health and published by the Social Care Institute for Excellence: Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. A link to the research report and summaries can be found in the references list;
- a study of serious case reviews (now safeguarding adults reviews) in cases of self-neglect, from which 3 papers have been published in the *Journal of Adult Protection*; again references can be found in the references list at the end of this report.

7.1.3. The focus here, in line with the remit of a SAR, is upon conclusions that can be drawn about multiagency and interagency practice. A number of agencies have indicated in their IMR that changes have been or will be made to their internal systems and approaches. These single-agency actions are not addressed below, but should the CHSAB choose to request actions plans from agencies, those action plans will clearly reflect single agency changes made in response to the review process, as well as actions that respond to the conclusions and recommendations specified here.

7.2. Housing

7.2.1. Mr BC was placed in an environment that was, from the start, not entirely suited to his support needs. Research[85] shows that providing support to tenants that goes beyond the level of support commissioned is a common experience for housing providers working with self-neglect. Here, Mr BC's needs were higher than notified to the housing association and involved risks that were not communicated to them. Relevant information about risks from his alcohol consumption and smoking, which were known to Adult Social Care, were not included the information given at application, whereas other factors such as his self-neglect, health issues and isolation were communicated. While it is not possible to identify why this was the case, and there is no evidence that information was deliberately withheld,

[85] Braye, Orr and Preston-Shoot, M. (2013)

or that the outcome of his application would have been any different, the fact that risks so quickly became apparent, and posed such challenges in the sheltered housing environment, indicates a need for a greater level of information sharing to facilitate more exact matching of provision to need.

7.2.2. Recommendation: There is therefore a need to review how communications between relevant agencies take place in the context of rehousing people with care and support needs that engage high levels of risk, either to themselves or to others.

7.3. Interagency risk-management strategy

7.3.1. The lack of overall risk management strategy was clearly evident in the way that agencies responded to Mr BC's needs, and to the risks he posed. While there were some effective lines of communication between different pairings of agencies on a day-to-day basis, a shared whole-system strategy was not in place. No one agency had the whole picture. Each agency focused on what they might be expected to do, given their core function, but often without linking this with what others were doing. This resulted in a number of shortcomings:

- matters that were no-one's job – for example, the smoked detector in the bedroom– did not get attended to;
- no shared perspective on the scale of risk or its management was developed;
- no shared consideration was given to options for intervention.

This is a common picture to emerge from safeguarding adults reviews in cases of self-neglect. When high-risk panels have been implemented, they have been found to be effective in improving interagency liaison on specific cases, and in sharing and managing risk more comprehensively.

7.3.2. Recommendation: A visible mechanism for escalated interagency risk management in high-risk cases is needed. This goes above and beyond what should be routine effective communication between practitioners in ongoing casework. It might take the form of a high-risk forum to which such cases can be escalated for discussion that brings all key agencies round the table to share information, discuss available options for intervention, plan and monitor a risk-management strategy.

7.3.3. Recommendation: Identification and active monitoring of such cases across the borough should be a priority, with a single agency identified for leadership on the mechanisms for implementation.

7.4. Leadership

7.4.1. The clear leadership that was needed in Mr BC's case was not forthcoming. In its absence, the fact that no agency took the initiative to convene the interagency system further contributed to the fragmented

nature of individual agencies' attempts to mediate risks. Again the need for strong leadership in self-neglect cases is a strong theme to emerge from safeguarding adults reviews[86].

7.4.2. Recommendation: High-risk cases that engage the attention of a range of agencies must have a named coordinator whose role it is to convene discussion that results in a shared risk management strategy.

7.5. Disconnected systems

7.5.1. Particularly problematic was the disconnect between safeguarding processes and adult social care responsibilities. The ongoing involvement of adult social care was given as a reason for not pursuing safeguarding processes, yet the safeguarding risks identified did not receive appropriate attention in ongoing care management, which focused primarily upon Mr BC's practical care and support needs. Even though risks were acknowledged and risk-reduction strategies attempted, their ongoing failure did not trigger any review of the cumulative picture, and the fundamental approach did not change.

7.5.2. Recommendation: Safeguarding processes should be reviewed to ensure:

- *that where it is proposed not to pursue a safeguarding process (because a case is open to adult social care), feedback is received on the actions taken/in progress to address the risks referred;*
- *that management oversight of referral closure is always in place;*
- *that a number of repeat referrals should trigger scrutiny of the cumulative picture rather than decisions in isolation.*

7.5.3. A further disconnect was between health and social care. The GP, who was proactive and engaged with Mr BC's situation, and in routine communication with his family and the housing scheme manager, had much to offer a more strategic level risk management discussion. Yet there is no evidence that such discussion took place, even when the GP raised the question of re-housing with adult social care. This was a key point at which a joint medical/social care approach to assessment, capacity assessment and care planning could have been fruitful.

7.5.4. Recommendation: Consideration should be given to how the potential of GP contributions to risk management can be enhanced.

7.6. Fire safety

7.6.1. Fire safety measures did not receive comprehensive attention. Concerns expressed in fire risk assessments about general safety of residents with low mobility did not prompt timely review by the housing association, and known shortcomings in the functioning of air vents were not attended to.

[86] Braye, Orr and Preston-Shoot (2015a; 2015b); Preston-Shoot (2016)

These points are not material in relation to Mr BC's death, but illustrate a need for more proactive follow up.

7.6.2. Recommendation: Housing providers must have robust measures in place to demonstrate that advice given in fire safety assessments is acted upon and be able to provide a strong audit trail on actions taken.

7.6.3. Recommendation: Assurance should be sought from providers about the quality and thoroughness of fire risk assessments, and how they comply with the duty for them to be suitable and sufficient.

7.6.4. More pertinently in relation to Mr BC, a smoke detector in the bedroom, given his known habit of drinking and smoking in bed, would clearly have been an appropriate addition to the fire safety measures in the flat. The SAR Panel was concerned at the different accounts given by the Fire Brigade and the housing scheme manager about whether a bedroom smoke detector was recommended after the moderate fire in June 2014.

7.6.5. Recommendation: The Fire Brigade should consider whether the detail of fire safety advice, particularly given in high-risk cases, should be recorded in writing to those with the power to act upon it (in this case the tenant/resident and the managing agent).

7.6.6. Recommendation: The Prevention of Future Deaths report from the Coroner on fire safety measures to be taken in respect of individuals living in high-risk situations will need to be considered. While the report is addressed to the Chief Executive of the local authority, it has implications for a number of agencies.

7.6.7. In addition to that practical measure, it is really not clear why a multiagency discussion of fire risks was not convened – this could have been initiated by any one of the agencies most centrally involved, and was arguably warranted on grounds of risks to others in the housing scheme, as well as to Mr BC himself.

7.6.8. Recommendation: Consideration should be given to what forum is best used for discussions of cases in which measures to contain high fire risk are required. This could be considered alongside the recommendation for an interagency high-risk case management forum.

7.6.9. Recommendation: Consideration to be given to whether 'near miss' fires should be referred to such an interagency panel.

7.7. Escalation

7.7.1. The overwhelming impression from the accounts of practice with Mr BC given in the IMRs and supporting documentation is of an approach in which a limited number of risk-management strategies was tried repeatedly – increased care, support and oversight from both the care agency and the

housing scheme staff, use of a key guard, key chain and door chain, discussion with the family, referral to substance use services, emergency service responses to incidents - despite evidence that they were not working. In these circumstances, escalation within agencies, for example within adult social care, might have been expected, to alert senior managers.

7.7.2. Equally, escalation between agencies would have been appropriate, yet did not happen. Concerns were routinely passed to others: the housing scheme raising safeguarding alerts; the care agency alerted adult social care when they could not deliver care; the GP wrote to adult social care about re-housing and capacity assessment. Not receiving feedback on such communications was part of the pattern of interaction, yet follow up and escalation did not take place. This lack of holding each other to account operationally contributed to Mr BC's case remaining 'under the radar' in terms of whether collectively the system was sufficiently worried about him. Despite repeated preventive home fire safety visits, it took an event (the fire in June 2014) to trigger senior manager involvement, but even then this was not viewed as an operational escalation of his case, the focus remaining on strategic liaison between agencies.

7.7.3. Recommendation: Staff in all agencies must be aware of triggers and mechanisms for raising and escalating concerns if feedback on routine requests and referrals is not received, and where high risks remain.

7.8. Relationship-based approaches

7.8.1. The adult social care focus on Mr BC's practical care and support needs gave appropriate attention to his personal care and care of his environment, such that those features of his self-neglect did not become extreme. Care staff and housing scheme staff were sufficiently persistent and persuasive to ensure that the care continued to be delivered, despite his reluctance and occasional refusal, and despite the aggressive challenges made by his neighbour and sometimes by Mr BC himself. However, even though the same social worker remained involved over several years, the opportunity for building a sustained relationship seems not to have been taken. Research[87] demonstrates that it is often only through relationship-based approaches that changes in an individual's pattern of self-neglect, or acceptance of risk-reduction measures, can be achieved. Yet there is little evidence here of exploring the reasons for Mr BC's behaviour, his life history and experiences, or of investing in a relationship of trust through which more assertive intervention could be negotiated.

7.8.2. Recommendation: There is a need for guidance for staff on working with people who do not/will not engage where risks are high.

[87] Braye, Orr and Preston-Shoot (2014)

7.8.3. Recommendation: Consideration should be given to how the time needed for relationship-based approaches - which go beyond practical care and support needs and explore the underlying reasons for behaviour, working for change based on trust - can be restored within the context of busy adult social care practice.

7.9. Mental capacity

7.9.1. Partly due to the absence of comprehensive risk-management strategy discussion, the agencies involved collectively failed to give systematic consideration to all available options for intervention. It seemed to be assumed, and in some cases was explicitly stated, that because Mr BC had mental capacity then if he chose not to change his behaviour or agree to moving to a more supervised environment nothing could be done. Yet the lack of documented attention to mental capacity, and indeed the nature of the documentation when it is present, raises concerns: whether the decision-specific nature of capacity was taken into account; whether capacity was reviewed at all appropriate points; whether assessment considered the possibility of impaired executive brain function; whether medical involvement might have been sought. These are all common themes to emerge also from safeguarding adults reviews in high-risk cases of self-neglect.

7.9.2. Recommendation: A renewed focus on mental capacity is necessary. Measures to support this might include:

- *Refresher training across a range of agencies on responsibilities for undertaking and participating in mental capacity assessment;*
- *Audit of case files to identify consideration given to mental capacity;*
- *Identification of triggers for multidisciplinary capacity assessment, and clarity over the routes for such requests;*
- *Review dates for repeat capacity assessments where people in high-risk situations are deemed to have capacity.*

7.9.3. Even with an enhanced focus on mental capacity in Mr BC's case, he may still have been deemed to have capacity to make key decisions relevant to his wellbeing and safety. In those circumstances, understanding of options for intervention when 'unwise decisions' place the individual or others at risk needs to be stronger than was evidenced in his case. This requires clarity over practice approaches (such as motivational work) that can have positive outcomes and on legal options for imposed intervention.

7.9.4. Recommendation: There is a need for guidance for staff on the range of options that need to be considered when people with capacity make decisions that place themselves and/or others at risk. This may need to involve training in particular skills/methods and on legal frameworks.

7.9.5. Recommendation: It will be important to ensure that legal advice is available to inform both single agency and interagency discussion of options for intervention.

7.10. Recording practice

7.10.1. Inadequate recording in a number of agencies, as detailed in the thematic analysis, has hampered the work of the IMR writers and of the SAR Panel in this case. More importantly, it seems likely that it will have hampered the ability of practitioners to build a clear and cumulative picture of risk in Mr BC's case, and to have easy access to a chronological overview of his situation.

7.10.2. Recommendation: There should be clear expectations on recording, both within agencies and within the interagency safeguarding process, with routine audit of compliance. Consideration should be given to the introduction of overview chronologies within client recording systems.

7.10.3. Recommendation: An audit of safeguarding referral form completion should ensure compliance with expectations on dates, signatures, reasoning of decisions, and management oversight.

7.11. Learning

7.11.1. It is vital that learning from this review is maximised. This will require a range of mechanisms for sharing the learning, but also consideration of the organisational contextual factors that facilitate learning transfer (Pike, 2010; Pike & Williamson, 2013). Equally, it is important to learn from examples of successful interagency working as well as from the kind of circumstances that trigger safeguarding adults reviews. Cases in which positive outcomes are achieved can help to identify the features and facilitators of good practice.

7.11.2. Recommendation: There should be a clear communications strategy for the review findings, under the leadership of the CHSAB.

7.11.3. Recommendation: Consideration should be given to developing a template for use by agencies to self-audit the key features on which action will need to be taken.

7.11.4. Recommendation: Learning and action plans from all agencies should be monitored.

7.11.5. Recommendation: The self-neglect protocol should be reviewed to ensure it reflects key features of learning from this review.

7.11.6. Recommendation: Alongside learning from cases in which a tragic death has occurred, consideration should be given to a practice development

strategy that learns from success through a focus on cases where there is evidence that the professionals involved have worked well together.

8. RECOMMENDATIONS: A SUMMARY OF THE RECOMMENDATIONS INTRODUCED IN SECTION 7 ABOVE

8.1. There is a need to review how communications between relevant agencies take place in the context of rehousing of people with care and support needs that engage high levels of risk, either to themselves or to others.

8.2. A visible mechanism for interagency case management in high-risk cases is needed. This goes above and beyond what should be routine effective communication between practitioners. It might take the form of a high-risk forum to which such cases can be escalated for discussion that brings all key agencies round the table to share information, discuss available options for intervention, plan and monitor a risk-management strategy.

8.3. Identification and active monitoring of such cases across the borough should be a priority, with a single agency identified for leadership on the mechanisms for implementation.

8.4. High-risk cases that engage the attention of a range of agencies must have a named coordinator whose role it is to convene discussion that results in a shared risk management strategy.

8.5. Safeguarding processes should be reviewed to ensure:

- that where it is proposed not to pursue a safeguarding process (because a case is open to adult social care), feedback is received on the actions taken/in progress to address the risks referred;
- that management oversight of referral closure is always in place;
- that a number of repeat referrals should trigger scrutiny of the cumulative picture rather than decisions in isolation.

8.6. Consideration should be given to how the time needed for relationship-based approaches - which go beyond practical care and support needs and explore the underlying reasons for behaviour, working for change based on trust - can be restored within the context of busy adult social care practice.

8.7. Consideration should be given to how the potential of GP contributions to risk management can be enhanced.

8.8. Housing providers must have robust measures in place to demonstrate that advice given in fire safety assessments is acted upon and be able to provide a strong audit trail on actions taken.

8.9. Assurance should be sought from providers about the quality and thoroughness of fire risk assessments, and how they comply with the duty for them to be suitable and sufficient.

8.10. The Fire Brigade should consider whether the detail of fire safety advice, particularly given in high-risk cases, should be recorded in writing to those with the power to act upon it (in this case the tenant/resident and the managing agent).

8.11. The Prevention of Future Deaths report from the Coroner on fire safety measures to be taken in respect of individuals living in high-risk situations will need to be considered. While this report is addressed to the Chief Executive of the local authority, it has implications for a number of agencies.

8.12. Consideration should be given to what forum is best used for discussions of cases in which measures to contain high fire risk are required. This could be considered alongside the recommendation for an interagency high-risk case management forum.

8.13. Consideration to be given to whether 'near miss' fires should be referred to such an interagency panel.

8.14. Staff in all agencies must be aware of mechanisms for raising and escalating concerns if feedback on routine requests and referrals is not received and where high risks remain.

8.15. There is a need for guidance for staff on working with people who do not/will not engage where risks are high.

8.16. A renewed focus on mental capacity is necessary. Measure to support this might include:

- Refresher training across a range of agencies on responsibilities for undertaking and participating in mental capacity assessment;
- Identification of triggers for multidisciplinary capacity assessment, and clarity over the routes for such requests to be shared;
- Review dates for repeat capacity assessments where people in high-risk situations are deemed to have capacity.

8.17. There is a need for guidance for staff on the range of options that need to be considered when people with capacity make decisions that place themselves and/or others at risk. This may need to involve training in particular skills/methods and in legal frameworks.

8.18. It will be important to ensure that legal advice is available to inform both single agency and interagency discussion of options for intervention.

8.19. There should be clear expectations on recording, both within agencies and within the interagency safeguarding process, with routine audit of

compliance. Consideration should be given to the introduction of overview chronologies within client recording systems.

8.20. An audit of safeguarding referral form completion should ensure compliance with expectations on dates, signatures, reasoning of decisions, and management oversight.

8.21. There should be a clear communications strategy for the review findings, under the leadership of the CHSAB.

8.22. Consideration should be given to developing a template for use by agencies to self-audit the key features on which action will need to be taken.

8.23. Learning and action plans from all agencies should be monitored.

8.24. The self-neglect protocol should be reviewed to ensure it reflects key features of learning from this review.

8.25. Alongside learning from cases in which a tragic death has occurred, consideration should be given to a practice development strategy that learns from success through a focus on cases where there is evidence that the professionals involved have worked well together.

9. REFERENCES

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10. APPENDIX 1: SAR PANEL TERMS OF REFERENCE

SAFEGUARDING ADULTS REVIEW: MR BC (deceased) - TERMS OF REFERENCE

A. General considerations

This Safeguarding Adults Review (SAR) will be carried out in accordance with the Safeguarding Adults Review Protocol of the City & Hackney Safeguarding Adults Board. The various contributors to the SAR will fulfil the roles allotted to them by the Protocol.

B. Case synopsis

At the time of his death Mr BC was a 72 year-old man of African-Caribbean heritage living in a supported housing scheme. Mr BC had problems with his mobility and balance. He mobilised indoors using a Zimmer frame and had difficulty transferring from chair and bed. He was reported to be neglecting his care needs and consuming excess alcohol. He was in receipt of a care package of 14 hours' support per week to support him with his personal care and activities of daily life. Mr BC was being supported by his daughters, who were managing his finances and paperwork and buying his food, giving him £80.00 per week from his benefits to spend on alcohol and cigarettes. They had also bought him some furniture.

On 16/06/2014 the smoke detector in Mr BC's flat activated due to Mr BC smoking in bed. Control Centre called the London Fire Brigade and they attended. There was a lot of smoke in the flat and a cloth on Mr BC's bedside table had also become burnt. Following this incident a review of Mr BC's placement took place involving care management, housing management, and Mr BC and his family. The risks around smoking were discussed in detail. The options of moving to a 24-hour supported living scheme or residential care were discussed. Mr BC was adamant that he did not want to move.

On 7/11/2014 the London Fire Brigade were called again to a fire in Mr BC's flat. They found that Mr BC had died due to smoke inhalation.

The coroner's court heard Mr BC's case on 30/04/2015. The verdict was of accidental death with recommendations for all professionals visiting vulnerable service users to check if adequate fire alarms are in place especially when fire risk has been identified.

C. Questions to be addressed by the SAR

1. What were the key points of assessment and decision making for Mr BC whilst he was being supported by health and social care services, and what can we learn from how these were carried out?
2. What was the professional understanding of Mr BC's risk and vulnerability at these key decision making points and how was this shared by the agencies involved?
3. What implications does this review have for multi-agency work with service users where there is an identified risk of fire?

4. Are there any issues of particular importance that the SAR Panel would like the CHSAB to consider in advance of completion of the report?
5. Where can we identify good practice in this case?
6. How can the City and Hackney Safeguarding Adults Board make sure the learning from this review leads to lasting service improvements?
7. What can the City and Hackney Safeguarding Adults Board do to hold agencies to account to improve the quality of services to service users where there is an identified risk of fire?

D. Membership of SAR Panel

- Chair: Chris Pelham, Assistant Director (Community and Children's Services), City of London Corporation
- Panel members:
  - London Ambulance Service representative to be confirmed[88]
  - Michael Pughsley, Property Programmes Manager (Centra – Part of Circle Housing)
  - Rod Vitalis, Station Commander (Shoreditch Fire Station, London Fire Brigade)
  - Robert Blackstone, Assistant Director of Adult Social Care (London Borough of Hackney)[89]
  - Dr Charlotte Morgan (NHS City and Hackney Clinical Commissioning Group)[90]
- Lead reviewer: Professor Suzy Braye, Independent Consultant

E. Information required from each agency/service area

- Internal Management Reports (IMRs) to be provided by named authors from the following agencies:

  - Adult Social Care, London Borough of Hackney
  - Landlord: Circle 33 Housing
  - First Choice Care Agency
  - GP: Heron Practice, John Scott Health Centre
  - London Fire Brigade
  - London Ambulance Service
  - Metropolitan Police

- The IMRs to include details of all staff members involved, a chronology of events, details of decisions taken and services offered, an analysis of practice, and suggestions/questions for the SAR Panel to consider (see Appendix C of the SAR Protocol for more details);

[88] Subsequently confirmed as Alison Blakely
[89] Subsequently joined by Adrienne Stathakis
[90] Subsequently joined by Teresa Gorczynska

- Supporting documentation (e.g. copies of assessments and support plans, minutes of meetings, emails and letters) to be made available if requested by the SAR Panel;
- Individual staff members to be available for interview by the SAR Panel if requested.

F. Outline timescale (for refinement by SAR Panel at its first meeting)

- 10 September 2015: first meeting of SAR Panel – to agree arrangements for IMRs and any other data collection, and liaison with Mr BC's family;
- End of October 2015: IMRs received by SAR Panel;
- November 2015 – January 2016: Analysis of IMRs and further information gathering by SAR Panel;
- Mid-February 2016: first draft of SAR report (to be discussed by SAR sub-group and agency representatives, and comments given to SAR Panel)
- Mid-March 2016: Final draft of SAR report/executive summary/ communication and improvement plan submitted by SAR sub-group to CHSAB for adoption