Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Lewisham Safeguarding Adults Board

Safeguarding Adult Review

Mr Cedric Skyers

Vic Citarella
July 2017

[1] Adult Services case record.

[2] The home is variously called a care home, nursing home and nursing centre. This report will refer to the home as Manley Court.

Board Statement on the Publication of the Safeguarding Adult Review concerning Mr CS

Lewisham Safeguarding Adults Board has today published a Safeguarding Adult Review that has scrutinised the circumstances surrounding the tragic death of Mr CS.

First and foremost all Board members wish to extend their sincerest condolences to Cedric's family and to express their determination that lessons will be learned from this review. The Board is also very grateful for the way in which Cedric's family has engaged with the review.

Lewisham Safeguarding Adults Board is under a statutory duty to commission a Safeguarding Adult Review where an adult has died as a result of abuse and/or neglect and there is concern about how agencies worked together. The review includes the terms of reference and details the findings concerning the circumstances surrounding Cedric's death as a result of burns sustained whilst smoking unsupervised by care staff.

The review explores the roles and responsibilities of care staff when working with disabled people who require care and support, and assistance with all aspects of daily living. It explores the use of paraffin-based emollient creams and medications that can cause sedation. It covers care home standards and contract monitoring, and best practice with respect to people who have mental capacity and prefer to smoke unsupervised but where this decision exposes them to potential risk. It covers the use of wheelchairs and posture belts for immobile residents who smoke, and evaluates the quality of risk assessments, medication reviews and supervision in this case.

There are recommendations that have emerged from an analysis of the available evidence, covering risk assessment and medication reviews, the roles and tasks of care home staff, and their recruitment and training. There are recommendations with respect to the use of enforcement and regulatory powers regarding care homes, practice standards in care homes, and the approach to safeguarding adult reviews when other investigations are running in parallel. Implementation of the recommendations will be designed to ensure that professionals involved in providing residential and nursing care, and in overseeing the quality of that care, are fully aware of their roles and responsibilities.

Lewisham Safeguarding Adults Board has required each organisation that had some involvement with Cedric at the time to prepare and submit an improvement action plan. These action plans have been scrutinised and approved by the Board, which will monitor implementation at subsequent meetings to ensure that the necessary policy and practice changes are achieved.

The Board will also ensure that a briefing summary is circulated to all staff members within the organisations involved to ensure that the learning from this case is disseminated widely. The review report will also be the focus of forthcoming learning and service development seminars, again to ensure that the learning is circulated widely and that the outcome of implementation of the recommendations gives reassurance about how organisations will provide quality care and support in future.

Professor Michael Preston-Shoot
Independent Chair
Lewisham Safeguarding Adults Board
October 2018

Introduction

1. Mr CS died on the 13th March 2016 in the resuscitation room of King's College Hospital, London. He was transported there by ambulance after having been discovered *engulfed in flames*[3] in the smoking shelter located in the garden of Manley Court Nursing Home[4] where he lived. Earlier he had been taken to the shelter in his wheelchair so that he could smoke. The cause of death was recorded as *extensive burning (50%).*[5]

2. Lewisham Safeguarding Adults Board (LSAB) determined that the death of Mr CS satisfied the Care Act 2014 (Section 44) statutory requirement for a Safeguarding Adult Review (SAR). It decided that an overview model, which documents events and analyses their causes, was appropriate in the circumstances; thereby satisfying the statutory guidance that the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

3. The overview report that follows has been independently authored by Vic Citarella. He has worked with a panel of the LSAB Chaired by Michael Preston-Shoot and had access to all the documents collected by the LSAB and those which comprised the bundles used by the inquest. The style of working has been based on some of the principles of root-cause analysis and has been both iterative and challenging for the professionals and agencies involved. Notwithstanding the multi-agency nature of a SAR, each agency is individually accountable for the analysis, review and improvement of its own policies, procedures and practices as well as being collectively accountable to each other and the public.

4. Being an overview, the work of preparing and writing the report sought to avoid duplication of work undertaken by individual agencies and regulatory bodies investigating Mr CS's death and the associated circumstances. The purpose of a SAR is to scrutinise and challenge the response of the LSAB partners, promote best practice, identify aspects for further improvement and recommend where multi-agency action is required. References in footnotes show sources of information and where matters are dealt with more substantially in other reports made available to the author. The report was written for publication and as such has been agreed by the LSAB.

Executive Summary

5. Mr CS died on the 13th March 2016 in the resuscitation room of King's College Hospital, London. He was transported there by ambulance after having been discovered engulfed in flames in the smoking shelter located in the garden of Manley Court Nursing Home where he lived. Earlier he had been taken to the shelter in his wheelchair so that he could smoke. The cause of death was recorded as extensive burning (50%).

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[3] Adult Services case record

[4] The home is variously called a care home, nursing home and nursing centre. This report will refer to the home as Manley Court.

[5] Autopsy Report 21st March 2016

6. The preparation of the SAR overview report involved consideration of the papers and findings of the Coroner's Inquest, reports submitted by BUPA – the operator of Manley

7. Court - and Lewisham Adult's Services plus the deliberations and thoughts of the LSAB panel.

8. The most probable cause for this fire was a cigarette coming into contact with Mr CS clothing, initiating a smouldering fire. The transition to a flaming fire would have been aided by the natural ventilation from the breeze in the garden[6].

Circumstances of the Death

Mr Skyers was a hemiplegic resident of Manley Court Nursing Home, who could not stand or reposition himself on his own, nor propel his wheelchair. He was wheeled into the garden to smoke, a regular routine, on the morning of 13th March 2016. He was assessed as safe to smoke on his own, but the staff were unaware that some of his laundered clothes had burn marks. He was known not to like supervision. He was unusually left alone in the garden and it was not evident how he could summon help. At about midday, he was seen to be on fire and immediate attempts were made to extinguish the fire by smothering and water, which was effective. It lasted less than five minutes.

It had been caused by the breeze fanning his smouldering clothes, burnt by his lit cigarette. Emergency services attended promptly and despite full resuscitation he died at 13.05 in hospital of extensive burning.

Had he been supervised or had means of alarm call, he would likely have survived.

Although not recorded, as evidence from the nursing home on the wearing of smoking aprons was not heard, Fire expert advice was accepted that had he been wearing a smoking apron, he would also have survived.

9. The Regulation 28 report[7] from the Coroner documented the circumstances of Mr CS death as:

10. The terms of reference of the SAR required a wider consideration of circumstances and context of Mr CS's death in respect of policy, procedure and practice. It was intended to support, scrutinise and challenge the subsequent actions of those involved as well as to aid future prevention and learning.

11. The SAR raises questions and offers responses in six areas:

    i. The use of paraffin-based emollient creams;
    ii. The matter of burn-holes found in Mr CS's clothing in his wardrobe;
    iii. Medications that can cause sedation;
    iv. Wheelchair use, posture belts and immobile residents who smoke (a concern raised by the Coroner);
    v. Whether Mr CS could have been 'saved';

[6] Fire Investigation Team Watch Managers report August 2016

[7] A report issued by the Coroner to prevent future deaths – the verdict is in the narrative. In the case of Mr CS, the report was sent to the Chief Executives of BUPA and CQC as well as the Independent Chair of Lewisham Safeguarding Adults Board.

vi. The question of supervision – and associated issues of risk assessment and preventative measures.

12. The review did not uncover any causative factors beyond those identified by the fire investigator and Coroner. However, Mr CS setting himself on fire through smoking was both predictable, even if at the lower end of the likelihood scale, and preventable with his consent to readily available harm reduction measures. Notwithstanding, a lack of supervision was accepted by both management and practitioners as a significant factor in the fire's consequent harm being deadly. The review suggests that it was the context of the rhythms and routines of the home, the care practices deployed and the short-comings of leadership and management where most improvements can be made and makes recommendations accordingly.

13. The review further raises issues of external oversight of Manley Court by the owners, the commissioners and inspectorate. How they dovetail their specific and collective efforts and resources to maintaining and improving standards both for individuals like Mr CS and for care home residents generally is a matter of concern to all Safeguarding Adults Boards. Again, recommendations are made.

Terms of Reference

14. Terms of reference were revised and agreed on 3rd May 2017 based on those used for investigatory work undertaken after the original decision to conduct an SAR soon after Mr CS's death. They were to:

i. Document and examine the events leading up to the fire on Sunday 13th March 2016.
ii. Review the original reasons for and suitability of Mr CS's placement and the outcomes of subsequent placement reviews.
iii. Review Manley Court care plans and risk assessments relating to Mr CS; examining whether Mr CS was subject to any Mental Capacity Assessments, and the outcome of these; and, any Physical Ability Assessments that were carried out.
iv. Examine the standards of practice within Manley Court managed by The British United Provident Association Limited (BUPA).
v. Consider whether these comply with BUPA-wide and/or local policies, procedures and guidance with particular attention given to care planning and risk assessment as well as smoking – residents, staff, visitors and contractors.
vi. Evaluate whether these met statutory and/or regulatory requirements and guidance (e.g. Health & Safety, Fire Safety, the Mental Capacity Act, and National Patient Safety Alerts etc.).

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Methodology

15. The approach and methodology utilised to address the terms of reference were intended to identify themes, solutions and achievable recommendations. The expectation was to contribute towards prevention of similar occurrences and to facilitate learning both specific to the incident and more broadly from the later life and subsequent death of Mr CS.

16. BUPA provided a root-cause analysis report (attached at Appendix C) which included a chronology. A report was received from Lewisham Adult Services which had a chronology covering the work of commissioning and safeguarding. Absence of case records meant that it was not possible to consider the reasons for Mr CS original admission and the suitability of the placement; nor his earlier life or care planning in the first few years of his stay at Manley Court.

17. The detailed chronology of the incident is taken from the witness statements provided to the coroner by those involved.

Circumstances of Mr CS's Death

18. "After breakfast, I got the standing hoist and entered in Mr CS's room about 10:30 XX said she is coming but I was aware she was attending another resident in room 40, so about 10:35 XX joined me to assist with transferring Mr CS from his bed into his wheelchair as he was already washed by the night staff, we did apply type of cream to his face or body.[8]"

19. "At 10:45 Mr CS was taken to the garden shelter with less than half[9] a packet of 10 RIP[10] cigarettes and a green lighter in his right-hand pocket. I pushed him in his wheelchair to the garden into the regular space under the shelter in the left corner, the large floor ashtray is also on his right side for easy access. It was a lovely sunny day but a little chilly with slight breeze, he said thanks, I gave him a big smile as I do, I then went back inside, this is a regular daily routine which Mr CS has done for many years going outside to smoke, he had full capacity to make his own choices, he was not a one to one for anyone to sit outside with him and supervise him smoking[11]."

20. At some time between 11:00 and 11:30[12] another care assistant took the left-side armrest to Mr CS which the first care assistant had forgotten when she took him to the shelter. She said she did this at the request of another resident. She went out to see Mr CS in the shelter and he asked for the armrest, she went and got it from his room and attached it to the left side of the chair. She stayed with him a few minutes checking he was balanced in the chair and adjusted his coat against the cold. He did not ask for assistance with lighting his cigarette, which he did on occasion, and she considered him safe to do so having seen him do it numerous times.[13]

21. Around 12:00pm was the next time staff were aware of Mr CS when he was seen from an upstairs window on fire. Staff went immediately to aid him and used water and

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[8] Mr CS's allocated care assistant that day

[9] The Fire Investigation Team reported there to be three left, suggesting Mr CS (part) smoked just the one that started the fire.

[10] Reduced Ignition Propensity designed not to continue burning when left 'unpuffed' see World Health Organisation - Fact sheet on reduced ignition propensity (RIP) cigarettes

[11] Mr CS allocated care assistant that day

[12] Times vary between witness statements

[13] Extracted from Statement of XX, care assistant, XX

blankets to douse the fire. LAS[14] were called. No one spoken to, among staff and residents, heard Mr CS cry out or shouting for help.[15]

22. At 12:02 the 999 call was received and three minutes later the Fast Response dispatched on a Red 1 call for a cardiac arrest/burns patient. By 12:07 an Ambulance was dispatched, and Fast Response had arrived on scene. “The wheelchair had been parked backwards in the smoking shelter with the patient facing outwards and the brakes applied. The patient was no longer on fire. Staff report they had extinguished him moments before my arrival. The patient's body was still smouldering and smoking. The patient felt hot to touch. The clothing on his upper body had been badly burned. The patient was displaying no signs of life. I removed the brakes on the patient's wheelchair and moved it out of the shelter. I then lay a blanket on the floor and the care staff assisted me in moving the patient to the floor. I then cut away the remains of the patient's top.

I was unable to feel a carotid pulse, although the patient had very bad bums to his neck. I had a listen to his chest and was unable to hear any breathing or heart sounds. The care staff started doing chest compressions under my instruction and I attached the defibrillator pads. I provided an initial update to the Advanced Paramedic Practitioner desk to inform them the patient was in cardiac arrest, had extensive bums and a difficult airway. Around this stage the ambulance, N304 arrived along with the London Fire Brigade. I provided a quick clinical handover and we discussed the next steps[16].

23. During the resuscitation of the deceased the paramedic first responders were stood approximately 10 metres away from the deceased and did not assist[17]. It fell upon the care home staff to remove the deceased from the wheelchair, position the deceased on the ground, and then I commenced CPR. I recall at around this time one of the paramedics suggested CPR should be commenced[18].

24. The Ambulance arrived at 12:11 and the LFB[19] (pump E301) arrived directly behind. My initial assessment (12:12) of the scene was that the patient was lying on his back on the ground, the clothes on his upper body were charred and tattered, and he had full thickness burns covering his head, neck and torso. There was a member of care home staff doing effective chest compressions, N950 was attempting to manage the patient's airway. Initially I instructed a member of the LFB to take over chest compressions from the care staff and requested that the LFB organise amongst themselves to change the person doing compressions every 2 minutes in order to maintain effective CPR. I put the metronome on the Lifepack and asked that the person delivering compressions follow the rate. The compressions were effective and remained so throughout…….[20]”

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[14] London Ambulance Service
[15] Statement of Metropolitan Police Service Officer XX
[16] Statement Fast Responder
[17] The inconsistency between statements is addressed – as far as it can be – in paragraph 77 below
[18] Statement of XX, RGN, Unit Manager, Jasmine Unit
[19] London Fire Brigade
[20] Statements of Paramedics

25. There followed detailed reports of treatments by the Paramedics with a decision made to transport Mr CS to hospital as a matter of urgency. It was noted that: "there was a delay in administering further doses of adrenaline as priority was given to removing patient from scene".

26. At 12:24 the police arrived and established a crime scene and informed CID. They checked for witnesses and established the CCTV was not plugged in[21]. At 12:29 the police constable went with Mr CS in the ambulance to hospital. His report said it stopped between 12:34 to 12:51 to undertake treatment to Mr CS at the roadside and arrived at Kings College Hospital at 12:59.

27. The stop for treatment was organised by the Paramedics at a rendezvous point so that an Advanced Paramedic Practitioner (APP) could take over management. The APP: "decided a surgical airway would need to be delivered and requested the patient be offloaded from the ambulance to allow full 360-degree access to perform the procedure. A second APP arrived to assist and agreed that a surgical airway was indicated and prepared the equipment, patient and crew for this to be delivered whilst CPR continued."

28. With some difficultly the APP "was able to get an i-gel into the patient which provided better ventilation. The patient was still in asystolic cardiac arrest and Advanced Life Support was continued throughout. The patient was loaded into the ambulance again and transported to Kings College Hospital as a priority trauma call."

29. "On arrival at Kings College Hospital at 12:59 the patient was still in asystolic arrest and showing no signs of improvement. We took him into the hospital and handed over to the trauma team. Shortly following this, at 13:05, the Emergency Department Consultant terminated the Resuscitation."[22]

30. "At 13:40 I placed items of clothing belonging to Mr CS into exhibit bags. I did not seal the bags as the LFB had to photograph them. It transpired that LFB personnel took pictures of all the exhibits. The exhibit bags were left with the body of Mr CS in room 10. I returned to Lewisham Police Station and sealed and stored the exhibits at 19:37."[23]

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Mr CS

31. Born on the 10th March 1947 in Jamaica Mr CS came to live in England as a teenager. He married and had two sons and two daughters, three grandchildren and one great grandchild. Subsequently he divorced. His son, described him as a likeable and popular man who was 'into his music' and poetry. He said his Dad liked to talk about his time in Jamaica[24].

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[21] It transpired not to cover the smoking shelter anyhow.

[22] This section comprises information taken from similar reports of the Paramedics involved

[23] Police statements

[24] Witness statement of XX

32. Mr CS was admitted to Manley Court on the 21st December 2006 aged 59 after a stroke resulted in him experiencing left sided paralysis which impacted on his ability to look after himself independently. He was deemed a young person with a disability. His medical records showed him to have had a history of schizophrenia (he was known to mental health services between 1994 and 2005 when he was discharged from the CMHT[25]), hypertension and diabetes.

33. Prior to admission Mr CS was at a Rehabilitation Centre and his home address was a hostel in Brockley Rise[26]. There were no records, made available, which told of Mr CS life before his admission to Manley Court.

34. Mr CS was re-assessed in May 2011 and at the time the recorded health issues were:

- Cerebrovascular Accident with left hemiparesis;
- Hypertension;
- Schizophrenia;
- Type 2 diabetes;
- Poor mobility due to pain in the knee and back pain;
- Poor speech.

All of which had continued impact on his general well-being and independence. Mr CS appeared to suffer from regular left sided pain – hand and foot including swelling. He was referred to a specialist for this and additionally for possible gastric/digestion problems. His ailments and pain were put down to lack of mobility and exercise and treated at various times with medications, among others, including Oramorph, Tramadol, Butrans and Fentanyl patches.

35. A letter[27] from Mr CS's GP showed there to be regular consultations in the year before his death. His medication regime had been reviewed on 25th February 2016 and tests resulted in a normal/no action outcome. The GP acknowledged that some of Mr CS medication could cause sedation or confusion. He said Mr CS had been on them for "many years and shown no signs of sedation or confusion during the time he had been on them. He added that it was not considered that smoking would increase or cause him sedation. There were no significant changes in Mr CS medication in the month leading to his death."

36. The continuing diagnosis of schizophrenia had been confirmed in December 2012 with the GP saying the illness was in remission and controlled by medication. The GP said, of Mr CS, that he "did not encounter him displaying any symptoms of mental disorder." He judged that over the time he knew Mr CS there to be "no concern about his capacity to consent to the medical treatments prescribed."

37. He was described as: "lucid and able to express himself clearly, for example, he would tell the carer what he did and did not want for breakfast. I believe he had capacity to make his own decisions. If he saw an incident in the unit he would usually tell staff. I believe he would be able to express himself if he felt the situation was unsafe. His

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[25] Community Mental Health Team

[26] The hostel is currently a residential facility for people recovering from alcohol and drug addictions.

[27] Letter to LSAB Business Manager 27th October 2016

memory was good and would often recall conversations from the previous day when discussing it the following day. He was most alert first thing in the morning when he was lying in his bed."[28].

38. Although Mr CS expressed a wish to return to the community, he was assessed as continuing to require assistance with all activities of daily living 24 hours a day. He was doubly incontinent and required assistance of two staff members for washing and dressing and to maintain his personal care. Mr CS was deemed not safe to self-medicate because he was sometimes forgetful and so had assistance. Likewise, he required assistance to meet his nutritional and dietary needs. By and large he could eat and drink without too much assistance and was aware of the need for a balanced diet as a diabetic. He was partial to the occasional brandy and coke.

39. Mr CS needed the support of two for all transfers using a standing hoist, and staff used a manual wheelchair for mobility around the home and outside. Additionally, he needed support with repositioning. The care plan included safe-handling in respect of mobility and required that Mr CS be secured by a posture-belt in his wheelchair to prevent falling. Additionally, Mr CS was at risk of falling out of bed and, with his consent, had bed rails in place to protect him.

40. Notwithstanding his physical dependency and enduring left-sided pain Mr CS came across as being strongly independent of will and spirit. He declined some personal support services, chose to eat takeaway food, dreamed of Jamaica and disliked what he felt was being 'treated as a baby'. A typical day saw Mr CS assisted with his personal care and in taking his "*due and prescribed"*[29] medications, he usually slept, ate and drank well and was supported to wash and toilet. He commonly, throughout the year (rain or shine), spent much of his day in the garden smoking and interacting with other service users. He watched some TV (football and cricket), listened to the radio, enjoyed a good book and joined in activities and outings – music, poetry, bingo, dominoes, arts, crafts and pottery, shopping and trips to the seaside. He had the occasional visitor – his son and a woman friend - and attended Catholic Church.

41. His care plan included assistance with cleaning his glasses – he could not do this because of his left-side paralysis – and a reminder to use the call system – his room was near the office and he tended to shout out for the nurse. The plan noted that he sometimes had trouble with his memory and suggested that staff repeat important information and post memory aide notes for Mr CS. The plan was strong on maintaining basic health, but lacked specific therapeutic input related to say exercise and speech but concerned to alleviate any boredom. Mr CS wanted to be involved in his own care planning and to involve his son (s). It was noted that he was most alert after breakfast as a time for care planning.

42. A general risk assessment was completed on the 3rd January 2016 after the absence of risk assessments in the care plan was raised at a review on 22nd December 2015. The reviewing officer made this an action point in respect of Mr CS's "smoking habits". The consequent risk assessment identified the hazards of burns, smoke inhalation and

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[28] Statement of XX, RGN, Unit Manager, Jasmine Unit

[29] A turn of phrase used routinely in the day logs of care staff

death. Harm could be caused to residents, staff, relatives, visitors and contractors. The current mitigation was the provision of the smoking shelter in the garden. Additional measures were for the admin/activity coordinators to buy Mr CS's cigarettes and they be "given to the nurse on duty to give to him whenever he asks for cigarettes" and staff to take him to the garden. Unfortunately, there was no consideration that Mr CS might harm himself from smoking and thus no self-protective measures included in the plan.

43. Notwithstanding, the rest of the care planning documentation supplied (2015 and 2016) impressed as being thorough. There were regular monthly updates and annual reviews recorded. Most key aspects of life, health and well-being were covered including mental capacity and future planning. There was no deprivation of liberty requirements in place as Mr CS was assessed as having capacity and capable of making his decisions. He had indicated he wanted to be cared for at Manley Court until his death. He had requested his son be informed of any decline in health, that he wanted to be resuscitated if needed and that he wanted to be attended by both Rastafarian and Roman Catholic priests at his end of life. He asked for a burial in Jamaica with a horse and cart funeral.

44. One observation made relates to Mr CS financial accounts. His account was opened on 22nd December 2006 - the day after admission – with £20. It gradually increased to a peak of £4,445.98 on 17th May 2011 and from there declined to a closing balance of £649.48 on his death. There was a total of 1,302 transactions and there was no obvious explanation for this pattern of accumulation and then spending. The largest withdrawal, leaving aside corrected errors, was for just over £300 for a TV in April 2011; there were no individual transactions that caused alarm. Expenditure itemised as 'cigarettes' increased in the latter years and a point of speculation was that Mr CS actually started, or re-started, smoking – something he most likely ceased as part of his stroke rehabilitation - whilst at Manley Court. His smoking appeared to have increased as the years passed – his final review in December 2015 commented on his habit – and along with the rising costs they together may account for the draining finances.

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Manley Court

Background

45. Manley Court is a purpose built home providing care and nursing. The CSCI[30] inspection report of May 2009 stated the home had been operating since 1996. It is arranged over two floors and is divided into four units of which two provide nursing care for older people with dementia, one for younger adults with physical disabilities and one for palliative care. The provider is BUPA Care Services who took over from Associated Nursing Services (ANS) who own the building.

[30] The predecessor regulator to CQC

Registration Category, Conditions and Inspections

Throughout the reports staff generally have been 'rushed off their feet' and, whilst work in a care home is always busy, there appeared to be several occasions when the low staffing levels, culture and the disjointedness in the work teams has meant the residents were not supported or supervised as they needed to be and as many of the staff would want them to be. It is possible that the staff were so busy attending to the needs of the frailer residents in a care task approach. Mornings always tend to be the busiest time in a home, it is suggested in several of the reports that residents were often left for long period in bed or in the day rooms *(or the garden shelter?)* without the vigilant presence of staff.

46. The CSCI May 2009 report states the home is registered to accommodate 85 people of whom 36 may have dementia, 49 may be frail older people of whom 6 may need palliative care and 14 may be aged over 40 years and have a chronic illness.

Under 65	**Dementia**	**36**
	Physical Disability	**49**
Over 65	**Old Age**	**49**

The CQC May 2012 report published in October 2012 recorded the Registration Category as providing accommodation and nursing care for a maximum of 85 older people.

The CQC April 2013 report published in June 2013 recorded the Registration Category, as a home that provides accommodation and nursing care for a maximum of 85 people who may be elderly, have dementia, or be younger adults with a physical disability. This category has remained the same up to the CQC March 2016 report.

47. Attached at Appendix A is a report summarising the findings from eight inspection reports undertaken since 2009. They show some patterns around the workforce, management and the environment. The picture is one of a home 'bumping along' just about maintaining 'good enough' standards to fend off determined enforcement action from the regulator. The final paragraph of the report is reproduced below:

Fire Safety at Manley Court

48. Typical occupancy rates run at between 77 and 85 residents. Manley Court is divided into four different units each providing focussed care for residents with different conditions as follows:

i. Hibiscus 26 beds – palliative care
ii. Jasmine 23 beds – younger physical disabilities
iii. Primrose 17 beds – elderly dementia
iv. Lavender 19 beds – elderly dementia

49. Mr CS lived in the Jasmine Unit where there were 21/22 people in residence at the time of the incident. Four of the unit residents, including the deceased, were smokers. Mr CS most commonly smoked in the outside shelter[31] with two other male residents. Residents were allocated a care worker each day/shift and the unit manager had an expectation that "the maximum time that may elapse between a resident being reviewed by his allocated carer is 20 minutes"[32]. (The registered manager said her expectation is 10/15 minutes and "it would be unacceptable for a resident to be unobserved for a period exceeding 30 minutes"[33]). There was no CCTV camera that provided coverage of the smoking shelter.

50. BUPA had policy documents: BUPA Care Services UK Property and Development – Smoking, and BUPA Care Homes Fire Risk Assessment which staff reported not to have seen. The smoking guidance was one of 23 fire guidance documents in the BUPA Fire Guidance Manual (BFM). Among other things "the smoking guidance requires that there is a local policy on smoking, and also a smoking risk assessment which should be performed in relation to individuals who wish to smoke. The individuals risk assessment should be retained in the individual's care records*"*[34]*.*

51. The smoking policy asked questions about the arrangements as follows:

- **i.** Is the home smoking or non-smoking?
- **ii.** Is there an external area where residents and their visitors can smoke?
- **iii.** Is there a designated smoking room, or if residents smoke in their rooms – is there an assessment in place, is it suitable?
- **iv.** Is there a staff smoking shelter/area – is the location suitable?

52. It went on to advise: "Following a number of fatalities in care homes while residents were smoking following the application of paraffin-based skin medication it is recommended that all resident smoking risk assessments are reviewed to ensure that the correct protection and procedures are in place." The relevant fire assessment at Manley Court had an action for the registered manager to complete by February 2016. There was no entry in the 'completed' column[35].

53. Fire Safety Awareness training provided at Manley Court was based on this BUPA policy of May 2014. On smoking, it started with the basic premise that: "BUPA takes the view that smoking is a hazard to the health of all employees either through the direct inhalation of smoke or as a result of passive smoking. It also considers that smoking and the use of ignition materials constitute a fire hazard." It went on to remind that every home will have local policy which addresses the questions identified in the policy about the arrangements for smoking if any is permitted. There were no documents that have been made available that indicate what the local policy was at Manley Court, although clearly the custom and practice was for residents (visitors and most likely staff) to make use of the shelter outside in the garden.

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[31] *Situated within the garden at Manley Court is a designated smoking shelter which is metal frame with clear Perspex sides* – Statement of XX, Manley Court, Maintenance Operative

[32] Statement of XX, RGN, Manager, Jasmine Unit

[33] Statement of XX, Registered Manager, Manley Court

[34] Statement of XX, BUPA Fire Risk Assessor/Safety Advisor

[35] BFM 20 and Manley Court fire risk assessment prior to the incident 7th October 2015

54. All staff at Manley Court had received Fire Safety Awareness training except the registered manager. Care staff could not commence work unless they had done this. The training included the need to "monitor smoking residents regularly and the risks associated with flammable substances."[36] It did not cover fire risk assessment or smoking risk assessment. These are clinical matters outside the scope of that training."[37]

55. Thus, neither fire nor care plan training included individual smoking risk assessments at the time of the incident[38]. The registered manager made a statement which said: "I found myself in a position at the care home whereby I had not received the appropriate level of instruction of training in relation to conducting a risk assessment. In addition, BUPA have a training department and, to the best of my knowledge, how to conduct an appropriate and thorough risk assessment was not on the programme for staff members."[39].

56. A BUPA Regional Director managed Manley Court along with several other homes in the London area (8-11). She said the home was not one that "caused me undue concern until this particular incident." There had been a safeguarding issue with London Borough of Lewisham in 2014 and a concern from Care Quality Commission about staffing levels in one of the units, but "not dissimilar to issues I encounter in other units."[40]

57. She indicated that she was responsible for assessing "particularly high-risk residents and ensuring that risk assessments have been completed". It was this Regional Director that prepared the BUPA Root Cause Analysis report which has been submitted to this SAR and to the coroner. That report is attached at Appendix C.

58. This author concurred with most of BUPA report – there are some immaterial matters of accuracy – and endorses the sections on contributing factors and the recommendations as providing a substantive contribution to this overview. They are replicated on the next page unchanged:

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[36] *The use of emollient creams is covered in training related to medications delivered by external trainers*
[37] Statement of XX, BUPA Area Trainer
[38] Statement of XX, RGN, Manager, Jasmine Unit
[39] Statement of XX, Registered Manager, Manley Court.
[40] Statement of XX, BUPA Regional Director

Contributing factors were:

- It was the practice within the home to comply with a resident's wish to smoke once it had been established that the resident had capacity to make the decision to smoke and that they were physically capable of doing so. There was no formal observation or periodic checking of residents who were smoking in the garden, albeit this did happen in practice more often than not. It was assumed by staff that a resident who was physically capable of smoking was not at risk of fire as a result of that activity and placed significant value on allowing residents their privacy where it was believed this was their preference.
- There was an unacceptable reliance placed upon other able-bodied residents who smoked and who would relay messages from wheelchair users to staff, for example if they had finished smoking and wanted to come back inside.
- The individual smoking risk assessment for CS did not identify the relevant risk to him.
- Staff did not think to offer CS a bell or pendant by which help could have been summonsed. However, accounts from staff familiar with CS record that he was an independently minded individual. It is therefore not known whether he would have tolerated carrying either a pendant or bell when smoking.
- Despite receiving training, and receiving reminders twice in November 2015, the home manager had failed to appreciate the extent of her role in relation to fire safety within the home and in particular in relation to smoking assessments required for residents.
- There had been a failure to communicate the findings of the fire risk assessment and a manager's briefing relating to smoking risks to all staff within the home.
- There was a lack of sufficient training for staff who were expected to conduct smoking assessments for residents.

Recommendations include:

- Improved smoking risk assessment to be produced for all residents – (implemented within 2 weeks of the incident) Training should also include appropriate risk factors relating to resident smoking (such as mental capacity / change in physical abilities relating to smoking / signs to check for around clothing / flammable topical ointments and the appropriate safety requirements needed to reduce the risk / outcome.
- All staff who are required to produce, write or own a risk assessment should have appropriate training on how to assess risk and implement strategies to reduce the risk.
- There should be training / coaching for nurses to write a supportive care plan based on the risk assessments and to be able to look at the monthly evaluations and ensure that they are fit for purpose and demonstrate safe person-centred care.
- The business should review the way in which Fire Safety is delivered to new home managers as part of their formal induction ensuring that this is conducted by an appropriate person, and the new home manager signed off as competent.
- There should be a review of fire training delivered within all homes to ensure that it includes resident smoking / smoking policy within the home.
- There needs to be a formal induction programme for home managers to attend all mandatory training within one month of starting within a home.

The BUPA report documented recommendatory action for the organisation to take in respect of care planning and risk assessment, training and home management, staff attitudes to smoking, fire risk assessment and the use of emollient creams. As a report, it came across as frank about the short-comings which most likely contributed

to the inability to prevent Mr CS's death. There are some suggestions in the conclusions and recommendations of this report below regarding how BUPA could improve its care practice and oversight of quality standards.

Commissioning for the service received by Mr CS at Manley Court[41]

59. As stated above Mr CS was placed at Manley Court by LB Lewisham in 2006 and re-assessed at a review in 2011. At the time, it was reported that Mr CS was 'not following the rules and procedure of the home' as he was smoking in his room and this was identified as a risk to the environment, however the assessor was told that this was being closely monitored by the staff at Manley Court. There was no record of any discussion about risk assessments or how this was being monitored, or whether this issue was reflected in Mr CS care plan at the time the re-assessment was completed.

60. Further reviews took place in 2012 and 2013. Both indicated that Mr CS liked to spend time with other residents in the smoking area in the garden and that he used some of his personal allowance to purchase cigarettes. Again, this was not identified as a potential risk, either by the staff at Manley Court or by the reviewing officer, and there was no discussion about risk assessments or how his smoking was to be monitored within his care plan.

61. It was not until the next review in December 2015 that Mr CS's smoking was identified as a potential risk when there was a discussion about the level of his smoking. A health care assistant stated that he used to smoke a few cigarettes a day but that he had been smoking a lot more recently, to the point that he was 'almost a chain smoker'. The staff member said that it was almost as if Mr CS was in competition with his friends as to who could smoke the most, and Mr CS, who fully participated in the review, laughed at this comment and agreed, stating that he enjoyed smoking. It was at this point that the review officer noted that there was no risk assessment or care plan in place regarding his smoking habits and she requested that this be rectified and identified it as an action point for the home's manager within the review.

62. The normal procedure following a review was for it to be finalised and authorised by a manager before being presented to the Vulnerable Adults Funding panel to agree funding for a further 12 months. Once the case was agreed at panel the review was sent out to the service user, the care home and any family members who were present or consulted with as part of the review. A letter would accompany the review form to the care home and this would refer to any action points that had been agreed at the review that required follow-up. If there were outstanding actions for the care home/others, the review officer would hold the case for a further 4 weeks to ensure that actions had been implemented. Due to a combination of annual leave and other work pressures Mr CS review was not presented to the panel until the 10th March 2016, a few days before his death. The review paperwork and letter to the care home were due to be sent out that week. Despite this the manager at Manley Court had already acted on the recommendations of the review officer by completing a risk assessment in early January 2016. It was viewed and copied by the Contracts Officer who visited the home the day after Mr CS passed away. This risk assessment was

[41] Information in this section is drawn from a draft report for the LSAB Chair prepared by XX, Service Manager, Safeguarding Quality Assurance, LB Lewisham, in March 2017.

deemed poor and did not appropriately address the risks associated with Mr CS smoking and how these were to be managed. Had the review been sent out earlier, together with a letter requesting this point to be followed up and had the placement review team seen evidence of the risk assessment earlier, they most likely would have gone back to the home to request that a more detailed risk assessment be completed.

63. LB Lewisham assured the LSAB that they have put in place measures to ensure risk assessments related to smoking are included in annual placement reviews. Further assurance has been given that review actions will be followed up within four weeks of reviews taking place irrespective of specific staff availability and of considerations of placement panels.

64. On a more general level, the quarterly contract monitoring activities of LB Lewisham Adult Social Care reflected similar concerns to those raised in the regulator's reports. Inconsistent management and the quality of leadership, particularly clinical, featured highly in the reports. In September 2015, an action plan had been sent to the home. This was because the new manager lacked relevant experience and was not a clinical leader. She was making increasing use of agency nurses, especially on the younger adult's unit (where Mr CS lived), where the team was not working well. In the opinion of the Contracts Officer this was "leading to inconsistent care planning and risk assessments."

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Analysis and Improvements

Cause of Mr CS death

65. "The most probable cause for this fire was a cigarette coming into contact with Mr CS clothing, initiating a smouldering fire. The transition to a flaming fire would have been aided by the natural ventilation from the breeze in the garden."[42]

66. The regulation 28 report[43] from the Coroner documented the circumstances of Mr CS death as:

Circumstances of the Death

Mr Skyers was a hemiplegic resident of Manley Court Nursing Home, who could not stand or reposition himself on his own, nor propel his wheelchair. He was wheeled into the garden to smoke, a regular routine, on the morning of 13th March 2016. He was assessed as safe to smoke on his own, but the staff were unaware that some of his laundered clothes had burn marks. He was known not to like supervision. He was unusually left alone in the garden and it was not evident how he could summon help. At about midday, he was seen to be on fire and immediate attempts were made to extinguish the fire by smothering and water, which was effective. It lasted less than five minutes.

It had been caused by the breeze fanning his smouldering clothes, burnt by his lit cigarette. Emergency services attended promptly and despite full resuscitation he died at 13.05 in hospital of extensive burning.

Had he been supervised or had means of alarm call, he would likely have survived.

Although not recorded, as evidence from the nursing home on the wearing of smoke aprons was not heard, Fire expert advice was accepted that had he been wearing a smoking apron, he would also have survived.

Coroners Concerns

67. The regulation 28 report indicated satisfaction that the management of the care home and the owners BUPA "have undertaken a thorough investigation and implemented a detailed Action Plan which has reduced many of the risks to life of accidental fires from resident's smoking identified in the inquest."

68. The Coroner had a remaining concern related to the process of mitigating the risks from personal risk assessment of immobile patients. "The only new question to be asked which would score a concern for a resident such as Mr CS, in a wheelchair, is one as to whether the resident has any difficulty in balance. If that is recorded as yes, the process requires the documentation of the steps to be taken to limit associated

[42] Fire Investigation Team Watch Managers report August 2016

[43] A report issued by the Coroner to prevent future deaths – the verdict is in the narrative. In the case of Mr CS, the report was sent to the Chief Executives of BUPA and CQC as well as the chair of the Lewisham Safeguarding Adults Board.

risks. Nowhere is the risk associated with immobility specifically recognised, yet patients who are immobile and smoke in bed are required to be supervised."

69. He went on to note that if an immobile patient smoked in bed then supervision would be required but there was discretion left with the nurse in other circumstances. The implication being that supervision ought to be considered for all immobile patients wherever and whenever they smoked. A BUPA Fire Risk Advisor told the court that he would recommend the same requirement should be made for those who are immobile but smoking elsewhere. The Coroner stressed in his report that if an immobile resident refused an apron, pendant alarm and supervision then their decision should be recorded as an unwise one against professional advice.

Other concerns

70. Firstly, the question of emollient cream and whether this acted as an accelerant to the smouldering cigarette. The laboratory tests[44] found "no evidence to indicate that any paraffin products were present on the clothing submitted." The report did raise a question about the integrity of the clothing samples – they had not been "nylon bagged so any potential paraffin contamination could have been lost over the course of the three and half months since the accident took place and the time of testing – but then went on to say: if the clothing had been contaminated by a paraffin-based product it would have been likely that some heavier organic chains would have remained." The evidence was that smouldering combustion could be initiated by a lit cigarette on the clothing sampled.

71. Notwithstanding, Mr CS did make use of paraffin-based emollient cream[45] daily. This should have been the subject of a personal risk assessment since the time it was prescribed on the 12th January 2012 which was after the Medicines & Healthcare Products Regulatory Agency guidance[46] on the matter in 2008. If this had happened, as directed by BUPA policy, then personal fire risk assessments for Mr CS would have become an integral part of the care review process. The absence of such a risk assessment was not picked up until the review of December 2015. The resultant assessment in January 2016 did not consider the possibility of Mr CS harming himself from smoking – a likelihood that should have been considered, the more so given the known hazards of using paraffin-based products.

72. Secondly, the failure to notice the burn holes in Mr CS clothing in his room, as recorded in the fire officer's post-incident report, seemed exactly that–a failure. Clearly, from their statements, the care staff had not noticed that Mr CS had burn holes in his clothes thus nor would they have been alerted to the possible implications of them being caused by him smoking. The warning signs were there, & they were missed; most remarkably in the personal fire risk assessment undertaken in January 2016. The BUPA action plan invests in training as a remedy, but fundamentally this

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[44] Bureau Veritas report August 2016

[45] Liquid and white paraffin ointment 50% for dry skin. Mr CS had been deemed as at risk of pressure sores in 2010 from the amount of time spent in a wheelchair. At the December 2015 review Mr CS was said to have a 'sore bottom'. He appeared to use two creams – one for dry skin and the other for pressure sores.

[46] See Paraffin-based skin emollients on dressings or clothing: fire risk (Accessed 9th July 2017).

short-coming was one of failure to turn the values of a personal service into practice. Residents clothing and appearance are indicators of care and having burn-holes in clothing suggested that Mr CS dignity and respect were being compromised in the way his care was provided. An improvement recommended is values-based recruitment and training with testing of the judgement of the workforce and management at the point of recruitment and through annual appraisal.

73. Thirdly, it was queried whether Mr CS medication caused him to be sedated. Did he drop his cigarette because he had fallen asleep? It is a question that cannot be answered, however Mr CS's GP testified that he did not believe it to be the case that medication caused him to become sedated. He had been on the same medications for some time and the doctor had no cause for concern at a medication review undertaken shortly before the incident on February 25th. As a point of note the possible effects of medications was something else that was absent from the personal fire risk assessment.

74. Related, the various schedules of medications provided did not always include Fentanyl[47] patches which seemed to be an error. The MAR sheet showed a 72-hour patch was applied the night before Mr CS death. The dosage had been increased on the 17th February 2016. "The most common side-effects are feeling sick, constipation, and feeling sleepy." Although there is no evidence to indicate medication was a causative factor in Mr CS death it is suggested that BUPA establish an approach to medication reviews which has the GP, pharmacist and registered manager working together as recommended in the materials available from the National Care Forum.[48]

75. Fourthly, the documents available did not provide certainty about whether the posture belt on Mr CS wheelchair was done up or undone. Nor is it clear what constitutes best practice in the circumstances presented by Mr CS – a smoker with left-side paralysis who had difficulty with balance and mobility. The care plan indicated it should be done up. It is likely that best practice is individual to the person and context. Again, this should have been addressed in a personal fire risk assessment.

76. The reports indicated that: "the wheelchair had sustained greater fire and heat damage to the left side. There was melting to the left armrest and heat damage to the side panel beneath it. The seat cushion had slight fire damage to its left side. The remainder was undamaged. It is unclear if the posture belt that was fitted to the wheelchair was beneath or above the seat cushion. This had suffered melting to its left side and was found hanging beneath the wheelchair. Witness information suggests that the posture belt would not have been in place to secure Mr CS in line with the protocols of the nursing home (Source witness information XX)."

77. Fifthly, could Mr CS have been 'saved' once the incident had happened? The Coroner was satisfied that the care staff had acted promptly and appropriately once the alert

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[47] Fentanyl is an opioid medicine (sometimes called an opiate). It is a strong painkiller. It works by binding to certain tiny areas, called opioid receptors, in your brain and spinal cord (central nervous system). This leads to a decrease in the way you feel pain and your reaction to pain. patient.info - Fentanyl for pain relief (Accessed 11th July 2017)

[48] Free resources for supporting the safe use of medications in care facilities see: national care forum.org.uk Medicine safety resources (Accessed 11th July 2017)

was raised. “Immediate attempts were made to extinguish the fire by smothering and water, which was effective.” BUPA should, nonetheless, ensure their arrangements for first aid training and cover are sufficient. The witness statements describe a scenario that lacked direction until the first responder arrived. There is inconsistency about who removed Mr CS from the wheelchair and placed him on a blanket. CPR was undertaken initially by care staff under the direction of the first responder before firefighters took over under direction from paramedics.

78. That Mr CS arrived at hospital alive was a credit to the prompt arrival and actions of the paramedics. The roadside procedure undertaken by Advanced Paramedic Practitioners appeared briefly life-extending for Mr CS, but sadly in vain.

79. Sixthly, and by far and away the greatest concern, was that of supervision of Mr CS when smoking. It was clear that his normal smoking behaviour and habits were known and accepted. He was regarded as safe to smoke unsupervised and that this was his preference. He was deemed to have the mental capacity to make this decision and physically capable of undertaking all the actions of smoking safely. This information was established after the event – witness statements and BUPA’s own investigations - but was not documented in pro-active care planning, review and risk assessment.

80. Care staff and management were unanimous in their views that Mr CS should not have been left alone and out of sight for as long (probably 45 minutes although accounts vary) as he was. That this should have happened was most likely a product of assumption – there were usually other residents (the impression was that people were rarely alone in the shelter with visitors using it and most likely staff) smoking with Mr CS and indeed one had alerted staff earlier to the absence of the left armrest on Mr CS’s wheelchair – that someone would raise the alarm if anything went wrong. Add to that the busy-ness of a care home – there was laundry to sort and other residents to tend to. Tasks often take priority over relationships with residents, particularly in the mornings when ‘jobs’ are done. A predictable and independent man, such as Mr CS, could have been ‘one-less to worry about’ in the circumstances of Manley Court.

81. How care staff supervise people – especially those not wanting oversight - is more about skilled and experienced practice techniques than having the bureaucracy of 15-minute monitoring systems. It is about professional leaders instilling in staff that the priority of the home is the safety and well-being of residents and that, if necessary some of the chores can wait. It is about keeping an eye on people, walking about, checking that all is OK, spending a few moments of courtesy chat, asking if people are alright and essentially being tuned in to the routines and rhythms of the home. The recipe for improvement here is competent and confident leadership, stable and consistent management and a values-centred workforce.

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Concerns about oversight of the service at Manley Court

82. As an overview, this analysis has revealed a common concern of Safeguarding Adults Boards and their professionals in respect of the overlapping roles of inspection, contract monitoring and case reviewing. It is the role of the CQC to register and inspect the service. LB Lewisham, Contract Monitoring to ensure that the individual is receiving the service that the local authority commissioned and that this represents continued value for money; whilst annual case reviewing checks that the individual is

getting the support they need from the service commissioned and more widely from other services and their family and friends. It additionally plans for the future with the clients consent or where this is not possible ensures advocacy, protection, deprivation of liberty and best interests' arrangements are in place.

83. With Manley Court and Mr CS the overview found:

- **i.** A context of a care home failing to improve over several years and inspections with the absence of any continued approach to enforcement. Action plans and warnings had failed to stimulate lasting improvements.
- **ii.** Contract monitoring and safeguarding staff not being able to stem a litany[49] of safeguarding alerts as breaches of contracts.
- **iii.** An approach to Mr CS case review that was working without history or any understanding of the purpose of the placement.

84. None of these were causative of Mr CS death but they are contextually significant. If the context had been more positive, then the circumstances of his death might have been predicted and prevented. Specifically, it was the work of contract monitoring and case review which caused there to be a fire risk assessment undertaken on Mr CS. That this risk assessment was inadequate is an issue for the service provider. It was not checked for fitness for protection from harm by the BUPA Regional Director or by the local authority as condition of continued contract or as grounds for further case review.

85. It is usual for Safeguarding Adult's Boards to have in place some arrangements for sharing concerns about service providers on a regular basis between agencies and the various parts of the local authority. It is believed Lewisham have such arrangements and it was a concern they were not able to either support or intervene effectively at Manley Court such as to improve the care context in which Mr CS died.

BUPA Improvements

86. BUPA reported the following:

- **i.** Each resident is issued with a pendant which they carry with them at all time the pendant alarm is activated, this activates an alarm on each units nurses stations;
- **ii.** A fire bucket containing sand has been positioned in the smoking shelter;
- **iii.** A fire blanket is now made available in the smoking shelter for smokers;
- **iv.** A revised smoking risk assessment;
- **v.** A fire extinguisher is now located in the smoking shelter;
- **vi.** Residents are advised (but cannot be compelled) to use a smoking apron. This is similar to an apron, but which comprises of fire-retardant materials such that a dropped cigarette should not cause the apron to catch alight;

[49] Between 2012 and 2016 there were at least 16 Safeguarding Case Conferences regarding a multitude of types of allegation – many of which were substantiated. The overall catalogue of concerns documented by LB Lewisham Safeguarding Quality Assurance Team over those years leads one to query the statement of the BUPA Regional Director stating she had no more concern about Manley Court than her other homes.

vii. The clothing of smoking residents is now checked by the resident's keyworker when they undertake the daily personal care regime for the resident and any burns of scorch marks are reported;
viii. Care assistants must undertake more frequent checks on smokers when smoking in the smoking shelter.

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Local Authority Improvements

87. The local authority reported the following:

i. Since this incident all placement reviews address the issue of smoking and associated risks and we request to see proper risk assessments and for this to be reflected in the service user's care plan.
ii. We are considering making changes to the placement review form so that there is a specific question relating to smoking and risk assessments.
iii. Since this incident, any action points or immediate risks that need to be addressed by the care home are followed up within four weeks by the review officer or the manager of the placement review team in their absence, irrespective of how long it takes to complete the review/panel process.

Issues of compliance with statutory duties, regulations and guidance

88. The police determined that there were no suspicious circumstances surrounding Mr CS death. The crimes of murder, manslaughter, suicide, assisting suicide and arson were ruled out. In the light of the Coroner's report and this overview the police may wish to now consider the evidence for the offences of corporate manslaughter or wilful neglect in health and social care (Sections 20-25 of the Criminal Justice and Courts Act 2015). A care provider can be held liable if:

- Someone who is part of the care provider's arrangements for the provision of care ill-treats or wilfully neglects an individual under the provider's care;
- The way in which the care provider manages or organises its activities amounts to a gross breach of a relevant duty of care owed by it to the victim; and
- If that breach had not occurred the ill-treatment or wilful neglect would have been avoided, or less likely (Section 21).

89. The reports did not reveal any breach of health and safety legislation or fire regulations. "A post-fire audit was carried out on the 14th March and the outcome was broadly compliant. A no smoking policy was in place in the building and Mr CS had been individually assessed as able to light and hold his cigarettes and smoke unsupervised. There were several residents that smoked and resided at the nursing home. BUPA stated that they would be purchasing fire aprons to reduce the risk from smoking."[50]

90. The current position of the Care Quality Commission on any enforcement action is not known. They should be invited to share their views on whether they could have acted more firmly on breaches of regulations over the seven-year period looked at in Appendix A.

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[50] Fire Investigation Team watch managers' report August 2016

Duty of Care

91. This overview led to a working hypothesis that Mr CS death was a predictable and preventable series of events. A thoroughly undertaken risk assessment, and one implemented with Mr CS's consent, would have significantly reduced the likelihood of the series of events happening and certainly limited the impact of the possible harm resultant. The home management had the relevant data and information available to properly assess the risks of harm in Mr CS smoking. They did not have the knowledge, skills and experience in place to make good use of that data and information thereby allowing them to manage and mitigate the risks of harm such that Mr CS could smoke in safety.

92. The findings of the Coroner and the actions put in place after the event suggested that a breach of the duty of care took place in respect of effective risk assessment and management. As the Coroner said, if Mr CS decision was not to comply with mitigation measures that was his right, but it should have been "recorded as an unwise one against professional advice."

Conclusion

93. Mr CS died of extensive burns after a smouldering cigarette which had dropped in his clothing became ignited by a breeze. He was alone smoking in the outside shelter at Manley Court and had been unsupervised by the care staff for around 45 minutes. The Coroner's report and this overview address the queries around his death. Had he been supervised, had he a means of calling for assistance or been wearing a protective apron he would have survived.

94. Critically had Mr CS been the subject of a thorough risk assessment both the likelihood of such an accident happening and its impact would have been significantly reduced. If he had decided not to consent to the protective measures of a risk assessment, as he was capable of doing, he would have been making an unwise decision against professional advice.

95. Smoking itself is a harmful activity and it should not have been so readily accepted (or even encouraged) that Mr CS should be enabled to smoke. The reports showed no efforts to support him cease his habit.

96. A prevailing concern emerged in this overview about what might be called the routines and rhythms of the home. The CQC said the home required improvement and had done so for several years. Contract monitoring showed continuing concerns about safeguarding. The home struggled to retain managers and lacked consistent leadership. The manager at the time of the incident was new[51] in post, not qualified or from a care home background. It is not surprising that the home had all the indicators of functioning to get the chores done (task orientated) as opposed to taking a personalised approach to meeting resident's needs (relationship orientated).

97. In this context, a man like Mr CS – habitual, high physical dependency but independent of spirit, content with smoking, the company of other smokers, but happy

[51] XX was appointed in June 2015

to join in activities and generally friendly – was not at the top of the care staff's priorities or the subject of their focus at that time of day. He had his routine[52] and the care staff theirs and the rhythm of the home took its course until it was disrupted by a dropped cigarette.

98. This is not to say the care staff were uncaring or not doing their job. There was nothing in Mr CS's care plan or risk assessment that indicated the 'allocated care assistant' should have been doing anything different with Mr CS. However, the signs were there that Mr CS's routines needed some changes – he was smoking more heavily, there were burn holes in his clothes, he was no longer the young adult admitted to the home in 2006, he was getting forgetful, his GP said he was a dementia risk, he was in pain, he had multiple long-term conditions – a little of this was picked up in the final care review in December 2015. The subsequent failure to undertake and implement a credible risk assessment of Mr CS's smoking meant the routine and rhythm of his habits and those of the care staff went unchanged until his death.

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Recommendations

It is recommended that:

i. The Safeguarding Adults Board consider establishing a steering group approach to oversee and communicate about investigations where there are fluid issues of primacy of investigator, complexity of legal and regulatory requirements and changing timetables.

ii. The Care Quality Commission are invited to share their views about how they use their regulatory and enforcement powers in circumstances such as those appertaining at Manley Court and advise on how concerns about providers are effectively managed by the SAB.

iii. The Police are asked to consider the evidence put before the Coroner to see if Mr CS has been the victim of wilful neglect under the Criminal Justice and Courts Act 2015.

iv. BUPA and other care home providers should actively support residents in smoking cessation programmes.

v. BUPA should clarify the roles and tasks of the 'allocated care assistant'.

vi. Notwithstanding the various recommendations and actions put in place by BUPA, it is suggested Manley Court engage in a wider approach to care

[52] Mr CS appeared to spend a long time in bed and looked forward to his 2 hours in the garden smoking according to review which took place in October 2013.

practice improvement such as those offered by SCIE[53], the Social Care Commitment[54], registered managers networks[55] and/or *My Home Life.*[56]

vii. BUPA and other care home providers should introduce values-based recruitment and training with testing of the judgement of the workforce and management at the point of recruitment and through annual appraisal.

viii. BUPA and other care home providers should establish an approach to medication reviews which has the GP, pharmacist and registered manager working together as recommended in the materials available from the National Care Forum.[57]

ix. The local authority should initiate joint work with LFB, BUPA, and other care providers in the borough on risk assessment – specifically to include fire, smoking, immobility, wheelchair use and first aid – to establish mutually clear and consistent standards and expectations.

x. The BUPA Responsible Individual and the Director of Adult Social Services should ensure their organisations have fulfilled their respective duties of candour.

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[53] Lewisham SAB has the SCIE Improving Personalisation in Care Homes – Action Planning Tool on its website at LSAB - Improving-personalisation-in-care-homes-action-planning-tool (accessed 14th July 2017). Links to all the good practice resources identified in this recommendation could usefully be added.

[54] Social Care Commitment - Closed 11-05-2018. (Accessed 12th July 2017)

[55] See Skills for Care Local Networks (Accessed 12th July 2017)

[56] See My home life My Home Life is a UK-wide initiative that promotes quality of life and delivers positive change in care homes for older people. (Accessed 12th July 2017)

[57] Free resources for supporting the safe use of medications in care facilities see: National Care Forum - Medicine Safety Resources (Accessed 11th July 2017)

Appendices

Appendix A - Review of Inspection Reports Manley Court 2009-2016

Appendix B – Statement from the Care Quality Commission

Appendix C - BUPA Root Cause Analysis

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Appendix A - Manley Court Care Home - an overview of inspection reports

1. Background

Manley Court is a purpose built home providing care and nursing. The Commission for Social Care Inspection (CSCI) inspection report of May 2009 states the home has been operating since 1996, it is arranged over two floors and is divided into five units of which two provide nursing care, two for dementia care and one for palliative care. The provider is Bupa Care Services who took over from Associated Nursing Services (ANS) who own the home.

2. Registration Category and Conditions

The CSCI May 2009 report states the home is registered to accommodate 85 people of who 36 may have dementia, 49 may be frail older people of whom 6 may need palliative care and 14 may be aged over 40 years and have a chronic illness.

Under 65 Dementia 36
Physical Disability 49
Over 65 Old Age 49

The CQC May 2012 report published in October 2012 recorded the Registration Category as providing accommodation and nursing care for a maximum of 85 older people.

The CQC April 2013 report published in June 2013 recorded the Registration Category, as a home that provides accommodation and nursing care for a maximum of 85 people who may be elderly, have dementia, or be younger adults with a physical disability. This category has remained the same up to the CQC March 2016 report.

3. Findings from the Reports
3.1. May 2009, Inspection Visit

The quality rating from the report was assessed as a **two star good service.**

Outcomes: **Seven Outcomes were rated as Good**

There were positive comments that Management and Staffing seemed to be working well to an acceptable level and were caring and kind. The manager had generally responded to the requirements of previous reports. Improvements had been made with staffing levels and the skill mix with some RMN nurses employed. Areas of concern were identified in the report and form the basis of the requirements and recommendations.

Statutory Requirements
There were **4** requirements made with a 2-month timescale for compliance:
2 requirements related to the management of medicine.
1 requirement related to making sure the type of foods that can be eaten are recorded and linked with people's medical condition such as Diabetes.
1 requirement was linked to improving the choice of foods each day and increasing the choices to meet cultural needs.

Recommendations
9 recommendations were made. These covered areas such as:
Management of creams, protecting meal times, range of activities, providing more age appropriate activities for younger residents, supporting residents to personalise their bedrooms, ensure professional references from previous employers are obtained on headed paper or be stamped with the organisations details.

There was concern about the layout of the gardens, which were described as small for the number of residents with concerns because of a steep slope along one side which someone from Bupa had visited and agreed the slope was of concern and needed levelling, however at the time of this visit the work had not been done.

The final recommendation was to carry out a refurbishment programme in a more robust way as many areas of the home were described as shabby and in need of redecoration.

3.2. **May 2012, Inspection visit** - report published October 2012

An inspection visit was carried out by CQC as part of the scheduled review of the service.

The following outcomes were assessed:

Outcome 1 (respect and involvement of residents) - **compliant** with this outcome.

Outcome 4 (people get safe and appropriate care) - **compliant** with this outcome.

Outcome 7 (people should be protected from abuse) - **non- compliant** with this outcome and will have a Minor Impact. People were not always protected from the risk of abuse, provider had not taken reasonable standards to identify the possibility of abuse and prevent it from happening.

Outcome 11 (people should be safe from harm from unsafe/unsuitable equipment) – **non-compliant** with this outcome and will have a Minor Impact. People were not protected from unsafe or unsuitable equipment. Action on repairs to some areas such as window locks and bedrails had not been taken in a timely manner.

Outcome 13 (this is about staffing levels) - **non-compliant** with this outcome and will have a moderate impact as there were not enough qualified, skilled, and experienced staff to meet people's needs.

Outcome 14 (staff should be trained and supervised) - **non-compliant** with this outcome and will have a Moderate Impact with areas such as not enough supervision, professional development and training on essential areas (mandatory courses). People were not supported to deliver care and treatment safely to an appropriate standard.

Outcome 16 (QA systems to manage risks, health, welfare) - **compliant** with this outcome. Effective systems of QA in place to monitor the service people receive.

Outcome 21 (Maintain people's records, safe/confidential) - **non-compliant** with this outcome and will have a Minor Impact. This was about consistency of record keeping

with care plans and medical records. The Local Authority had requested an improvement with care plans relating to pressure ulcers.

Statutory Requirements/Compliance Actions
15 Requirements had been determined with a request for an action plan to be submitted to CQC within 7 days of receiving the report showing how they were going to be complied with.

Summary
It is evident from the report the home had deteriorated in many areas since the previous inspection.
Generally, the visit found people were respected and their privacy maintained. They were cared for with dignity, independence and their views were considered. Improvements were noted arising from the previous report. Two relatives expressed some concerns about standards of care.

The issues were about staff training in keeping people safe and the provider had not taken reasonable steps to identify and prevent abuse. Local Pan-London and the provider's policies were in place. The manager had notified the CQC and local authority of safeguarding concerns relating to the use of bedrails, management of ulcers and challenging behaviour. This was considered to have a minor impact as it was acknowledged the home has processes in place to learn from incidents.

Concerns were expressed about Health and Safety issues in the home particularly around bedrails and unsafe or unsuitable equipment. The home has a health and safety committee that met regularly to discuss relevant issues.

The report identified there were not enough staff on duty in numbers and not sufficiently skilled, experienced, and/or qualified. The rota's showed the home was not meeting the minimum number of staff on duty as recommended by the provider. The local authority was involved and were monitoring the situation.

There were concerns at the level of staff receiving mandatory training, the Local Authority safeguarding team were also concerned that in 2012 only a few staff had attended mandatory training. Staff said they received supervision but records for 2010/2011 showed only a few staff received more than one supervision session. There was a lack of clarity on how staff's training needs were identified.

April 2013, Inspection Visit – report published June 2013

Standard 1 (Respecting and involving people who use services) - **Met this standard**

Standard 2 (Consent to Care and Treatment) - **Not meeting this standard**
Moderate Impact as Suitable arrangements not in place for obtaining consent.

Standard 4 (Care and Welfare of people who use services) - **Met this standard**

Standard 7 (Safeguarding people who use services) - **Met this standard**

Standard 10 (Safety and suitability of premises) - **Not meeting this standard**
Minor impact on people, issues identified in the May visit had not been addressed and this led to people being at risk.

Standard 13 (Staffing) - **Not meeting this standard**
Moderate Impact as not enough qualified staff on duty, not enough people who were qualified and experienced to meet people's needs. Provider said 1 staff member to 5 residents. They were not adhering to their own staffing level analysis based on needs. One night rota seen showed 1 RGN with 1 care assistant for 16 people with dementia and complex health needs. Shortage of catering staff leading to late breakfast and lunches. Some residents in their rooms and in bed all day. Comments from visitors and residents say not enough staff around and some were not so confident staff would help them when they required support.

Standard 14 (Supporting workers) - **Met this standard**
Improvements in supervision training and appraisals.

Standard 16 (assessing and monitoring quality of service) - **Met this standard**

Standard 21 (Records) - **Not meeting this standard**
Moderate Impact on care plans, health records, risk assessments not always up to date and some 'not fit for purpose.'

Summary
Out of the **9** standards **5** were rated as met and **4** as not met. There had been some improvements and some previous requirements unmet. There are some contradictions in the report regarding the quality of care provided and information about the state of the staffing and records. A concern is issues within the environment still not fully addressed. It is 'puzzling' how Standard **16** was met with **4** requirements/compliance actions of which some have been made before.

23rd July 2013, Inspection Visit – report published August 2013

This visit was carried out in response to concerns that one or more of the essential standards were not being met for people living in the dementia unit.

Standard 1 (respecting and involving people who use services)
Not met
Moderate impact on people's privacy, dignity, and independence not respected, 1 HCA (health care assistant) supporting the catering and 1 HCA serving meals in an unacceptable way. People left on their own for long periods in the day rooms, no staff to address and support agitated residents.

Standard 3 (care and welfare of people who use services)
Enforcement action taken
Major Impact on people**.** Records poorly completed, not updated to reflect changing needs, people at risk from conflicting information in care plans, not meeting times for repositioning of people in bed leading to people possibly developing pressure ulcers. One resident who wanted a daily shave had not been supported with this for several days. Staff told the inspector a daily shave was dependent on their workload. People left in bed all day, one without an accessible call bell and staff said we keep an eye on them when passing. A formal Warning Notice was sent to the provider and this had to be met by 13 September 2013.

Standard 13 (Staffing)
Not met

Moderate Impact on people. There were not enough skilled, experienced or qualified staff to meet people's needs. This was a requirement in the April visit and had not been met. There were not enough staff on duty and this was confirmed by relatives and observations during the visit. It was noted that one person had not received their peg feed overnight as the agency nurse did not know how to administer this, people were left unattended, waiting for meals and drinks, using the toilet. Some staff had received the training in dementia and were unable to describe the course or what they had learned. They did not demonstrate an understanding of communication needs of people with dementia. One nurse did not take any breaks from the unit as there was no one to cover for her.

Regulation 18 (Notification of incidents)
Non-compliant
The provider was not complying with regulations that required the provider to notify them of events that affected the health, welfare, and safety of the residents. There was an injury to a person that had not been notified to CQC. In looking at records, one person was admitted to hospital for a hip injury and malnutrition, cause unknown, CQC had not been informed of this incident.

Summary
Of the 4 standards/regulations looked at during this visit, it was assessed that all 4 were non-compliant.

3 further compliance actions/requirements were made along with the Warning Notice.
It is evident that staffing levels and skill mix continue to be a serious issue for this service. Whilst this visit focused upon the Dementia Unit and how care needs were being met, there appears a lack of staff knowing standards, lack of leadership. It seems that training has been provided but there was no evidence how this learning worked in practice.

3.3. 24th September 2013, Inspection Visit - report published November 2013

The purpose of this visit was to check whether the service had acted to meet **7** Standards.

Standard 1 (Respecting and involving people who use the service)
Met this standard
Review of staffing levels had taken place and catering staff and the activities co-ordinator were involved in supporting mealtimes. Care Plans seen had been reviewed and residents were signing the plans. Staff were engaging with people and a Dementia Champion had been appointed although not for each unit.

Standard 2 (Consent to Care and Treatment)
Met this standard
Improvements were seen with records and staff's understanding of DoLS and MCA

Standard 3 (Care and Welfare of people using the service
Not Met
Moderate Impact on people. Care and treatment were not always delivered in line with the individual care plan. Staff were not following care plans for treatment of pressure ulcers, end of life care, fluid intake records. The records were not being kept

up to date. Some improvements were seen. Care Plans and Risk assessments were reviewed monthly. The newly appointed manager had reorganised the staff teams and evidence of clinical review meetings were held. One person who was always in bed had been left without a call bell, the manager took immediate action and rectified this.

Standard 10 (Safety and suitability of premises)
Not Met
Minor impact on people using the service. The provider had identified that repairs to windows and locks however the work needed was not taken. Repairs identified in previous reports in 2013 were still outstanding leaving people at potential risk.

Standard 13 (Staffing)
Met this standard
Staffing levels had increased and an additional carer was available. Staff had individual training plans and an increase in mandatory training. The Regional Quality Manager had said they were in the process of recruiting a clinical practice trainer.

Regulation 9 (Notification of incidents)
Met this standard

Standard 21 (Records)
Not Met
Minor Impact on people. People's records not up to date, not always accurate or fit for purpose. Signing of sheets by the Nurse in charge could not be produced and some plans in relation to turning people in bed to prevent pressure ulcers were not updated, one record implied a 10-hour gap which could lead to risks and is unsafe practice.

Summary
Of the **7** standards reviewed **4** were assessed as met and **3** were still non-compliant. **3** Compliance actions were made and the provider was requested to send an action plan by the 19th November 2013 on the actions they were going to take.

The service is still having difficulties making improvements in some areas and sustaining these. There is concern on the environmental outstanding issues but no reasons provided why these are not being actioned.

3.6 31st July 2014 Inspection Visit – report published September 2014.
This was described as a scheduled routine inspection but linked to concerns received from a member of the public.

Standard 3 (Care and Welfare of people using the service)
Met this standard

Standard 7 (Safeguarding people who use services from abuse)
Met this standard
The service had made improvements and responded appropriately to allegations of abuse and worked with the Local Authority safeguarding teams to investigate allegations. The provider has instigated their own internal procedures when required and took steps to safeguard people.

Standard 9 (Management of Medicines)

Not Met
Minor Impact on people who use services. Only nurses administer medicines and policies were in place. Many aspects were satisfactory but the fridge thermometer was not working and the temperature charts were out of date. An envelope containing seven tablets was seen on one floor with no name or label on it. Liquid medicine left in a medicine pot that the nurse said it was liquid soap and left by the cleaner. It was stated this could pose a risk.

Standard 10 (Safety and suitability of premises)
Met this standard
A maintenance worker was responsible for the day to day repairs and said there were no current issues. The home was clean and well decorated and all Health and Safety records and maintenance were up to date. Staff showed an understanding of Health and Safety procedures.

Standard 11 (Safety, availability, and suitability of equipment)
Not Met
Minor Impact on people using the service. It was assessed people could be at risk as out of date medical devices such as syringes, needles, nebuliser, plaster and pen needles were in the medical room. The expiry date for many was 2007, 2009 and 2011, there was no system for checking this stock.

Standard 13 (Staffing)
Met this standard
There were sufficient numbers of appropriate staff to meet needs. The comments seemed to suggest the staff were working better as a team.

Standard 14 (Supporting Workers)
Met this standard
Comments suggest staff have more access to training, supervision, and support, with comments staff enjoyed their work and there was good staff retention.

Standard 16 (Assessing and monitoring the quality of the service
Met this standard

Regulation 9 (Registration regulation on Notification of events)
Met this standard

Standard 21 (Records)
Met this standard
People's records, staff, Health and Safety records were up to date.

Summary
Of the **10** Standards reviewed **8** were assessed as being met and 2 were non-compliant.
2 Compliance actions were made and the provider was requested to send an action plan by the 3rd October 2014. It was reported the instability in management for over a year and on the day of the inspection. The relief manager in post informed the inspectors it was her last working day and a new interim manager would be in post the following week. Whilst there appeared to be improvements with the culture of the staff team, along with the standards, the problems of retaining managers are unknown.

3.7 16th/17th April 2015, Inspection Visit - report published July 2015
CQC had changed their inspection methodology and report format. The report and ratings are on the five questions: Is the service, Safe, Effective, Caring, Responsive and Well-Led? There were 76 people using the service at the time of the visit. There was no registered manager in place but the manager had applied to CQC.

Is the service safe? - Requires Improvement
Staffing Levels was insufficient to adequately and safely meet the needs of people. There was not always sufficient staff on duty, this led to people waiting for call bells to be answered, people not getting up until mid- morning, not enough carers or nurses, staff not coping with the level of work and comments such as the residents are at risk. Nurses struggled with the work load. Records such as care plans were not always kept up to date. High use of agency staff. Improvements had been maintained with safeguarding and training and Induction. The report mentions the service involved the local police in one case and this showed the service took safeguarding concerns seriously. There is no information to suggest what this was about.

Is the service effective? - Requires Improvement
Comments such as 'they know how to look after us well' and most of the staff are good at their job, however staff did not feel supported or have time for effective supervision. Concerns were identified by staff regarding communication issues and they were afraid to write incident reports. The senior managers at the service were unable to show any paper evidence of how they had dealt with these matters. People had access to healthcare services and were supported with any external visits and records showed appropriate interventions with healthcare issues. Peoples' dietary needs were met and choices provided and special diets catered for. MCA and DoLS were in place and people being involved in choices over their lives.

Is the service caring? - Good
There were many positive comments about the approach by staff who showed respect and were polite. Care records detailed personal histories and how people want to be cared and supported including cultural needs. Relatives were as involved as they wished to be, End of life care was described as good.

Is the service responsive? - Good
People's care needs were being met in a planned way and care plans written showed individual needs. Residents and relative meetings were held and a range of activities. Service addressed complaints satisfactorily.

Is the service well-led? - Requires Improvement
Improvements had been made to peoples' lives by actively involving them and setting up new projects such as a gardening club and a community café. Lessons were learnt from incidents and risk assessments were updated as they needed to be. The quality of the service was monitored by clinical audits and a Home Review audit. Health and Safety officer carried out audits and areas of concern had been addressed. Concerns were identified by the low staff morale and staff made comments about being under pressure to meet targets with limited resources and a lack of recognition from managers. Staff did not appear to be consulted and not asked their views, just told what to do. Other comments such as the manager is not approachable and nobody cares. Staff retention was poor and staff leave after a few months which has created

instability in the team which has impacted on the quality of the service. High use of agency staff particularly in nights.

Summary
Of the five areas reviewed **2** were assessed as Good and **3** required improvements. **1** requirement was made regarding insufficient number of staff suitably qualified, competent, skilled and experienced to safely meet needs. **3** recommendations were made in relation to temperature controls in the medicine room, effective system of support supervision and appraisals for staff and about motivating staff and team building.
Whilst it appears some improvements to record keeping, activities, safety, and the environment and the involvement of people have been maintained, issues relating to the management of staff have declined and this has led to serious retention issues.

3.8. 18th/ 23rd March 2016, Inspection Visit – report published July 2016
The inspection visit was brought forward due to receiving information of concern. **75** people were using the service at the time of this visit.

Is the service safe? - Requires Improvement
The service was not always safe due to insufficient staffing levels to meet people's needs. Risk assessments were not carried out adequately to identify risks to people so plans to mitigate risks were not put in place. The report describes several concerns that shows little progress has been made since the last report. The providers own staffing guidance was not being complied with and in discussions with the manager, it was claimed there were enough staff but this was disputed by front line staff and some relatives. Observations were made and it was noted there were different staffing levels on each unit and the manager linked this to the dependency, however staff suggest staffing levels have not been increased related to dependency. Staff report they had tried to raise their concerns with the manager regarding staffing levels. The service was trying to recruit more staff but there was little information about trying to retain people.

Inspectors focused on risk assessments and assessed people were at risk because they were not specific to people's needs. This is the first inspection report that risk assessments are mentioned in any detail. There was also reference to PEEP (personal emergency evacuation plan) and it was felt that those viewed did not reflect people's needs due to their reduced mobility. There was also a first reference to managing smoking including how the manager had ordered fire protectors for people smoking. Comments such as improving recording burn marks on clothing and not to use flammable sprays in the same area where they smoked. The conclusion was staff had implemented safety precautions to reduce the risk associated with people smoking in and around the home.

Is the service effective? - Requires Improvement
The recommendation from the previous inspection had not been fully addressed and there was a lack of clarity and consistency on the frequency of supervision and support. Staff still reporting that they did not feel listened to and if issues were raised they felt nothing happened after the meetings. Staff, did not always work within the MCA and DoLS framework, a lack of information on how conclusions were reached and this led to concerns that people may not be assessed accurately. There was also a lack of evidence to show if meetings had taken place as expected.

Is the service caring? - Good
Inspectors received many positive comments and observed interactions with residents that demonstrated staff are doing their best to care for people in a dignified and respectful way.

Is the service responsive? - Good
People were supported in a variety of ways to meet their assessed needs. There had been improvements from a survey to show that residents and relatives were satisfied and the relationships were improving. There was a wide range of activities being provided that showed they listened to people's choices and interests. Several relatives felt the complaints they made were not always acted upon in a timely way.

Is the service well-led? - Requires Improvement
There had been instability in the management arrangements at the home. The manager in post at the time of this visit had been at the home since June 2015. There appeared to be mixed views about the management approach and still there were comments from staff about not feeling involved in the service. Concerns were expressed about the culture of the home in some of the units and particularly the working relationships between care and nursing.
It was of concern the reports said the manager was not aware of the registration requirements of a manager in relation to notifications about DoLS to CQC. She immediately rectified this by submitting the notifications. Internal audits are still part of the QA system but there is little information if the service was acting on audits.

Summary
The report stated that the provider had not addressed all the concerns from the last inspection and particularly the staffing levels and that remained a breach of the regulations. **2** areas were assessed as Good. There were **4** new breaches of the regulations; Staffing, Good Governance, Safeguarding Service Users, Need for Consent, Notification of Incidents to CQC. In addition, concerns were expressed about the standard of the risk assessments and care records as they were not fully completed. Information was not shared as required that could put people at risk. Some practices had been maintained, the working relationships between residents and staff continued to improve and residents generally were satisfied with the care and support provided. Staff supported residents in a respectful way.

4. Conclusion
Reviewing the eight inspection reports from May 2009 – March 2016 some patterns emerged with difficulties the service has experienced in sustaining improvements and building on them to achieve consistent standards of care. The service has just about managed to demonstrate the staff try to form working relationships with residents with good evidence of respect and dignity when supporting people. The reports all mention varying degrees of 'customer satisfaction'. However, the fundamental standards for consistently achieving this have fluctuated over the years such as management and staffing. It is difficult to see how standards are set at the home and whether there is agreement on the purpose of the home and how to achieve that for the people who live there.

The communication systems at the home need improving as front-line staff seem not to have been included. This is not unusual in a care home with nursing where nurses are the senior people. It is despite the comments about the number of nurses

appearing to have been low. Another aspect which has limited mention in the reports is how the needs of individual residents in varied categories and ages of people are being met. For example: how are staff trained in meeting such a wide variance in age and needs? Concerns over workforce issues have been a major problem for the service for many years. The provider uses a dependency tool but there are times they do not meet their own standards. This has created uncertainty and observations that the service is ignoring its own tool. Not always having the skill mix needed must have a detrimental effect on the staff. There must have been a serious effect on the residents; such as people left in bed, lateness with meals, level of interaction and activities and meeting basic care needs. There has been a high use of agency staff. Particularly on the night shifts and again this leads to inconsistency and variability for the residents.

At different times the reports suggest an underlying issue with the culture within the workforce and even within the teams. It was difficult to understand how staff are organised to work on different units. It appears to be a traditional approach between nurses, care staff and management. There appears little clarity on roles and responsibilities and it is suggested in some reports that some care staff feel they are not valued, have no voice, and often have minimal support systems. The decline in retaining staff needs further examination. The reports do not reveal the reasons for the many changes in managers and this is a significant issue with achieving consistency and sustainability. The role of external people in the organisation who may have a monitoring role does not come through nor is it clear how managers are supported with supervision and appraisals. There has been a reoccurring problem with keeping good standards of the resident's records. This is possibly due to a lack of understanding of the purpose of some records and staffing levels. It may be the amount of records have increased as a way of resolving symptoms rather than addressing the real causes of problems. It may be the staff don't have time to maintain records or are they all completed by nurses which is common in this type of service. With this mix of residents and the complex needs it is difficult to understand why there has been a lack of focus on risk assessments. These are key in supporting people to retain some independence, have control over their lives and for staff to be fully aware of the benefits of good risk assessments. The reports rarely mention risk assessments until the March 2016 inspection which is after the serious incident which triggered the SAR.

CQC have recorded some of the breaches as having a minor effect on the residents which is a difficult position for them to take. For instance: why they have continued to rate the QA system as being Good -this may be about the paperwork and not the practice and experience of the residents.

There were times when the fluctuations in the standards could have led to a more robust approach from CQC -the repeated breaches in certain areas is not satisfactory and the 'Impact approach' often leads to 'it is just about good enough approach'. The reports have not written in detail about the management and leadership of the service and they do not comment on the standard of the action plans submitted. The only reference to governance in the reports was at the last visit in March 2016. There was no formal enforcement following the March 2016 visit other than the requirements.

There is no information to suggest any enforcement action was taken other than the Warning Notice in July 2013 which was around the Care and Welfare of People. There

is no information to show if there were any suspensions on the admission of new residents. It is a serious concern that the March 2016 inspection, following the death of Mr CS that the service still was in difficulty with the breaches identified again repeating earlier breaches. After such an occurrence, most providers would check all aspects of the service thoroughly knowing CQC would be involved. There is an absence of information in the reports about the provider's role in supporting the home during this time. There seems to have been delays in complying with basic standards such as the environment, workforce issues and listening to some of the complaints. It may be the managers did not have the level of authority and active support they need to do this job. Throughout the reports staff generally have been 'rushed off their feet' and, whilst work in a care home is always busy, there appeared to be several occasions when the low staffing levels, culture and the disjointedness in the work teams has meant the residents were not supported or supervised as they needed to be and as many of the staff would want them to be. It is possible that the staff were so busy attending to the needs of the frailer residents in a care task approach. Mornings always tend to be the busiest time in a home, it is suggested in several of the reports that residents were often left for long periods in bed or in the day rooms (or the garden shelter?) without the vigilant presence of staff.

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Appendix B

Statement from the Care Quality Commission

We have provided a summary of our inspection reports and action taken below:

Manley Court

Manley Court Care Home provides accommodation with nursing care for up to 85 people. People using the service are younger adults and older people, some people are living with physical health difficulties, and others with dementia. At the time of or last inspection there were 77 people using the service.

We have provided a brief summary below of our inspections dating back to 2015 when our new methodology was introduced. However, copies of reports in full can be found here http://www.cqc.org.uk/location/1-127818698/reports

CQC inspected on 16 March 2015 and published our inspection report on 17 July 2015. The service was rated 'Requires Improvement' overall.

Overall	Requires improvement
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 HSCA (RA) Regulations 2014 Staffing. There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to safely meet the needs of people. 18 (1)

We made recommendations in relation to providing a system to control the temperature of the medicine room, about putting effective system in place to support, supervise and appraise staff; and about motivating staff and team building.

We inspected again on 18 and 21 March 2016. This following receipt of the sad news of Mr Skyers tragic death. We published our inspection report on 21 July 2016 and the service was rated 'Requires Improvement' overall.

Overall	Requires improvement
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

At this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing (regulation 18); good governance (regulation 17); safeguarding service users from abuse and improper treatment (regulation 13); need for consent

(regulation 11); Also, a breach of the CQC (Registration) Regulations 2009 for notification of other incidents.

CQC is still considering what action to take following the death of Mr Skyers and the incident is being investigated by the Fire Authority.

We inspected the service again on the 21 July 2017. We followed up on the breaches of regulations to see if the registered provider had made improvements to the service. We published our report on the 23 December 2017 and the service was rated 'Requires Improvement' overall.

Overall	Requires improvement
Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Good
Well-led	Requires improvement

We found that the registered provider had taken some action to meet the regulations. The improvements we found were in relation to safeguarding service users from abuse and improper treatment, need for consent and notifications. However, we found continued breaches in good governance and staffing.
New breaches in relation to safe care and treatment and meeting nutritional and hydration needs were also found.

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Appendix C

Root Cause Analysis (RCA) Investigation Report

Incident Investigation Title:	Manley Court: CS
Incident Date:	13th March 2016
Incident Number:	129795
Author(s) and Position Titles	XX Regional Director
Investigation Team Positions Titles:	
Investigation Report Due Date:	1 November 2016

Contents

1.0 Executive Summary

Incident Description:

On 13th March 2016 a 69 year old gentleman (CS), resident at Manley Court, asked to go to the garden for a cigarette. His carer supported his wish and took him outside at around 10.45am. CS was in his wheelchair and despite having left sided weakness due to a previous stroke he was physically capable of lighting and smoking cigarettes independently. There were no other residents, staff or visitors in the garden at this time and CS was not required to be under supervision at all times.

Approximately 15 minutes later another carer went out to the garden with the arm rest for CS's wheelchair at around 11.00am. The arm rest is used to support CS's left arm. CS's cigarette was not lit at this point. CS had his cigarettes and lighter in his right trouser pocket.

Between 11.50am and 12 noon staff (in differing locations around Manley Court Care Home ("the home")) became aware that a resident, later identified as CS, was on fire in the garden near the smoking shelter.

Staff have confirmed that the top part of CS's body was engulfed in flames but that he was not making any sounds. Staff put out the flames with buckets of water and several calls were made to the emergency services by various members of the staff in the home.

When the first responder arrived at the home they advised the staff to start CPR. Staff did begin to perform CPR until paramedics took over. CS was being taken to Kings College Hospital but unfortunately he died on the way to the hospital.

The emergency social worker was informed by the fire brigade and he made contact with the home. The police and fire officers spoke to the staff on the day however it is unclear whether either organisation obtained signed statements from staff. The fire brigade carried out their investigation and completed an initial walk round of the building.

On 14th March 2016, the fire brigade returned to the home and completed a full audit with XX, Bupa fire officer. Lewisham Social Services visited the home at around 09.45 am on 14th March 2016 and CQC inspected the home on 18th and 23rd March 2016.

Following the incident an investigation was opened by XX, Regional Director. The investigation found that there were areas for improvement around risk assessments and care plan documentation. It was also identified that improvements could be made with the way in which the Fire Risk Assessment was owned and implemented in the home and also with the way in which wider support services could have been available for the home at an earlier stage. The results of the investigation are set out in this RCA.

Contributing factors were:

- It was the practice within the home to comply with a resident's wish to smoke once it had been established that the resident had capacity to make the decision to smoke and that they were physically capable of doing so. There was no formal observation or periodic checking of residents who were smoking in the garden, albeit this did happen in practice more often than not. It was assumed by staff that a resident who was physically capable of smoking was not at risk of fire as a result of that activity and placed significant value on allowing residents their privacy where it was believed this was their preference.
- There was an unacceptable reliance placed upon other able bodied residents who smoked and who would relay messages from wheelchair users to staff, for example if they had finished smoking and wanted to come back inside.
- The individual smoking risk assessment for CS did not identify the relevant risk to him.
- Staff did not think to offer CS a bell or pendant by which help could have been summonsed. However, accounts from staff familiar with CS record that he was an independently minded individual. It is therefore not known whether he would have tolerated carrying either a pendant or bell when smoking.
- Despite receiving training, and receiving reminders twice in November 2015, the home manager had failed to appreciate the extent of her role in relation to fire safety within the home and in particular in relation to smoking assessments required for residents.
- There had been a failure to communicate the findings of the fire risk assessment and a managers briefing relating to smoking risks to all staff within the home.
- There was a lack of sufficient training for staff who were expected to conduct smoking assessments for residents.

Recommendations include:

- Improved smoking risk assessment to be produced for all residents – (implemented within 2 weeks of the incident) Training should also include appropriate risk factors relating to resident smoking (such as mental capacity / change in physical abilities relating to smoking / signs to check for around clothing / flammable topical ointments and the appropriate safety requirements needed to reduce the risk / outcome.
- All staff who are required to produce, write or own a risk assessment should have appropriate training on how to assess risk and implement strategies to reduce the risk.
- There should be training / coaching for nurses to write a supportive care plan based on the risk assessments and to be able to look at the monthly evaluations and ensure that they are fit for purpose and demonstrate safe person centred care.

- The business should review the way in which Fire Safety is delivered to new home managers as part of their formal induction ensuring that this is conducted by an appropriate person, and the new home manager signed off as competent.
- There should be a review of fire training delivered within all homes to ensure that it includes resident smoking / smoking policy within the home.
- There needs to be a formal induction programme for home managers to attend all mandatory training within one month of starting within a home.

2.0 Main Report

2.1 Incident Severity Rating

Major

2.2 Incident Description

CS had been in the Jasmine Unit at the home for nearly 10 years and historically sat out in the garden and smoked independently. The Jasmine Unit was developed especially for residents such as CS, and who had assessed as Young Physically Disabled (YPD). According to staff CS was able to independently light his cigarette and staff would respect his privacy and leave him with his packet of cigarettes and his lighter. He had suffered a stroke prior to coming to the home and had a left sided weakness and was unable to move his left arm and leg.

On 13th March 2016 CS was taken into the garden at around 10.45 am by carer XX who been assigned as CS's primary carer. When I questioned XX as to what checks they would normally carry out on a resident who was in the garden XX stated that normally another resident who was mobile would either bring the resident back into the home or would come and tell the staff CS was ready to come into the home.

XX also mentioned that there were several residents on Jasmine Unit that smoked as well as staff and relatives and that someone was always in the garden. XX stated that XX had asked CS if he was happy being in the garden and he said yes he was. XX took this to mean that he was happy being in the garden on his own.

As a result he was left in the garden as he had the capacity to make the decision. During the investigation staff reported that they felt CS had capacity as he was able to make decisions and he would be able to reflect on the events of the day and discuss this with staff. He would clearly be able to tell staff if he was unhappy with his care or if he wanted to do something specific or different. Having reviewed his care plan his level

of capacity was not demonstrated in this level of detail. There was also no recorded monthly evaluation of his capacity. There was also no care plan relating to his ability to safely smoke that incorporated capacity.

At around 11.10am XX was making tea and was informed by another member of staff XX, that XX had forgotten to put the arm rest on CS' wheelchair. When XX went to go and get the arm rest, XX told XX that XX had already done that.

During the investigation the two staff members who were with him in the garden, XX and XX, stated that they asked him if he was ok to be in the garden and he stated that he was. However on checking the daily notes for the day in question there is no record of this. This however may be as a result of the level of shock staff were in after the incident and some staff were sent home. As part of the investigation his daily notes were checked to establish if it was customary practise to record discussions around smoking. On checking the daily notes it does not appear to be a consistent practise for staff to document discussions around smoking. Some staff would reference that he was smoking in the garden with other service users and some staff would make no reference to it in their notes.

Staff have confirmed that normally there are several residents in the garden who smoke together. On the day in question CS was in the garden alone. When questioned, staff said they did not think anything unusual about CS being in the garden on his own as he regularly smoked in the smoking shelter and without any previous difficulties. When I spoke to the staff who were on duty at the time of the incident they stated that although no one would be specifically allocated to go and check on the residents in the garden, they would check when they were in the residents' rooms which over looked the garden. During the investigation and during the debriefing of the incident with staff they all stated that staff and visitors would go and smoke in the garden with the residents so there would be informal frequent checks of the garden.

When speaking to XX they stated that CS kept his cigarettes in his pocket. He was able to take a cigarette out of the packet and light it himself using his unaffected right hand. CS would either put the lighter back in his pocket or he would hold it in his hand.

Registered Nurse (RN) XX, who was the nurse on duty on Jasmine Unit at the time, stated that at about 11.55 hrs she was in reception and heard shouting coming from the Jasmine Unit. XX stated during her interview that she went to collect the laundry from upstairs at about 11.25am and she was gone for about 15-20 minutes. XX stated that when she returned to the unit she spoke to XX and then went down to the end of the unit. Someone said that a resident was on fire in the garden. When XX reached the garden she saw that it was CS and she helped with getting water to put the fire out.

XX then heard shouting and heard that Care Assistant XX, who was working in Hibiscus Unit, stated that she was in the Hibiscus Unit dining room. XX went to throw her hand paper towel in the rubbish and happened to look out of the window into the garden and saw CS on fire in the chair. She came down stairs and went to the linen cupboard which is normally open and wanted to get a blanket to smother the flames. The linen cupboard was locked so she grabbed a blanket from room 42. However she recalls that someone said that she needed to get water and

she dropped the blanket. She then worked with the other staff who were going backwards and forwards to the bathroom to get water to put out the flames.

The RNs from Hibiscus (XX and XX) came downstairs when they were alerted to the incident. XX went to call the emergency services and acted as the link between the home and the emergency operator. She relayed information from the staff to the operator and gave instructions from the operator to the staff dealing with the incident. The home manager, XX, was also informed about the incident. Due to the location of the phone she did not have clear sight of the garden and the events as they were happening as there was no hands free phone on the unit and she had limited movement with the desk top phone. XX and XX were in the garden with other staff trying to put out the flames. Staff used buckets to get water from the bathroom which is opposite the door leading from the garden – they didn't use a fire extinguisher. Staff said the bathroom opposite the door from the garden into the unit was the first thing they thought of as it was the nearest source of water to CS.

The emergency services arrived between 12.05 and 12.08, when the paramedic came into the garden the staff had just extinguished the flames and the paramedic directed them to put CS on the ground and commence CPR. During the interview XX stated that one of her colleagues thought CS was trying to talk to them but she stated she couldn't find a pulse. The paramedics took over and shortly after they found a weak pulse. CS was taken from the garden to the ambulance and was taken to Kings College Hospital. The home was later informed by the hospital that CS had died on the way to the hospital. During the investigation it became apparent that staff on the units upstairs had also placed 999 calls.

The police on site spoke with the staff and took notes. The fire brigade did a walk round of the home and spoke to staff. XX arrived at the home at 1pm. The Area Manager for the home, XX, was informed of the incident at 1.15pm.

Staff have since confirmed that the fire officer and Police spoke to them on the night of the incident. It is unclear whether they took formal statements. However the fire officer did note that there were burn marks on CS's clothes that were in his wardrobe when he checked his room. This either hadn't been picked up by staff or its significance was not recognised. The police left the home at 7pm and DC XX met with XX and confirmed that there were no suspicious circumstances and that their investigation was closed. He confirmed that he would be visiting the home on 31st March 2016 to re-interview some staff. The fire brigade had informed the duty social worker that evening and XX spoke to the on call social worker. This is written in the daily notes for CS.

Counselling was organised for the staff and residents on the 14th March 2016 and took place over 2 days, 17th and 18th March 2016, with follow up telephone support.

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POST INCIDENT INVESTIGATION

- Care plan and risk assessment

Following the incident and the internal investigation the Bupa smoking policy was reviewed in line with CS care plan. The policy states that ***'the personal plan must include details of supervision (if required), their ability to hold the smoking material safely, (if not a smoking apron may be required) and how cigarettes etc. are stored safely.'***

The risk assessment that was in place at the time of the incident was written on a general risk assessment form. During her interview XX stated that she had re-written the risk assessment on 3 January 2016 as she thought it looked 'tatty' rather than it being unsuitable. The risk assessment made no reference to CS's ability to safely smoke or any risks such as emollients / clothing / being unsupervised in the garden.

The risk assessment however did identify that CS was to use the smoking shelter. The assessment does not identify how harm could occur. The risk assessment does state that cigarettes were purchased by the activities team and will be given to the nurse on duty. The nurse will then give CS his cigarettes when he asks for them. Staff would then take him out to the garden. However the risk assessment is incomplete without any other actions / owners and any other links to relevant documents.

When the care plan documentation was checked there was no specific care plan for smoking in line with the recommendations of the smoking policy. In the care plan there was no reference to CS ability to make informed decisions or any actions to mitigate any risks.

Since the incident the business has implemented a smoking risk assessment which forms part of the residents care plan. There are clear actions for the nurses to take where they trigger a 'high risk' area and this is to be captured in an additional plan of care for smoking. This care plan focusses on the residents' ability to smoke safely, their physical ability, mental capacity as well as the wearing of a smoking apron. These care plans are reviewed every month and have been regularly checked by the supporting quality and regional teams to ensure that this new document is robustly embedded into the home.

- Training / Home managers training

Training at the home is given to all staff on starting at the home and at intervals thereafter. In the context of risk assessments, these are the responsibility of the RN staff. Typical RN training would be a mixture of induction training and also being closely mentored by more experienced RN staff during shifts at the home. This would include training on risk assessments. It was found that training on more central clinical areas such as falls was expressly covered, but in the context of smoking, the RN staff were expected to consult the Fire Folder held at the home to

update individual resident's assessments. However it was found that this had not been followed up in the case of CS. The general fire training delivered in the home was found not to not cover smoking risk assessments nor the smoking policy.

Since the incident with CS the training in the home covers:

- -Common causes of fire
- -Recognising different types of fire extinguishers that have been used in Bupa care home and their uses
- Fire triangle
- -Emergency contacts
- -Smoke/heat detectors/ and their uses
- -Fire control point
- -Fire control panel/emergency folder and what to do as an in-charge
- -Staffs' responsibility in the event of fire
- -Staffs' responsibility as soon as alarm goes off
- -Fire compartment
- -Fire evacuation techniques

And showing staff around and making them familiar with fire equipment that is available for use in the home. As a consequence training now includes training on written fire and smoking risk assessments and where any uncertainty or lack of knowledge prevails, for this to be raised with Bupa's Fire Officers or Property Team depending on the query.

The home managers' induction programme, which is held in Leeds, includes members of the support services speaking about their departments' role within care services. During this time they will also highlight any key areas of responsibility and key documents. The induction programme has a session which covers fire (and other property risks) and also the nature of the Bi-annual review which also features a review of the Fire Risk Assessment. This course was attended by XX in November 2015. A copy of the programme is attached to this RCA at Appendix 1. Although this is dated September 2015, it is the same programme as was used in November 2015.

The health and safety section programme co-ordinator was able to supply the 'Guide to fire safety for home managers' which is a document that gives the key areas of information and resources for home managers.

The 'Guide to fire safety for home managers' references that the home manager needs to 'Ensure that the home has a clear smoking policy for residents and staff'. However, it appeared that risk assessments were not checked by the home manager nor that there was a robust system in place to ensure that key members of her team, which key tasks were delegated to were able to ensure that this was completed, on her behalf.

This document does make reference to residents smoking assessments and identifies the smoking policy for home managers to have reference to as well as highlighting the home manager's responsibility in ensuring that the risk assessments are reviewed and fit for purpose for those residents who smoke. It also clearly states that the home manager can call upon the fire officers for any assistance that they require.

- Staff attitude to smoking

It appears that staff had become used to CS going out in the garden and had not considered that his abilities and safety may have changed over the ten years that he had been in the home. They were of course familiar with his abilities as they cared for him every day and regularly observed him doing activities for himself such as smoking.

From interviewing the staff it appears that there was an informal method regarding the checks that were carried out on residents who smoked in the garden; as well as a general acceptance that other residents would come and call for assistance if needed. Staff felt that because CS had always been in the garden and would say that he was happy to be in the garden that it was acceptable on this occasion. No one seemed to consider that there might have been a risk to CS by being outside alone.

As the smoking assessment for CS did not include some of the risks and control measures that have now been identified, the nurses did not review these as part of his monthly care plan evaluation. There was therefore no sufficient trigger for the nurses to have to reassess his ability to safely smoke.

During the interviews all the staff commented that they should not leave a resident alone in the garden or anywhere in the home for more that 15-20 minutes. Unfortunately this did not happen on this occasion.

Since the incident the staff have now implemented formal checks of residents in the garden and all residents have smoking aprons and call bell pendants. Where residents decline the use of these items, as is their right if they have capacity, this is documented in their care plans. All the staff when interviewed have stated that they are much more vigilant around those residents who smoke and that Care Assistants are checking clothes frequently for burn marks and those residents who smoke are considered high risk and as such are frequently discussed by the clinical team to ensure that their documentation is appropriate.

The home leadership team has become more aware of these actions and are following up on them as part of their audits / checks and regular meetings.

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- Fire Risk Assessment (FRA)

The FRA is specific to each home and is completed in line with a standard template that is used across all the homes. This document identifies the lay out of the building, associated hazards and life risk and then the active, passive and managed fire precautions required to provide a satisfactory standard of fire protection in the building.

This document is completed by one of Bupa's fire officers and is sent to the home manager with a covering letter, guide to fire safety and also a feedback sheet which the home manager is able to complete and identify any areas which the home manager may feel they require further support / assistance on. The document has an action plan at the end of the report.

The most recent FRA for the home was sent to the previous home manager who forwarded it to XX on 23rd November 2015.

Within this document there is a section (9.23) for the inspector checking the risk assessments for smoking rooms and residents who smoke in their bedroom. Below are the questions asked and the actions noted.

9.23 Smoking Arrangements *(BFM 20 – Smoking)*

Is the home smoking or non-smoking?

Is there an external area where residents and their visitors can smoke?

If there is a designated smoking room, or if residents smoke in their rooms –

Is there an assessment in place, is it suitable?

Is there a staff smoking shelter/area – is the location suitable?

Following a number of fatalities in care homes while residents were smoking following the application of paraffin based skin medication it is recommended that all resident smoking risk assessments are reviewed to ensure that the correct protection and procedures are in place.

From carrying out the RCA, I believe that there has been a missed opportunity for the smoking risk assessment for the home to be reviewed. As well as having subsequently checked the smoking risk assessments of residents who smoke at the home, I have also checked several

FRA's and smoking risk assessments for homes in my region. I was reassured to note that the shortcomings identified at the home appear to have been local to Manley Court and that since the incident Manley Court has taken steps to address these shortcomings.

The FRA which was checked did not reference any checks of assessments being done.

The Bi-Annual review (which is carried out by the Estates team twice a year), and in this case performed by BAR, it found that the FRA was not available when the audit had taken place. It is the home manager's responsibility to ensure that the FRA was available and the Estates team should have followed up with the home manager to ensure that the position was rectified.

As part of the Bi-Annual Review the action plan from the FRA are checked to ensure that any actions are completed or are in progress in accordance with appropriate time frames. There is however currently no system for capturing compliance at a home level. The fire officers do not currently come out to a home on a routine basis unless there is a visit from the fire brigade or the home manager flags an issue that they need support with.

Other factors

CS was prescribed '50/50' emollient cream and there is an incomplete topical medication sheet in his folder. It does not appear that the newsbrief / managers briefing which was provided for home managers in April 2015 was robustly implemented into the home with regards to the safe use of paraffin based creams. The report from the London Fire Brigade following the incident confirms that there was no emollient on CS clothes. While this may not have been a contributing factor to the fire it is an identified risk area which was not appropriately addressed before the incident.

Event date and time	21/12/2006	01/06/2015	October 2015	November 2015	December 2015	03/01/2016
Event	CS is admitted to the home	XX starts as the home manager for Manley Court	FRA states that the HM must ensure fire training is updated as well as sharing the FRA with the home. Also the FRA identifies action that are needed to be taken in light of paraffin based creams	XX attends induction at Leeds	BAR states that the FRA is not available	XX completes a smoking risk assessment for CS
Supplementary Information		Completed her induction with her 'buddy' home manager as well as the HM induction in place at the time.	9.23 of the FRA states that smoking assessments for residents who smoke in their room or smoking assessments for a smoking rooms should be reviewed. In the comments section there is no reference to the general smoking assessment for the home being checked.	Covers a variety of topics including health and safety		Focuses on taking CS to the garden
Good Practice				Managers guide to fire safety is forwarded to the home manager following the induction		
Care/Service delivery problems			There is no evidence that this was shared with the home. XX did not recall seeing the FRA during her investigation meeting.			There is no reference to regular checks, capacity to hold cigarettes and lighter

Event date and time	21/12/2006	01/06/2015	October 2015	November 2015	December 2015	03/01/2016
						The nurse has not indicated if there is to be a further assessment on the specific risks identified.

Event date and time	13th March 2016 11 am	13th March 2016 11.15	13th March 2016 11.50 – 12.00	13th March 2016 12.06	13th March 2016	13th March 2016 18.35
Event	CS is taken into the garden at his request for a cigarette.	Staff member takes his arm rest out into the garden.	Staff see CS on fire.	Emergency services on site.	CS taken to Kings College Hospital. Home manager arrives at around 13.00 hrs.	XX Duty social worker called the home – upset that the home hadn't contacted him before the fire brigade.
Supplementary Information	Staff have confirmed that the lighter was left with CS and it was left in his pocket. CS was able to light his own cigarette.		Staff attempted to put out the flames.	CPR commenced at the request of the paramedics.	Hospital confirmed that he passed away on route 13.05 hrs.	
Good Practice			Emergency services are called. Several staff were	CS was put on the floor and CPR commenced	13.00 hrs son was contacted and asked to call the home	XX explained that she had been with the police and fire brigade and

Event date and time	13th March 2016 11 am	13th March 2016 11.15	13th March 2016 11.50 – 12.00	13th March 2016 12.06	13th March 2016	13th March 2016 18.35
			calling the emergency services.	no pulse initially found.	urgently by the home.	supporting staff and residents. SW happy with the response and apologised for his earlier comment.
Care/Service delivery problems	No evidence in the daily notes of any conversation with CS about being happy to be in the garden on his own. None of the staff thought to check on CS.		Staff didn't use a fire extinguisher.		Staff who were distressed at the events sent home by the home manager – replacement staff brought into the home to ensure that continuity of service.	

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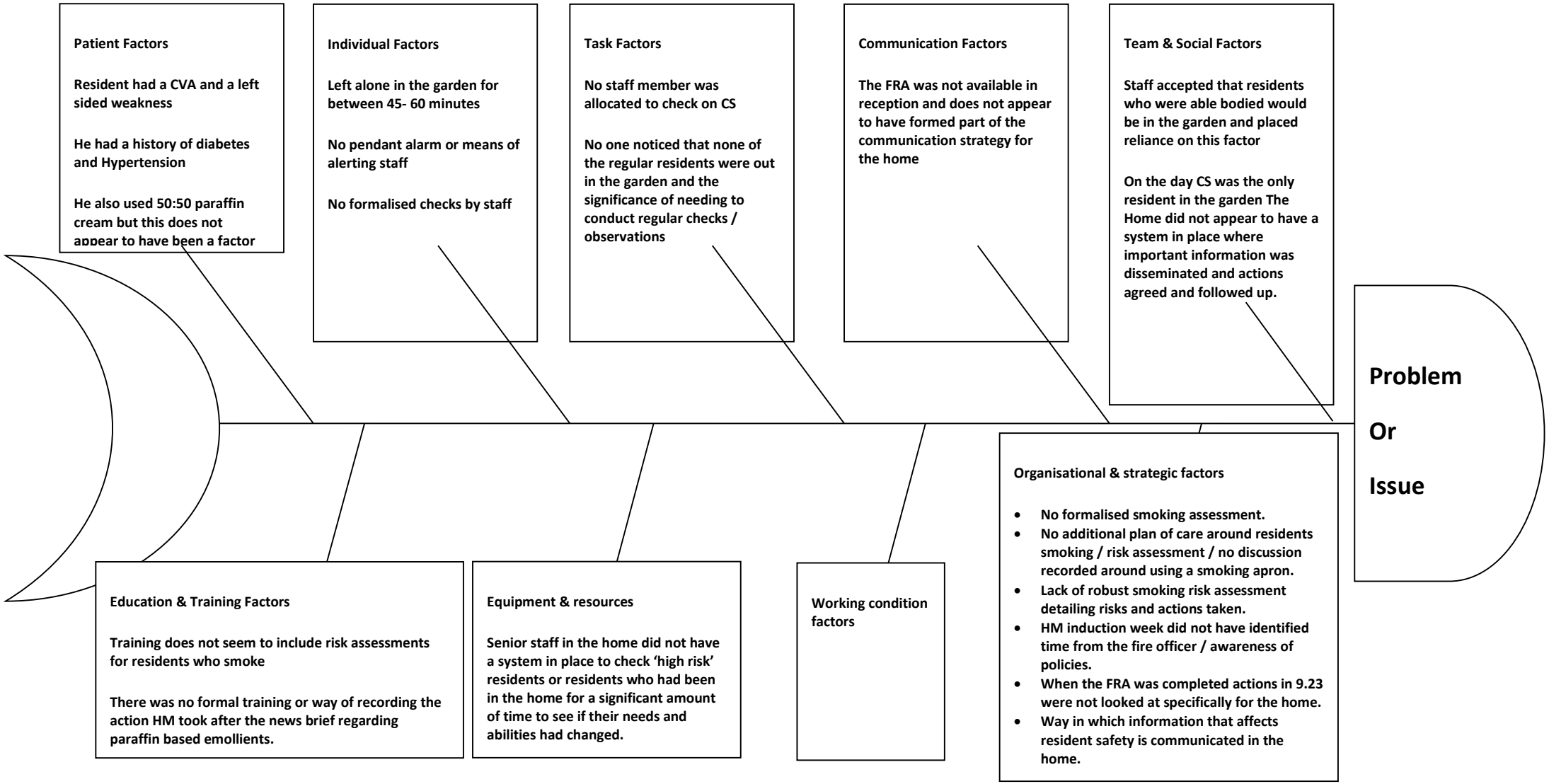
4.0 Fishbone Diagram



5.0 Contributing Factors

CATEGORY	KEY FACTOR	YES	NO
COMMUNICATION (Were issues relating to ***communication*** a factor in this event?)	Communication issues between staff?		✓
	Communication issues between staff and patient/family/carers?		✓
	Documentation	✓	
	Patient Assessment	✓	
	Information not provided	✓	
	Misinterpretation of information		
	Other		
KNOWLEDGE/SKILLS/ COMPETENCE (Were issues relating to ***knowledge/ skills/ competence*** a factor in this event?)	Staff training/skills	✓	
	Staff competence	✓	
	Staff supervision	✓	
	Use/not using/misuse		✓
	Other		
WORK ENVIRONMENT/ SCHEDULING (Were issues relating to ***work environment/ scheduling*** a factor in this event?)	Work place design		✓
	Suitability of work environment		✓
	Environmental stressors		
	Safety assessments/evaluations/procedures	✓	
	Shortage of beds/rooms/resources		✓
	Staff timetabling		✓
	Other		✓
PATIENT FACTORS (Were issues relating to ***Patient Factors*** a factor in this event?)	Communication difficulties		✓
	Medical History / Known Risk		✓
	Patient Condition		✓
	Personal Issues		✓
	Other		✓
CATEGORY	KEY FACTOR	YES	NO
EQUIPMENT (Were issues relating to ***Equipment*** a factor in this event?)	Suitability/availability/lack of equipment		✓
	Safety Maintenance		✓
	Appropriate use of equipment		✓
	Emergency provisions/backup systems		✓
	Other		✓
POLICIES/ PROCEDURES/ GUIDELINES	Absence of relevant/up-to-date policies, procedures or guidelines		✓
	Implementation issues	✓	
	Education/training	✓	

(Were issues relating to ***policies/ procedures/ guidelines*** a factor in this event?)	Issues in applying policies, procedures or guidelines	✓	
	Absence of audit/quality control system		✓
	Other		✓
SAFETY MECHANISMS (Were issues relating to ***safety mechanisms*** a factor in this event?)	Lack of appropriate safety mechanisms/systems in place	✓	
	Breakdown of safety mechanism		✓
	No evaluation of safety mechanisms		✓
	Other		✓
OTHER (If there were other factors contributing to the incident which do not fall into the above categories, please provide details?)			

6.0 Recommendations

- A smoking assessment to be devised to act as a robust framework for additional plans of care and risk assessments to be completed.
- Staff to have formal training in writing risk assessments as well as any associated plans to reduce / manage the risk.
- Content of the fire training for staff to include smoking and checking clothes and how we can assess someone's safety in this area.
- That consideration is taken on how information is shared in homes and followed up by the Home Leadership Team.
- That on the home managers induction in Leeds that fire safety have a specific session and the importance of the FRA and the role of the Home Manger is discussed.
- The way in which the Key policies and key areas to be identified to home managers and team.
- Follow up on actions outstanding in the FRA to be followed up be appropriate specialists.
- The way in which information is cascaded within the organisation.

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