HARINGEY SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULT REVIEW: Ms Taylor[1]

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[1] Ms Taylor is a pseudonym.

1. INTRODUCTION

1.1. Overview of the circumstances that led to this review

Ms Taylor died in a fire at her home in October 2017, aged 71. A heavy smoker and with severely impaired mobility since a stroke in 2003, she lived alone in a second-floor supported housing provided by Homes for Haringey. Here she was bedbound, receiving care and support visits 4 times a day commissioned by London Borough of Haringey Adult Social Care, with additional support from the housing scheme manager. She had multiple health needs, including osteoporosis, chronic obstructive pulmonary disease, atopic dermatitis, incontinence, anaemia and epilepsy. She also had a complex mental health history, including recurrent depression and alcohol dependency, and had made suicide attempts in the past. Home Fire Safety Visits had been made by the London Fire Brigade in June 2016 and July 2017 but a recommendation that she be provided with fire-retardant bedding had not been actioned. As identified in the Coroner's Record of Inquest[2], the cause of her death was multiple organ failure following 45 percent full thickness flame burns, with contributory factors including the presence of cigarettes and lighters in and around her bed, the absence of flame-retardant bedding and the presence of an airflow mattress.

1.2. Statutory duty to conduct a Safeguarding Adult Review

1.2.1. The Haringey Safeguarding Adults Board (SAB) has a statutory duty[3] to arrange a Safeguarding Adults Review (SAR) where:

a) An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
b) There is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult.

1.2.2. Board partners must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[4]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

1.3. Haringey SAB's decision to conduct a review

1.3.1. A SAR Panel was appointed to undertake the review. Membership of the Panel comprised senior representatives of some of the agencies involved with Ms Taylor; the chair and the lead reviewer were independent of those agencies.

- Panel Chair
  - Hannah Miller, Consultant in Social Care and Health
- Independent lead reviewer and overview report writer

[2] 8th May 2018
[3] Sections 44(1)-(3), Care Act 2014
[4] Section 44(5), Care Act 2014

    - Suzy Braye, Independent Adult Safeguarding Consultant
- Barnet, Enfield and Haringey Mental Health Trust
    - Ruth Vines, Head of Safeguarding
- Metropolitan Police Service
    - Adam Ghaboos, Detective Chief Inspector
    - Jonathan MacDonald, Specialist Crime Review Group
- Haringey Clinical Commissioning Group
    - Hazel Ashworth, Designated Professional for Safeguarding Adults
- Homes for Haringey
    - Puneet Rajput, Director of Corporate Affairs
- London Borough of Haringey
    - Christopher Atherton, Principal Social Worker & Head of Assurance
    - Farzad Fazilat, Head of Brokerage and Quality Assurance, Commissioning
- London Fire Brigade
    - Simon Amos, Haringey Borough Commander

1.3.2. The SAR Panel received legal advice from Stephen Lawrence-Orumwense, Assistant Head of Legal Services and Legal Advisor to the SAB.

1.3.3. The SAR Panel received administrative support from Rebecca Waggott, the Haringey SAB Governance and Improvement Officer.

1.4. Terms of reference for the review

1.4.1. The scope of the review was defined as being agencies' engagement with Ms Taylor between 1st April 2015 and 5th October 2017. In addition, the panel asked agencies to identify and summarise any information that they considered significant regarding their involvement with Ms Taylor prior to the review period.

1.4.2. The following factors were identified as requiring particular focus:

a) The key points of assessment and decision-making regarding Ms Taylor's care and support, housing needs and safeguarding risks, specifically regarding fire risks;
b) Professional understanding of Ms Taylor's safety/safeguarding risks and vulnerabilities at these key decision-making points, and how was this shared by the agencies involved;
c) Whether appropriate safety/safeguarding risks and needs assessments were completed and acted on;
d) How information about Ms Taylor's mental health and mental capacity affect the assessment of risk, enablement of risk and choices, and maintaining wellbeing;
e) The level and impact of management involvement;
f) Any organisational and/or operational difficulties being experienced within or between agencies;
g) Missed opportunities to involve Ms Taylor's family in her care planning;
h) Implications of this review for multi-agency work with service users where there is an identified risk of fire;
i) Where good practice can be identified in this case;

j) Service improvements required to improve the quality of services to service users where there are safety and safeguarding risks, including risk of fire;
k) Learning from this case that can inform the work of the Fire Prevention Task and Finish Group.

1.5. Other investigations

1.5.1. London Fire Brigade undertook a fatal fire review on 30th November 2017. Firefighting actions at the scene were found to be in accordance with LFB procedures. The internal issue of provision of fire-retardant bedding was raised and the criteria for providing this have since been changed. The Borough Commander stated his intention to work with local partners to provide education and training specifically for those receiving care in Haringey

2. THE REVIEW METHODOLOGY

2.1. The review model

The approach chosen was a review model that involved:

- Chronologies of involvement from all agencies who provided services to Ms Taylor in the 2½ years prior to her death;
- Internal management reports (IMRs) prepared by the same agencies, reflecting on and evaluating their involvement;
- Thematic analysis of the learning themes emerging from the chronologies and IMRs;
- A learning event involving discussion with practitioners and operational managers who had been directly involved with Ms Taylor, with the purpose of seeking their perspectives on the events of the case, to ensure that the review's analysis and recommendations were informed by those most closely involved;
- SAR Panel meetings for discussion and analysis;
- Formal reporting to the Haringey SAB to inform its planning, implementation and monitoring of relevant actions across the partnership.

2.2. Agencies providing information to the review

2.2.1. The SAR panel received chronologies and where necessary additional information and/or documentation from the following:

Barnet Enfield and Haringey Mental Health Trust (BEHMHT)	BEHMHT is an NHS trust providing mental health services; it is regulated by the Care Quality Commission. Ms Taylor was a patient between 2011 and 2017, and for some of that time was on the care programme approach (CPA)[5].

[5] CPA is for those with complex characteristics whose needs are met by a number of services or whose risk profile indicates a need for a higher level of engagement, co-ordination and support. The responsibilities of the care coordinator include ensuring the care plan is regularly reviewed in line with practice standards, co-ordination of on-going risk assessment, co-ordination of reviews and dynamic risk formulation and risk management.

Somerset Gardens GP Surgery	The GP surgery provides general primary medical care for a registered patient population; it is regulated by the Care Quality Commission. Ms Taylor was a registered patient of the practice
Flexserve UK Ltd (Flexserve)	Flexserve are registered with the Care Quality Commission for the purposes of carrying out the regulated activity of personal home care and were an approved spot provider with Haringey Council. They provided domiciliary care services to Ms Taylor for 3 years, from 9th October 2014 to 4th October 2017. This comprised personal care, shopping, laundry and (in later stages) collection of her money.
Homes for Haringey	Homes for Haringey is an arm's length management organisation that manages Haringey's council housing, including (since September 2014) sheltered and supported housing. It is responsible for day-to-day tenancy management, income collection, estate services, asset management, repairs, annual maintenance and resident involvement. Ms Taylor lived at Latimer House, a sheltered housing block, staffed between 9am and 5pm (with an out of hours emergency response service provided by Adult Social Care). Support managers are the main point of contact for tenants living in sheltered housing; they conduct risk assessments and review of service users' home environment to identify potential safety issues or concern relating to their functional abilities.
London Borough of Haringey Adult Social Care (ASC)	ASC is responsible for assessing needs and arranging care and support under the Care Act 2014, including responsibilities for adult safeguarding. Ms Taylor had been in receipt of a care and support package since 2005, which was reviewed annually.
London Borough of Haringey Commissioning (LBH Commissioning)	LBH Commissioning are responsible for commissioning and quality assurance of external providers of services. While not in receipt of any concerns about services provided to Ms Taylor, the unit carried out two quality assurance visits to Flexserve during 2016, followed by further engagement with the agency.
London Fire Brigade (LFB)	LFB have a statutory responsibility to respond to fires and to provide information and advice to individual and agencies in respect of fire safety. LFB attended the fire on 4th October 2017 in which Ms Taylor died, and had also previously attended the property on 17th June 2016 and 26th July 2017 to give fire safety advice.
Metropolitan Police	The Police were involved on a number of occasions relating to Ms Taylor experiencing abuse from a friend at her property and alleging financial abuse by her carers. Ms Taylor also on occasion made frequent calls to the police, which were not acted upon as their purpose was unclear; she was noted to be a repeat caller with mental health issues.
Whittington Health Trust	Whittington Health Trust provides district nursing services; it is regulated by the Care Quality Commission. Ms Taylor was a patient on their caseload for grade 1 pressure ulcer care to her sacrum and heel, for which she received

	visits twice a week, and for pressure area monitoring involving a monthly visit. The district nurses also monitored her blood pressure and carried out routine blood tests when requested by her GP. She was known also to the bladder and bowel team, receiving continence pads and annual review.

2.3. Participation by Ms Taylor's family

2.3.1. The SAB advised Ms Taylor's daughter and nephew that the SAR was being undertaken and invited them to participate. Early in the process, the independent reviewer and the Chair of the SAB had a telephone discussion with Ms Taylor's daughter and granddaughter, which resulted in an additional focus in the terms of reference on whether there were missed opportunities to involve Ms Taylor's family in her care planning. Ms Taylor's nephew did not wish to be involved in the review, advising that Ms Taylor's daughter was now dealing with her affairs.

2.3.2. A further phone discussion took place at the end of the review process between the independent reviewer and Ms Taylor's granddaughter. The independent reviewer outlined the review process followed, together with the review's findings, conclusions and recommendations. Ms Taylor's granddaughter expressed her appreciation of the in-depth, methodical approach the review had taken. She expressed her full support for all its recommendations and for publication of the report so that lessons could be widely learnt and her grandmother would not have died in vain.

3. Ms Taylor: THE PERSON

3.1. Sources of information

This section brings together background information and observations from the agencies' submitted chronologies and reports, the perspectives of those who worked with Ms Taylor, and the views of her daughter and granddaughter.

3.2. A pen picture

3.2.1. Ms Taylor, aged 71 when she died, was the fourth of eight siblings. Her parents separated when she was a child and her mother met a man whom Ms Taylor referred to as her stepfather. He sexually abused Ms Taylor between the ages of 14 and 18, stopping only when she left home. She also had an older brother whom she alleged was sexually abusing her, claiming to have had a son by him when she was 17, who died soon after being born. On leaving home she undertook cleaning and factory work. Between 1965 and 1989 she was convicted of 69 offences, which included prostitution, assaults and miscellaneous matters, and she sustained several head injuries and other physical injuries.

3.2.2. In 2003 she had a stroke, which left her with right sided hemiparesis and she walked with a rolling frame. During this period she was in a relationship with a man who subsequently died, a bereavement that she struggled to come to terms with. She was known to associate with others who did not

always have her best interests at heart and who harmed or took advantage of her; from 2011 she was in a relationship with a male friend who abused her, financially, emotionally and physically, separating from him (with some difficulty) in 2015.

3.2.3. Ms Taylor had a daughter, whom she left aged 8 months with her mother and partner when she left home for London. For most of her life she had no contact with her parents or daughter, indicating that an incident in her childhood had resulted in her not wanting any family contact. She did however keep in touch with her older sister and remained in contact with her nephew (her sister's son). Her housing tenancy record named three emergency contacts: the nephew (who was also noted as next of kin), her daughter and a long-standing female friend. The record also refers to Ms Taylor stating she had a son also, living in Belfast, but didn't see either of her children. She did have sporadic phone contact with her daughter, which in the last year before her death became more regular and positive, at times involving her granddaughter also, although she did not reveal to either of them how she was living or the abuse she had experienced.

3.2.4. She referred herself to occupational therapy in 2005 and following assessment by the ASC Physical Disabilities Team received a care package that supported her to live independently in the community. She used a zimmer frame to mobilise indoors and an electric wheelchair when out in the community.

3.2.5. In 2011, when living in a general needs ground floor adapted flat, Ms Taylor started a fire at her home in what she claimed was a suicide attempt (although she later amended this, stating it had been accidental). She spent several months receiving in-patient mental health care and was discharged to temporary accommodation before returning home. In 2012 a further fire occurred (arising from use of kitchen equipment). She moved to a safe flat on safeguarding grounds, having been physically and financially abused by the male friend she had taken into the flat. In 2013 she had a further stroke and in 2014 was admitted to hospital after a fall. On discharge she spent six months in a nursing home before returning to sheltered housing. In April 2015 she moved to Latimer House, a sheltered housing scheme, where she lived until her death in October 2017.

3.2.6. Between 2011 and 2015 she was in regular contact with mental health services, having been referred by her GP shortly before the first fire at her home. She had recurrent depression and had also experienced alcohol dependency in the past. She displayed signs of personality disorder, although this was not formally diagnosed, and sometimes had psychotic symptoms. She was described as finding it easy to make attachments to people but ending them more difficult. As a patient on the care programme approach, she received regular mental health review and very close support from a mental health care coordinator. At the time of closure of the care programme approach in November 2015 she was reported to be in good spirits, felt well supported and had no concerns about being abused by anyone.

3.2.7. At Latimer House, with limited mobility and unable to walk, Ms Taylor had a care and support package provided by Flexserve, whose carers visited four

times a day. Her flat was equipped with a community alarm cord near her bed. She also had district nurse visits to monitor her health, food delivered fortnightly and medication delivered monthly. She had daily contact with the housing scheme support manager who assisted her with all practical arrangements and took steps to arrange whatever attention she needed from other agencies and to share concerns about risks. She had frequent telephone contact with her GP surgery, on numerous occasions having phone consultations with a doctor and (during the review period) two home visits and three face to face appointments at the surgery for medication and mental health review.

3.2.8. It was known that Ms Taylor liked consistency; she had one consistent Flexserve carer, who worked closely with the mental health services during their involvement and with the housing scheme support manager. During 2015 she liked going out in her wheelchair accompanied by her care worker. However, by 2016 her mobility had declined further; she could no longer sit in her wheelchair and spent most of her time in her bed. She was a heavy smoker and, in the light of concerns about fire risk, her care workers attempted to ensure that she smoked only when they were present. The Fire Brigade undertook home fire safety visits and fire-retardant bedding was discussed but not provided.

3.2.9. Ms Taylor is described for the most part as alert and capable of working closely with those supporting her in relation to the arrangements for her daily life. However, she could change her mind about what she wanted to happen, sometimes withdrawing concerns she raised about being abused. One police officer noted that she had difficulty with dates and with staying on track in a discussion, concerned she may have dementia or some other mental health issue. An occupational therapy assessment noted that she had lapses of memory and muddling of past events, and an ASC review notes that she did not easily focus on conversation due to cognitive difficulties arising from her stroke.

3.2.10. She is described by those who worked with her as a strong-willed woman who was assertive and adamant about her wishes, in particular about her intention to continue smoking. She could be fiercely uncooperative if her wishes were not granted and she often chose not to engage with professionals' concerns. She was considered to be skilled in not revealing things about herself. She was known to be lonely and her smoking was in part due to feeling bored, particularly after she became confined to her bed as her mobility deteriorated. Those who worked with her have described the impossibility of persuading her to carry out or cease actions when she did not wish to and have indicated that staff faced aggressive and personalised verbal abuse as she claimed her right to live as she chose. Those attempting to support her faced extensive challenges when she chose not to engage or cooperate with their attempts to keep her safe, preferring to continue to live in the way she chose.

4. CASE CHRONOLOGY OVERVIEW

This account has been created from the chronological information submitted to the SAR panel by participating agencies. Its purpose is to establish a clear narrative understanding of events as they unfolded over time.

4.1. Events prior to the SAR review period

4.1.1. In December 2010, a social worker called the police to attend when Ms Taylor was found asleep in the rain holding a knife, having taken too many of her epilepsy tablets. The police completed a Merlin report and liaised with ASC. She was discharged from hospital 5 days later. She was using a wheelchair at this point but was able to mobilise with a zimmer frame.

4.1.2. Shortly after this, she reported feeling depressed and suicidal and her GP referred her to BEHMHT. She became more reluctant to engage with her care workers. The police were called to her flat on 20th February 2011 by her GP, who reported Ms Taylor wanted to commit suicide as a result of hearing voices. The police attended to find the Fire Brigade had rescued Ms Taylor from her flat, where she had set fire to her bedding. The Fire Brigade found clear evidence that the fire had been started deliberately. She was admitted to hospital suffering from smoke inhalation and carbon monoxide poisoning. There was extensive fire damage and injury to other residents also.

4.1.3. After the fire, following treatment for smoke inhalation and carbon monoxide poisoning she was transferred to St Ann's Hospital for mental health assessment. She claimed to have started the fire in response to a male voice giving command hallucinations, but later said it was an accident caused by a candle or a cigarette. She was discharged to the care of Haringey Older People Community Mental Health Team. Her discharge summary gave a diagnosis of recurrent depressive disorder and past suicide attempts.

4.1.4. Discussions took place between the Police and Homes for Haringey about her returning home, with the Police expressing concerns about the safety of other residents in the light of evidence that she had started the fire deliberately. She did return to her home. After receiving medical evidence about Ms A's mental health the Police decided to take no further action in relation to criminal charges, as intent would not be established.

4.1.5. In December 2011, Ms Taylor alleged assault by a friend she allowed to stay overnight. She subsequently refused to provide a statement but was advised by the police about injunctions and non-molestation orders.

4.1.6. In January 2012, the Fire Brigade undertook a home fire safety visit to Ms Taylor, and two hours later were called to a further fire at her property, caused by unsafe use of a kitchen appliance.

4.1.7. In March 2012 safeguarding concerns were raised when Ms Taylor claimed her male lodger/friend was abusing her financially, emotionally and physically. She moved to a safe house but refused the offer of housing transfer.

4.1.8. In 2012 she was also known to the Whittington Health podiatry team, who were caring for her feet.

4.1.9. In 2013 BEHMHT placed her on the care programme approach (CPA) and she saw her care coordinator on a weekly basis. Risk assessments formed a rolling assessment of past and present risk. Risk formulation included triggers, immediacy, protective factors and influencing factors such as drug and alcohol misuse and physical issues[6]. It was noted that Ms Taylor had stopped smoking and that risks had therefore reduced.

4.1.10. In April 2013 Ms Taylor informed her social worker that her male friend had said he was going to shoot his drugs intervention programme worker. This resulted in liaison between the police and the drugs intervention team, although the threat was not deemed credible and no further action was taken. In June 2013, the police attended Ms Taylor's property where her friend was banging on the door. He was arrested for breach of a court order. Again in December 2013 Ms Taylor called the police saying she wished her friend to leave, indicating that he was violent to her. Her friend complied with her request and Ms Taylor did not respond to any follow up calls. The police completed a Merlin report but did not share it with the local authority ASC as they did not deem her vulnerable.

4.1.11. During 2014 Ms Taylor re-started her relationship with the man who had been abusing her, who then continued to abuse her and encouraged her to smoke. In March 2014, the police were alerted by ASC that he had assaulted her. She reported that he had also taken money from her account. The lodger was arrested in September that year, by which time Ms Taylor was living at a different address and did not want to go to court. No further action was taken, as she was the only witness.

4.1.12. In April 2014 she was admitted to hospital following a fall at home. She was assessed by ASC in order to support her discharge pathway and also due to concerns raised by medical staff about potential financial abuse, violence and intimidation by someone who had access to her home. She was placed in a nursing home. During her time at the nursing home Ms Taylor repeatedly stated how unhappy she was there; she moved back into her flat in October 2014 and was referred for permanent sheltered accommodation due to her vulnerability.

4.1.13. At this point, Ms Taylor began to receive domiciliary care services from Flexserve, commissioned by ASC - an arrangement that continued through her move to different accommodation in April 2015 and continued until her death (at which point her care package totalled 2¾ hours per day, spread across four visits, with an extra 1½ hours per week for cleaning and an extra 1 hour per fortnight for collection of her benefits from her appointee, Haringey Council).

4.1.14. In January 2015 BEHMHT continued to be concerned about abuse of Ms Taylor and discussed the risks with the Council's safeguarding team but were advised not to pursue a safeguarding referral as Ms Taylor's lack of

[6]CPA and clinical risk training is mandatory for all clinical staff in inpatient and community settings and must be accessed very three years.

engagement would militate against a positive result. In February BEHMHT undertook an assessment of her mental capacity to decide on living with her male friend who could be verbally and physically abusive, finding that she did have capacity to make this decision.

4.1.15. During this period Ms Taylor was visited by the district nursing team for pressure ulcer care and continence assessment, with the latter completed on 19th January 2015. She was also under the care of the community rehabilitation physiotherapy for mobility practices.

4.1.16. In February 2015, ASC undertook an annual review of her care and support package, noting no change in her circumstances and recommending further review in a year's time. She received a home visit from her GP on 20th February.

4.1.17. On 18th March 2015, Ms Taylor's carer raised concern that Ms Taylor had a swollen cheek and had reported that her lodger physically abused her. Her mental health care coordinator visited and learnt the assault had happened in the context of the lodger demanding money; the care coordinator raised safeguarding concern the following day. The police arrested and charged her friend (although the case was later dismissed with no evidence offered). The police completed and shared a Merlin report. In the weeks that followed, Ms Taylor followed up with several calls to the police enquiring what had happened to her friend. She was noted to be a frequent caller and no police officer was assigned.

4.2. The review period

4.2.1. On 15th April 2015, Ms Taylor moved to live in a flat in Latimer House, with Flexserve continuing to provide her daily domiciliary care package. The Homes for Haringey tenancy support manager carried out a welcome visit and completed risk assessment checklists, including discussion on fire safety procedures. Like all new tenants, she was referred for a routine Fire Brigade visit, which does not, however, appear to have taken place. The Fire Brigade requested that access take place through a relative, as Ms Taylor was bedbound, but it appears no further action took place to facilitate a fire service visit at this point. The housing scheme support manager carried out a risk assessment and support plan in April/May 2015, but this did not note that Ms Taylor smoked (although previous records showed that she did).

4.2.2. On 14th May 2015 she received a continence assessment visit for annual review, which resulted in appropriate continence aids being ordered.

4.2.3. BEHMHT risk assessments that took place during this period clearly note the known fire risk but observe that the risk was reduced as she was no longer smoking. BEHMHT held CPA reviews to which the GP, Flexserve care worker and housing scheme support manager were invited. Joint visits also took place. The care coordinator reported a good relationship with the housing scheme manager; Flexserve were reported as helpful and supportive, and there were no communication concerns. By this time Ms Taylor used a wheelchair and had difficulty mobilising. She was pleased with the move and stated she was satisfied with the care she was receiving.

4.2.4. BEHMHT note that at the time of her move to Latimer House, Ms Taylor was seeing community nurses twice a week for treatment of a skin condition and was referred to a dermatologist. Her mental health appeared stable, although in July 2015 she displayed psychotic symptoms, believing that a person was on the walls of her flat. In August BEHMHT assessed her capacity to consent to treatment with psychotropic medication, finding that she did have capacity.

4.2.5. On 26th August 2015, Ms Taylor attended a surgery appointment with her GP for blood pressure monitoring, medication review and mental health review.

4.2.6. Homes for Haringey records show that from early on in her tenancy Ms Taylor made frequent use of the Community Alarm Service to request practical assistance out of hours – help to reach her remote control, to secure a glass of water, to reach her mobile phone, milk and tissues, to restore lighting when it failed, or to pick up her cigarettes.

4.2.7. In November 2015, Homes for Haringey arranged for a key safe to be fitted to enable carers to gain access to Ms Taylor's flat without disturbing her.

4.2.8. Whittington Health Trust district nursing visits are recorded to have occurred on 12th September 2015 (blood pressure) and 2nd December (skin care). During the same period she was, at the request of her GP, referred for a replacement wheelchair as her own privately sourced wheelchair was uncomfortable. A wheelchair assessment took place on 27th January 2016 but Ms Taylor did not attend a subsequent appointment (due to absence of funding for the additional care worker provision necessary for her to be safely taken out of bed). In October 2016 her case was closed by the Wheelchair Service as no further contact had been received; no wheelchair appears to have been provided.

4.2.9. In November 2015 the CPA involvement with Ms Taylor ceased as she no longer needed that level of support from mental health services. Although shortly after the closure she again reported a further hallucination, it was thought this could be related to displeasure at not seeing her mental health care coordinator. Her psychiatrist undertook to see her as an outpatient, but this does not appear to have happened in the 18 months following the end of CPA. In January 2016 there was some telephone contact between Ms Taylor and her psychiatrist, Ms Taylor stating that she was merely calling to see how the psychiatrist and the care coordinator were. There was then no further contact for over a year.

4.2.10. On 4th December 2015, Ms Taylor was visited at home by her GP for an annual review.

4.2.11. In December 2015, the Flexserve carer reported that Ms Taylor had given the key safe access number to someone who had previously abused her. Homes for Haringey arranged for the key safe code to be changed.

4.2.12. Also in December, in the face of continued requests from Ms Taylor for minor matters of practical support, the emergency response officer asked Flexserve to ensure essential items were left accessible to Ms Taylor

overnight. They also advised Ms Taylor that her requests did not constitute an emergency.

4.2.13. In February 2016, the housing scheme manager requested an urgent review by Haringey Council's Integrated Access Team, concerned that Ms Taylor was being assisted by a care worker who was under review for a safeguarding matter. ASC safeguarding have no record of this request.

4.2.14. By February 2016 there is mention in Flexserve's records of Ms Taylor enlisting staff help to get cigarettes.

4.2.15. The Homes for Haringey annual risk assessment and support plan review on 19th May 2016 noted Ms Taylor's heavy smoking and associated fire risks. The Flexserve care worker was putting cigarettes out of her reach in an attempt to reduce her smoking. Arising from this review, a home fire safety visit from the Fire Brigade took place on 17th June 2016. There is some discrepancy between Homes for Haringey and the Fire Brigade's information about this visit, Homes for Haringey indicating that the Fire Brigade recommended fire-retardant bedding, whereas the Fire Brigade have indicated that only general advice was given.

4.2.16. On 23rd May 2016, Homes for Haringey raised a safeguarding referral to the ASC's Integrated Access Team, concerned that Ms Taylor had not received any bank and Post Office account statements for a year. She was £3,000 in debt to a catalogue company and there were concerns that carers owed her money. Flexserve also raised a safeguarding referral about the same matter.

4.2.17. Ms Taylor initially refused to engage with the police and the safeguarding team about the allegation and the safeguarding screening was terminated at her request. The Police investigated allegations[7] that two carers had stolen money through cashpoint withdrawals and by ordering gifts from a catalogue company used by Ms Taylor. One carer, when interviewed by the Police, admitted that she had obtained goods from Ms Taylor, albeit she claimed with consent and she had repaid Ms Taylor. Although Ms Taylor later did cooperate to the best of her ability, it was not possible for the Police to source sufficient evidence to prepare a file for CPS and no one was charged. The police completed a Merlin and shared it with ASC. Ms Taylor's door lock and key safe number were changed. Flexserve removed the carers from all calls due to breach of their finance policy, a step against which Ms Taylor protested as she wished them to continue supporting her. The agency understood the Police conclusion to be that Ms Taylor had capacity and was deemed to have made an agreement with the person concerned[8]. The housing scheme manager supported Ms Taylor to request statements relating to her bank and post office accounts and later to complete a direct debit mandate to her bank, and a keyworker session took place to put in place risk management measures.

4.2.18. During this period also, on 28th May 2016 a professional review meeting was convened by ASC to review financial and smoking risks, and Homes for

[7] Noted in Police records as arising on 1st June 2016.
[8] The Police record does not state that Ms Taylor had reached an agreement with her care worker; her account was different from that of the care worker but lacked consistency and specific detail. It is this that led to the Police decision not to proceed.

Haringey made a referral to the Council's Integrated Access Team requesting hearing impairment equipment be installed to enable Ms Taylor to watch television without disturbing other residents.

4.2.19. On 29th May 2016, Ms Taylor made three 999 calls to the police. Two were abandoned calls, the third was garbled but believed to relate to a historical allegation that she was pushed out of her wheelchair. She did not appear to be in distress and the matter was closed as police attendance was not required.

4.2.20. During subsequent days Ms Taylor made a series of 999 calls saying she wanted to make amends with police officers in Tottenham and with a midwife. She was unable to clarify what she meant, and no police officer was allocated. Subsequently she alleged, in a series of 999 and 101 calls, that the police had done nothing about a carer who had pushed her out of a wheelchair. She was noted to be a frequent caller with mental health issues, and no officers were assigned. On subsequent calls she further alleged that in May 2015 when being visited by CareWatch UK she had been pushed out of her chair on four occasions when she was listening to the television too loudly. As this was beyond a possible 6-month charging window for common assault, and being unable to identify the carer, the police took no action.

4.2.21. On 20th June, the Homes for Haringey housing scheme manager requested ASC review Ms Taylor's situation due to debts that Ms Taylor had incurred.

4.2.22. On 23rd June 2016 a police officer noted after visiting Ms Taylor that she had difficulty with dates and with staying on track in a discussion. Concerned she may have dementia or some other mental health issue, they resolved to share information with ASC.

4.2.23. On 24th June 2016, the housing scheme manager liaised with the district nursing service and the GP about the need for Ms Taylor to have her ears syringed. The GP attended 3 days later and prescribed medication in response to a carer's report that Ms Taylor had a breathing problem. The housing scheme manager advised Flexserve that due to unused blister packs Ms Taylor appeared not to have been given her medication at the weekend (although Flexserve have stated that this was not the case).

4.2.24. On 27th June 2016, Ms Taylor attended a surgery appointment with a health care assistant for blood pressure review and referral to smoking cessation advisor, Nicotine patches were prescribed. She also saw her GP the same day, resulting in medication and referral for ear syringe. The GP made a home visit on 29th June.

4.2.25. Concerns about Ms Taylor's finances arose during the summer, following the discovery of her debts - it emerged that Ms Taylor had other debts, including unpaid domiciliary care bills from Haringey Council. The Homes for Haringey housing scheme manager was proactive and persistent in sorting things out, helping her to clear debts and make suitable arrangements to prevent recurrence. In July the scheme manager supported Ms Taylor to set up direct debits to pay her bills.

4.2.26. On 21st July 2016, ASC reviewed Ms Taylor's care and support package and referred her for occupational therapy due to a decline in mobility. An appointeeship to Haringey Council for management of her finances was discussed and agreed by her. On 27th July the OT assessment resulted in a recommendation for aids and equipment, including a hoist, to assist transfers from her bed, to reduce the amount of time she spent in bed and the risk of pressure sores.

4.2.27. During the summer and autumn Flexserve, Homes for Haringey and the ASC social worker worked jointly to manage the risks associated with Ms Taylor's smoking and the risks of financial abuse. Ms Taylor agreed to use nicotine patches or e-cigarettes in order to reduce fire risk and it was agreed that these would be purchased for her by Flexserve. However, this was quickly followed by Ms Taylor making 43 calls over 2 days to out of hours support, requesting cigarettes. She had access to friends who would give her money. On one occasion the police were called to deny a male visitor access to her flat.

4.2.28. ASC approved Flexserve's request for double-handed support to assist Ms Taylor in using the hoist to transfer from her bed (thus reducing fire risk from smoking).

4.2.29. On 11th August 2016 Ms Taylor received an annual continence service review.

4.2.30. During August 2016 and subsequently, the Homes for Haringey housing scheme manager liaised with Flexserve, food delivery companies, physiotherapy, occupational therapy, district nursing and Mobility Seating Solutions about Ms Taylor's care. She was to receive a new powered wheelchair.

4.2.31. In August 2016 ASC applied to the Department for Work & Pensions for appointeeship in relation to Ms Taylor's finances.

4.2.32. On 13th September 2016, Homes for Haringey completed a risk assessment and support plan review for Ms Taylor, noting that the hoist was not suitable and would be removed. It was noted that Ms Taylor continued to ask carers to take money from her bank account, giving them her PIN. ASC were in the process of arranging appointeeship for her finances. Ms Taylor had declined to use the nicotine patches and continued to smoke 40-60 cigarettes a day.

4.2.33. On 22nd September 2016 Ms Taylor refused to go to hospital after an ambulance was called by the ERO having been alerted by Ms Taylor that she was on the floor.

4.2.34. On 11th October 2016, the Homes for Haringey housing scheme manager liaised with the ASC social worker to confirm arrangements with all the services for which new financial arrangements had been necessary. All direct debits were now to be cancelled as the appointeeship was operational. There was consultation about what would be a sufficient sum that would enable her to buy cigarettes and it was arranged that Ms Taylor's pocket money would be collected from ASC fortnightly by Flexserve carers. The Homes for Haringey housing scheme manager successfully intervened to

request the catalogue company debt be written off on grounds of Ms Taylor's inability to pay.

4.2.35. On 18th October 2016, ASC (with the Homes for Haringey housing scheme manager present) undertook a further assessment of Ms Taylor's care and support needs due to the need for increased care as a result of the occupational therapy assessment. The recommendations for a hoist and slings to be used required double-handed care from Flexserve. She was also referred to physiotherapy for review of her mobility and potential to use a standing transfer hoist in future. However, Ms Taylor did not engage well with using the hoist; the equipment was later removed and the care package was reduced back to single-handed calls.

4.2.36. On 4th November 2016 Homes for Haringey completed a further risk assessment and support plan review, noting that district nursing visit were reduced to monthly. A police investigation into the allegation of carers removing money from Ms Taylor's bank account was ongoing. The main risks remained Ms Taylor's vulnerability to exploitation and her continued smoking.

4.2.37. In December 2016 there were further discussions between the social worker, Homes for Haringey and Flexserve about who would be sourcing the food that Ms Taylor required. Ms Taylor continued to receive rent arrears demands, despite appropriate notifications having been given about the appointeeship. Ms Taylor's friend was concerned that some of the bedding she had bought for Ms Taylor had gone missing. Homes for Haringey liaised with the phone company and secured a refund relating to her mobile phone.

4.2.38. On 9th March 2017 the district nursing service visited Ms Taylor in response to a request from the GP surgery for an urgent visit. All skin areas were intact. She was visited again on 29th March 2017 and again no pressure damage was observed and no dressings were required. She was advised not to place an incontinence sheet over her mattress as this could cause deterioration in pressure areas but she was reluctant to take this advice; equally she was reluctant to take advice on use of cream on her sacrum.

4.2.39. In March 2017 Flexserve made a courtesy phone call to Ms Taylor to check her satisfaction with the service she received. She confirmed she did not want to change anything and this was confirmed in a quarterly Flexserve review.

4.2.40. On 6th April 2017, the district nursing service was again requested to visit due to Ms Taylor experiencing a breakout of sores on her legs.

4.2.41. In May 2017 the BEHMHT psychiatrist made a home visit in response to the Homes for Haringey housing scheme manager reporting that Ms Taylor was unable to attend the clinic. The psychiatrist found her bedbound, but well, with her mental health stable and mood good. She was cooperating with care, was taking her medication and had a good relationship with the scheme manager and no concerns about any of the other residents. No new risks were identified and she was not in need of mental health services. The consultant did not directly question Ms Taylor about smoking but observed

no signs on this visit that she was smoking. She was discharged back to the care of her GP.

4.2.42. In May 2017, the GP advised Homes for Haringey that Ms Taylor's address did not fall within their catchment area for visits[9].

4.2.43. On 28th June 2017 the district nursing service visited Ms Taylor to perform wound care; dressings were applied but Ms Taylor declined further checks and the nurse alerted her senior. A further visit took place on 5th July, during which Ms Taylor declined some aspects of care. There is no indication that this was escalated as a concern. On 8th July she declined all care during a further visit. On 18th July Ms Taylor allowed leg dressings to be changed but refused care to her sacrum. Again there is no indication that this was escalated. On 30th July following a further visit the district nurse referred her to physiotherapy and occupational therapy for assessment of transfers from bed to chair. On 7th August, at a further visit, both legs were observed to be oedematous, with shallow ulcers, which were dressed.

4.2.44. In July 2017 at a further Flexserve review meeting Ms Taylor was adamant that she did not intend to stop smoking. She was extinguishing her cigarettes in a bowl of water. The risks of smoking in bed were highlighted to her again at a subsequent review in September 2017, at which she made it clear she understood the risks but that it was very hard for her to reduce her habit.

4.2.45. On 26th July 2017 the Fire Brigade undertook a home fire safety visit. The housing scheme manager raised the question of fire-retardant bedding but, finding no evidence of careless disposal of smoking materials or of near misses, such as burn marks to carpet or bedding, the Fire Brigade advised the Homes for Haringey housing scheme manager that the criteria for funding fire-retardant bedding were not met.

4.2.46. On 7th August 2017, two visitors entered the scheme building, one entering Ms Taylor's flat as she had supplied her code. The Homes for Haringey housing scheme manager gave Ms Taylor safety advice. The key safe code was changed.

4.2.47. On 15th August 2017, ASC undertook a review of Ms Taylor's care and support. Ms Taylor stated she was happy with the care she received but would like more pocket money. No recommendations for change were made but fire risk and the recommendation for fire-retardant bedding were noted. On 25th August ASC requested by email to Homes for Haringey and Flexserve that one of the two agencies support Ms Taylor with the purchase of fire-retardant bedding. The email was initially sent to the wrong care provider but was subsequently forwarded to Flexserve. In the event, no fire-retardant bedding was sourced. Flexserve have stated that they did not receive the email, and that they would not have considered it appropriate for them to purchase the bedding in any case. Homes for Haringey have stated that their expectation would be that ASC would be responsible for providing such equipment.

[9] The surgery has clarified that as long as Ms Taylor remained registered she would continue to receive necessary treatments, including home visits.

4.2.48. On 9th and 14th September 2017 Ms Taylor's legs (with multiple ulcers) were cleaned and dressed on further district nursing visits.

4.2.49. On 3rd October, the day before she died, Ms Taylor's Flexserve care worker found her unusually sleepy on morning and lunchtime visits, although once woken she ate well. The care worker advised the Flexserve office that she had some concerns as Ms Taylor was not herself. The following morning, when Ms Taylor still seemed unwell, the care worker called the GP surgery, speaking to the receptionist who indicated that a GP would call back. The care worker notified the Flexserve office, who advised waiting to see how Ms Taylor seemed at the lunchtime call. When the care worker returned, she noted that although Ms Taylor still appeared confused, she was eating well and the nature of her condition did not give rise to concern that would have led her to call emergency services. She did, however, pass the GP surgery number to the Flexserve office, as the GP had not yet responded. The GP surgery has indicated to this review that their notes contain no records of a call from the care worker, and that Ms Taylor did not appear on any of the GPs' lists for that day.

4.2.50. On 4th October, in the evening, smoke detection within the flat activated the community alarm system; being unable to make contact with Ms Taylor, the operator notified the Fire Brigade. A couple of minutes later Ms Taylor activated her pull cord alarm and could be heard calling for help. Her Flexserve carer, arriving for the evening visit, encountered thick smoke and also called emergency services. Ms Taylor was taken from the flat with extensive burns and following treatment at the scene was taken to hospital by London Ambulance Service, where she died the following day.

4.2.51. After Ms Taylor's death Flexserve sent a standard notification to CQC.

5. THEMED ANALYSIS

The following section addresses the learning themes arising from the SAR panel's analysis of the information available. It considers key learning about how risks were assessed and managed, how mental capacity and mental health were considered, and the nature of interagency communication and case coordination.

5.1. Needs and risk assessment and management

Care and support needs

5.1.1. Ms Taylor's care and support needs were long-established and met by ASC through provision of a care and support package commissioned from Flexserve. Reviews were conducted annually and adjustments to the care and support provided appear to have been made as necessary. The focus of her care and support package was on personal care and household tasks; Ms Taylor, as someone who could no longer bear weight and had restricted movement and dexterity, and spent her days in bed, was entirely dependent on her care workers to meet her needs. She appears to have expressed satisfaction with her care and support whenever it was reviewed.

5.1.2. During the early days of her residence at Latimer House, her Flexserve care worker would take her out in her wheelchair, enabling her to visit the post office and shops, but she later became unable to sit in her wheelchair for any length of time due to discomfort and the outings ceased. A replacement wheelchair assessment took place but was not completed due to absence of funding to provide additional care staff to support her in attending a subsequent appointment. This matter appears not to be been pursued by any agency and the absence of a usable wheelchair would have contributed to her growing isolation.

5.1.3. There were nonetheless some challenges in the provision of care and support. OT assessment indicated that it would be beneficial for Ms Taylor to use a hoist to leave her bed to reduce the risks of skin deterioration, but she refused to use the hoist that was provided to enable her to leave her bed. Her preferences were respected; she would not cooperate if they were not and was generally not open to persuasion. There is no evidence, however, that her refusal to use the hoist to enable her to leave her bed was revisited or further discussed with her, even in the context of the need for fire risk strategies to minimise her smoking in bed.

Housing needs

5.1.4. The supported living scheme where Ms Taylor lived is staffed during the daytime and she received extensive support from the housing scheme manager. Her flat was private accommodation held under an assured shorthold tenancy agreement in a supported living unit[10]. Communal areas are subject to inspection under the Regulatory Reform (Fire Safety) Order 2005 and on previous routine inspection had been found to be compliant with requirements. In a post-fire inspection the premises were found to be in a good state with regard to fire safety regulation[11]. The building is fitted with a combined telecare and automated fire alarm system monitored by the community alarm service and Ms Taylor's flat had a smoke detector in the entrance hall, a heat detector in the kitchen, and emergency pull cords in the kitchen, living room, hall, bathroom and bedroom. On the advice of the Fire Brigade, Homes for Haringey has a 'Stay Put' policy for the building in the event of fire, a copy of which is given to all residents and displayed in the communal area. The policy states that people who are not able to leave the building on their own in case of an evacuation will be rescued by the Fire Brigade and Ms Taylor's name was on the resident evacuation list, immediately accessible to attending fire officers to facilitate safe evacuation.

5.1.5. There is no indication that her accommodation was thought unsuitable in any way or that its suitability was reviewed by either Homes for Haringey or ASC as her needs increased. At the time of her move to Latimer House, there is no evidence that alternative options such as extra care housing were considered and it would probably have been known that Ms Taylor had disliked living in nursing home care during the six months she spent there in 2014. However, during this review Homes for Haringey have questioned whether sheltered housing, which is generally suitable for people with a degree of independence, albeit with support, was suitable to meet her needs.

[10] Such accommodation is not required to be registered with the Care Quality Commission.
[11] A notice was issued in relation to some minor deficiencies observed.

This is a matter that Ms Taylor's family have raised also, believing that she should have been accommodated in residential care. Participants at the learning event who knew her, however, were clear that she would never have agreed to enter residential care, and that maintaining people in their own homes in the community was a priority in both policy and practice.

Health needs

5.1.6. Ms Taylor had frequent contact with her GP surgery, with calls exchanged up to 6 times a month at certain periods, about a variety of matters relating to medication, skin breakdown and care, wheelchair referral, district nursing service requests and blood pressure checks. In addition, during the period under review three face to face contacts with doctors and one with a health care assistant took place at the surgery.

5.1.7. As someone at risk of developing pressure sores due to her constant use of her bed, she received district nursing services from Whittington Health Trust throughout the period under review. The frequency varied - at times visits took place every 3-4 days, at others less frequently but nonetheless regularly. Her skin was therefore monitored and treated but her occasional refusals of care were not always escalated. Whittington Health have indicated that one-off refusal would be documented; it would be continued refusal would give cause of concern.

5.1.8. Some agencies knew that Ms Taylor had historically used alcohol heavily. This was well documented in earlier BEHMHT assessments and was known also to Whittington Health as it was noted on GP referrals. Other agencies knew nothing of alcohol use, and it appears that she did not drink during the period under review. ASC have stated that all mentions of her alcohol use on record relate to historical circumstances.

5.1.9. One matter that this review has been unable to resolve is the response to Ms Taylor's health needs on the day she died. Flexserve have indicated that their care worker called the GP surgery as Ms Taylor seemed unusually sleepy and confused, speaking to a receptionist who indicated that a GP would call back, but no call was received. The surgery has stated that there is no record of a call from the care worker, and that Ms Taylor did not appear on a GP list that day. It is regrettable that Ms Taylor did not receive some medical oversight at a time when the care worker (who knew her well) considered her to be 'not herself' but this review has not been able reconcile the conflicting information.

Safeguarding, risk assessment and management

5.1.10. Ms Taylor moved to Latimer House during a period in which she had been financially and physically abused by a man with whom she was in a relationship. It is also clear that at times Police involvement did not result in information-sharing with ASC, for example in December 2013 when although subject to domestic abuse she was not deemed vulnerable and the Merlin report was therefore not shared.

5.1.11. Both ASC and the police were involved in safeguarding relating to the abuse in March 2014, but Ms Taylor appears to have been ambivalent about

seeking protection, refusing to provide evidence that could be used in court. During this review, the Police have reflected that during this episode consideration could have been given to an evidence-led prosecution or providing assistance in obtaining a civil order against the abusive friend. Neither are recorded as options within the crime report. There is recognition, however, that Ms Taylor's own continuation of the relationship with the abuser made protective intervention difficult.

5.1.12. BEHMHT were concerned about the impact of the abuse on her mental health and in January 2015 undertook an assessment of her mental capacity to make decisions about the relationship with her friend. They discussed the risks with safeguarding and were advised not to make a safeguarding referral on the grounds that Ms Taylor's lack of engagement would militate against a positive result. They have reflected on whether there was a missed opportunity to refer her to the Multi Agency Risk Assessment Conference during this period.

5.1.13. Although Ms Taylor moved home to avoid the relationship, it clearly continued and on occasions the key safe code outside her flat at Latimer House had to be changed because she had given it to the friend. This was later managed by not giving the key code to Ms Taylor herself, recognising that she could place herself at risk by revealing it. The risks do appear to have receded during this period, and Ms Taylor is recorded on review documents as saying she felt safe at Latimer House.

5.1.14. Safeguarding involvement was necessary again in 2016, triggered by financial concerns. In May the Homes for Haringey scheme manager learnt that a care worker owed Ms Taylor money. A week later Ms Taylor alleged to Police that two care workers had stolen from her. One carer, when interviewed, admitted to the police that she had obtained goods from Ms Taylor, albeit she claimed with consent and she had repaid Ms Taylor. Again, Ms Taylor's ambivalence made it difficult to pursue matters. She refused to engage with the safeguarding team or the police, and the safeguarding screening was terminated at her request. There was insufficient evidence for prosecution. Ms Taylor also complained to Flexserve about their decision to suspend the care worker, wishing to continue to be cared for by her. The episode did trigger review of how Ms Taylor could be supported to manage her finances, resulting in her agreement to make Haringey Council her appointee, managing her bills and releasing a small regular amount to her to spend, thus reducing financial risks. It does not appear, however, that any discussion or follow up action took place with Flexserve about the risks posed to others by the care workers in future employment[12].

5.1.15. Also during May and June 2016 Ms Taylor made a series of calls to the police, some of which were abandoned or were unclear in their purpose. Some appeared to relate to a historical allegation that she was pushed out of her wheelchair by a carer, complaining that the police had done nothing about this, and others to her wish to make amends with police officers and with a midwife. The police viewed her as a frequent caller with mental health issues

[12] Flexerve have stated that without allegations being upheld they did not consider it appropriate to report to DBS, but that they would include mention of the allegations in any future references for the carer in question.

but did not pursue enquiries about the carer, again leaving open risks to others who might have been at risk.

Fire risk

5.1.16. In addition to the safeguarding matters above, given the circumstances in which Ms Taylor died this review has focused on how fire risk arising from her smoking in bed was identified and managed by the agencies involved in her care.

5.1.16.1. It is clear that there were different levels of awareness about Ms Taylor's smoking. Ms Taylor described herself (in review documents) as smoking 40-60 cigarettes a day. Her GP record from 2016 notes 40 per day. Homes for Haringey risk assessment refers to her smoking 20 a day, and Flexserve has referred to her smoking 15 a day. Whittington Health have stated district nurses were not aware that she smoked; this is despite smoking being clearly identified in the GP surgery records and nursing staff regularly treating her skin with emollient creams. BEHMHT believed she had stopped smoking in 2012 and that fire risks were therefore much reduced; they have commented that had they been aware that she had started smoking again they would have addressed this in their work with her. This review considers it would have been appropriate for smoking to be explicitly included in the assessments undertaken by district nursing and, given their knowledge of her history, by mental health practitioners.

5.1.16.2. Ms Taylor was offered but declined both nicotine patches and electronic cigarettes, maintaining that it was her right to smoke and that she would continue to do so. The purchase of cigarettes was included in the shopping done for her by care workers, an arrangement Flexserve have stated was agreed with ASC and Homes for Haringey. It appears that the care workers would attempt to limit her smoking to the periods during which they were present in her flat, putting her cigarettes away out of reach when they left. One care worker has referred to giving her 10 cigarettes to smoke after her lunch. A note addressed to the care workers was pinned to her bedroom door: "*Please only give (Ms Taylor) 5 cigarettes each shift, total 15 cigarettes a day, 5 morning, 5 afternoon, 5 evening*". Given her limited manual dexterity, the agreed arrangement was that she would extinguish cigarettes by dropping them into a cup of water on her bedside table, provided by her care workers.

5.1.16.3. But there were shortcomings to these measures and it is apparent that Ms Taylor secured access to cigarettes through other means. She received visits from friends, at least one of whom was known to supply cigarettes, and she also at times used the out of hours community alarm service to request their assistance in reaching her cigarettes (which was sometimes given, although the practice ceased following advice from the care agency that Ms Taylor should only smoke when care workers were present). Flexserve have commented that she would also hide cigarettes from the care workers, going to any lengths to pursue her determination to smoke;

it was difficult for them to keep track of her habit, and there is acknowledgement that there could have been times when she smoked without a carer present. The agency considers there were limits to how assertive care workers could be in restricting her smoking and that it would have been inappropriate for care workers to search Ms Taylor's bag to check on the presence of cigarettes and ignition sources. They believe that such invasion of privacy would have resulted in Ms Taylor physically resisting and fighting staff off her lighters. In the post-fire inspection by the Fire Brigade, officers found the remains of a long-reach gas hob lighter and two burnt packets of cigarettes in her bed, with a third found under the bed; another long reach gas hob type lighter and two cigarette lighters were on the bedside table. Bedding and night-wear showed evidence of historical cigarette burn marks.

5.1.16.4. The shortcoming of the strategy were noted by the Coroner, whose Record of Inquest[13] notes: *"The plan to restrict the use of smoking materials to the times when carers were present was well-meaning but was bound to fail, particularly as cigarettes were important to Ms Taylor's quality of life and Ms Taylor was allowed to keep a lighter next to her bed".* The report suggests that care workers would have known that the strategy was failing: "*a cup of water was found beside the bed following the fire, raising the suggestion that staff knew Ms Taylor might smoke when on her own*".

5.1.16.5. Risks arising from her smoking do not appear to have been comprehensively assessed and addressed. They are mentioned in some but by no means all of the documentation supplied to this review.

- The first Homes for Haringey risk assessment in May 2015 does not mention smoking;
- A Flexserve risk assessment in March 2016 records her smoking but does not mention any fire risk management strategies;
- A Homes for Haringey assessment in May 2016 records that she smoked 40-60 cigarettes a day, putting them out in water, and that the care workers were putting cigarettes out of reach when they left;
- The ASC review in July 2016 mentions her heavy smoking but makes no mention of risks arising or the need for risk management;
- A Homes for Haringey assessment in September 2016 notes that the Fire Brigade visit had taken place, and one in November 2016 notes that they gave a recommendation for fire-retardant bedding but does not indicate what action was being taken to secure this;
- A Flexserve care plan in July 2017 notes that Ms Taylor had rejected measures such as nicotine patches and electronic cigarettes and that the risk of fire was critically high, particularly in the presence of ignition sources. It notes her method of extinguishing cigarettes in water and the care workers' role in supervising her smoking;

[13] 8th May 2018

- The ASC review in August 2017 mentions fire hazards from heavy smoking but no risk management measures other than Homes for Haringey indicating that fire-retardant bedding had been ordered through the fire service;
- ASC have confirmed that from the reviews undertaken in 2016 and 2017 there is no documented strategy on how the smoking was to be managed and no evidence of conversation with Ms Taylor with regard to management of smoking risk.

5.1.16.6. A further concern is that Ms Taylor used an Airflow mattress, designed to prevent pressure sores. However, such mattresses present a high risk of fire in circumstances where an individual smokes in bed. If the mattress is punctured (for example by an ignition source) escaping air can cause any fire to increase in intensity and to spread quickly. Yet throughout the documentation supplied to this review, including care plans and risk assessments undertaken at the time, there is no mention by any agency of risks from the mattress. Both ASC and Homes for Haringey have confirmed that their staff were not aware of the risks. District nursing staff do not appear to have included it in any risk assessment. The Fire Brigade were not advised about the presence of the mattress, nor did they identify it when conducting their home fire safety visits in 2016 and 2017.

5.1.16.7. Equally, Ms Taylor, under the guidance of the district nursing service, used emollient creams to treat her pressure sores. Emollient creams are known to be highly flammable, posing risks if they are present in clothing and bedding[14]. Again, there is no mention of risks relating to the creams in the documentation supplied by Whittington Health to the review. Equally, there is no evidence that it was considered as part of the fire risk evaluated by the Fire Brigade or as part of any risk assessment by ASC, Homes for Haringey or Flexserve.

5.1.16.8. The Fire Brigade carried out two Home Fire Safety Visits (2016 and 2017) as part of an overall group risk strategy, visiting care homes and sheltered accommodation across the Borough. An initial visit in 2015 was requested but not carried out:

- For the first visit in 2015, requested soon after Ms Taylor's arrival at Latimer House, the fire service asked Homes for Haringey to provide a contact who could give assistance with access, but it appears no arrangement to visit was made, and this was not followed up by either party.
- In relation to the June 2016 visit, there is a discrepancy in the information supplied to this review: Homes for Haringey state that the Fire Brigade recommended fire-retardant bedding at this point, but the Fire Brigade state that only general fire safety advice was given, with fire-retardant bedding only raised at the

[14] A further recent government alert has been issued on this matter: https://www.gov.uk/government/news/emollient-cream-build-up-in-fabric-can-lead-to-fire-deaths

later visit in July 2017. Certainly no action was taken at this point by anyone to source such bedding for Ms Taylor.

- At the July 2017 visit[15], the Fire Brigade noted the need for fire-retardant bedding, but later the same day advised the housing scheme manager by email of their decision that Ms Taylor did not meet all the criteria for the bedding to be supplied by them.

5.1.16.9. It is questionable what factors were taken into account by the Fire Brigade at their 2017 visit. It later emerged that the eligibility decision was based on the absence of signs of enhanced risk, such as burn marks Yet the post-fire investigation found evidence of historic burn marks on Ms Taylor's bedding and night-wear, raising questions on whether the bedding and clothing were viewed at the visit. The presence of an Airflow mattress and emollient creams do not appear to have been noted, and it is unclear what view was taken of her means of extinguishing cigarettes given her immobility and limited dexterity in her arms. This review has learnt also that at the time of undertaking the home fire safety visits, LFB staff were not aware that Ms Taylor had in the past been involved in two fires in her previous property. Fires are logged by address of the property involved, not by name of householder. Thus the visits took place without information that would have enabled officers to conduct comprehensive appraisal of fire risk.

5.1.16.10. While Ms Taylor's flat was well equipped with heat and smoke detection equipment, her means of raising the alarm was by using the pull cord close to her bed to communicate with the Community Alarm Service, a manoeuvre that required a degree of mobility and coordination. Despite her impaired mobility, impaired dexterity and difficulty raising her arms, she did not have a pendant alarm worn on her person that she could use to summon help.

5.1.17. When the fire occurred, the Fire Brigade response appears to have been timely and appropriate. Two fire crews were dispatched within a minute of receiving an alert from the community alarm service, followed by a third on receipt of the call from the care worker and a fourth on arrival of the first crew at the scene 8 minutes after dispatch.

5.1.18. The Fire Brigade's investigation of the fire found that "*the burn patterns observed at the scene indicated that the fire started on top of Ms Taylor's bed and the evidence suggests that the most probable cause of the fire was an event involving smoking materials. It is possible that the fire started as result of a lit cigarette coming into contact with Ms Taylor's bedding or night wear. It is also feasible that the fire started during the process of lighting a cigarette with the long reach gas hob lighter. It has not been possible to discern which event caused this fire*." Analysis of her bedding confirmed that it did not have fire-retardant properties and that refined petroleum products present in emollient creams were present, leading to the view that "*the Airflow mattress along with an emollient produce would exacerbate any fire situation by increasing the rate of fire spread*".

[15] The 2017 visit is supported by documentary evidence from the Fire Brigade, but Homes for Haringey have no record of it having taken place.

5.1.19. It is clear that no comprehensive risk assessment covering all domains of risk took place during the period under review. Individual elements of risk, such as financial abuse, received a response, but at no point did any agency bring together all the features of Ms Taylor's situation that required risk management. No one agency was aware of the full picture. Equally, there was no coordinated, shared and documented risk management plan relating to her smoking. Measures to reduce risk, such as smoking only when supervised, were not systematically recorded in risk management plans or care plans, nor was the adequacy of the measures put in place to manage her smoking monitored and reviewed, despite acknowledgement that they were not fully effective. As such, there seems to have been insufficient concern about and engagement with fire risk, and an absence of shared recognition of the need for high-level and proactive risk management. No consideration was given to referring Ms Taylor to the Haringey High Risk Panel and ASC have indicated to this review that practitioners working with her had little knowledge about the panel and the opportunities it presented for escalation and management.

5.2. Mental capacity

5.2.1. BEHMHT was the only agency that undertook assessments of Ms Taylor's mental capacity:

- January 2015 in relation to her decision to continue to live with her male friend who was abusing her financially, verbally and physically, resulting in a finding that she had capacity to decide on this;
- August 2015 in relation to consent to treatment with psychotropic medication resulting in a finding that she had capacity to decide on this.

5.2.2. There are virtually no references to mental capacity from other agencies, the one exception being the decision to close the safeguarding screening relating to financial abuse by a care worker in May 2016, in which capacity was given as one of the reasons for the closure, although there is no evidence to suggest that this resulted from a capacity assessment.

5.2.3. The absence of focus on mental capacity is concerning. There is ample evidence of decisions on Ms Taylor's part that should at least have triggered an assessment. It may be the case that those working with her assumed that she had capacity but, in the face of the high risks she ran, such an assumption would need to be evidenced and documented through formal assessment. As ASC reflect: *"the importance of beginning with the assumption that the individual is best placed to judge their wellbeing and building on the principles of the Mental Capacity Act needs to be evidenced. Even if a formal capacity assessment was not undertaken, a discussion around the impact of the choices she makes was not clearly documented".* In situations where an individual repeatedly makes what the Mental Capacity Act 2005 calls 'unwise decisions'[16], as did Ms Taylor in relation to smoking in bed, the Act's Code of Practice[17] explicitly advises investigation of capacity. Those working with

[16] The concept of 'unwise decisions' is contained within the principles set out in the Mental Capacity Act 2005, which states (section 1) that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".

[17] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*. London: DCA. Para 2.11 "*There may be cause for concern if somebody repeatedly makes unwise decisions that*

her questioned the rationality of her decision-making but did not test her understanding of the risks she faced, or her use of that understanding in making her decisions through formal assessment. Flexserve raised the question with ASC and were advised that her capacity had been assessed, but there is no mention in ASC records submitted to this review of a capacity assessment in relation to any of her decisions, including in relation to smoking.

5.2.4. In interactions with Ms Taylor there was evidence that should have triggered capacity assessment. An occupational therapy assessment noted that she had lapses of memory and could become muddled over the sequencing of past events. The July 2016 ASC review states *"cognitive difficulties as a result of a stroke meant she was not always focused on the conversation and kept wanting cigarettes."* At around the same time a police officer noted her difficulty with dates, and with staying on track in discussion, concerned that she may have dementia or some other mental health issue. ASC have reflected that it would have been appropriate to consider the impact of her mental health – notably her depression and other symptoms of mental distress - on her capacity for decision-making: "*On reflection, the completion of a mental capacity assessment to determine her ability to make informed decision in regard to her care and support needs may have been useful. (She) may have appeared coherent, assertive in communication with professionals, which is likely why it was not evident that a Mental Capacity Assessment was required or could have served to support decisions she was asked to make".*

5.2.5. It is also of concern that capacity was not assessed in relation to other matters: financial management, given evidence that Ms Taylor had found this problematic; refusing to use the hoist to assist transfers out of bed; declining treatment for her pressure sores, in relation to which Whittington Health reflect: "*this is something the district nurses could have done to ensure Ms A had capacity to make informed decisions as well as offer the right support she required*". Also of concern are the Flexserve care workers' client notes from the day she died, which were retrieved from Ms Taylor's flat by the Fire Brigade after the fire. Two entries record that Ms Taylor was confused during the visits earlier that day (at lunch time and tea time). It is known that she was not feeling well and that the GP had been contacted the previous day, but the care workers' notes raise further questions about how agencies responded to evidence that her ability to make decisions about keeping herself safe might be impaired.

5.2.6. A further matter relating to Ms Taylor's understanding and participation in discussions with practitioners is the question of whether she could have benefitted from the appointment of an advocate to help and support her decision-making[18]. Even if she did not lack capacity to make key decisions

put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character. These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices."

[18] The Care Act 2014 places a duty on local authorities to arrange an independent advocate to be available to facilitate the involvement of an adult who is the subject of an assessment, care or support planning or review process (section 67) or who is the subject of an adult safeguarding enquiry (section 68), where appropriate, if the local authority considers that the adult would

about her safety, there was evidence that she may have struggled to take part in assessments and reviews of her care and support needs; the July 2016 ASC review noted that "*cognitive difficulties as a result of a stroke meant she was not always focused on the conversation and kept wanting cigarettes".* The ASC review form prompts the reviewer to consider advocacy, but in this case no reason is given on the form for the decision that she did not need it, despite the practitioner stating that Ms Taylor's friends may be unreliable in supporting her. Learning event participants emphasised that Ms Taylor knew her own mind and could ask for help when she needed it but emphasised equally that having capacity doesn't mean that agencies walk away from difficult issues. An advocate may have been able to support Ms Taylor in engaging more fully with evaluating the risks she faced.

5.3. Mental health

5.3.1. Ms Taylor had a history of mental health problems and had been treated by BEHMHT since the fire in her flat in 2011, which was started deliberately. She initially stated it was a suicide attempt (although she later said it was accidental). She had a diagnosis of recurrent depression with traits of emotionally unstable personality disorder, and at times experienced delusions/hallucinations. She had made multiple suicide attempts in the past. Following a period of in-patient treatment after the fire, she was discharged from hospital in June 2011 and received regular follow up and review, as well as occupational therapy. Her care was managed through the care programme approach, involving visits from a care coordinator, and she engaged well with services, participating in and complying with her anti-depressant treatment. She was described as pleasant and chatty but would not be told what to do. In November 2015, when it was decided that she no longer needed support of that intensity and could be transferred to outpatient mental health services. At this point there was a long break in service, with no appointment forthcoming until 2017, with the result that her mental health was not actively monitored by specialist services. The reason for this is unclear and is under investigation by BEHMHT. When she was finally seen by BEHMHT again, however, in May 2017, the consultant psychiatrist found her well and discharged her to the care of her GP. Because of the absence of information to this review from the GP surgery, it has not been possible to identify how the surgery monitored her mental health.

5.3.2. ASC considered and recorded her mental health needs at annual reviews. They have reported to this review that Ms Taylor's mental health was being monitored by her care workers and were to report any changes in mood to her GP. There is no evidence of such monitoring being built into Flexserve's care plan, however, or that care workers were briefed on what to look out for, or that they communicated with anyone about her mental health. Flexserve have stated that ASC advised them that Ms Taylor's assertive and sometimes aggressive interaction with visitors was the norm. But it is unclear what understanding the care workers had of expectations that they should report changes. The fact that they did log Ms Taylor's confusion earlier on 4th October 2017, the day she died, indicates they were alert to

experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes, or feelings.

changes in her mental health. Flexserve have stated that the care worker raised her concerns with the GP surgery when she rang the surgery to report Ms Taylor was unwell, and that the care worker also raised it with their own manager. The GP surgery, however, has no record of the call in Ms Taylor's notes, and Ms Taylor does not appear on any GP list for the date in question.

5.4. Management involvement

5.4.1. The SAR panel requested information from agencies on management scrutiny of Ms Taylor's case and of decisions made by practitioners.

5.4.1.1. ASC have indicated that all assessments, reviews and care plans require management sign off, without which these work steps cannot be completed. Supervision records demonstrate that during 2015 Ms Taylor's case was discussed in supervision four times, although the notes give little indication of the nature of the discussions. During the 5 months for which her case was open in 2016, there are two managerial entries – one relating to the decision to initiate an appointeeship to manage Ms Taylor's finances, and one relating to a case update from the OT. The closure of the safeguarding screening in May 2016 was signed off by a manager. It does not appear that fire risk received any management scrutiny. In August 2017, the practitioner who undertook the care and support review discussed the recommendation for fire-retardant bedding with her manager, who advised asking Homes for Haringey and Flexserve to arrange for the care workers to support Ms Taylor to purchase the bedding. The manager was later involved in re-directing the reviewing officer's request (which had been made to the wrong care provider) to Flexserve, but it appears no follow up took place with either agency to check that the bedding had been supplied. It seems that ASC management was not sighted on the level of risks in Ms Taylor's case; ASC have reflected that with stronger management oversight could have ensured the case was escalated to the Haringey High Risk Panel, where it would have received closer multiagency scrutiny.

5.4.1.2. Flexserve placed Ms Taylor on the agency's field supervisors' critical monitoring list to ensure that supervisors were closely monitoring her care during 2016 and 2017, when ex-carers were barred from making contact with her. Emergency protocols were in place enabling care workers to contact the office to seek back up should they find anyone visiting Ms Taylor. The manager undertook visits to Ms Taylor to discuss her safety, and also advocated for an alternative means of managing Ms Taylor's finances, as the involvement in care workers in this contravened the agency's policies.

5.4.1.3. It is clear from Flexserve's reflections during this review that they believed the task of supervising Ms Taylor's smoking was not one that could realistically be fully achieved, given the alternative means she had of sourcing cigarettes, her habit of hiding cigarettes and ignition devices, and her hostility to interference with her smoking by care workers. Yet there is no evidence that the agency raised concerns with ASC about the viability of the arrangements while they

were in place. Such escalation could have triggered stronger engagement by ASC with the need for greater attention to risk management.

5.4.1.4. Homes for Haringey have indicated that the service manager and team leaders within the staff team have regular sessions to discuss tenants' support plans and to pick up on any particular cases. Ms Taylor's case was discussed in detail with senior managers.

5.4.1.5. Whittington Health records show that in March 2017 a district nurse advised the GP surgery that Ms Taylor had declined pressure area care advice that the nurse had made. No response was received from the GP. In June 2017 a nurse escalated to a deputy manager concerns about Ms Taylor declining pressure area care; no change of action resulted on the grounds that Ms Taylor had capacity to make informed decisions.

5.4.1.6. Ms Taylor's psychiatrist was the most senior psychiatrist in the BEHMHT team, and BEHMHT have stated there was therefore no reason to further escalate her case. Supervision discussion did take place, along with multidisciplinary team discussion during 2015.

5.4.1.7. LFB undertake an internal review after every fatal fire and have done so in this case.

5.4.1.8. ASC Commissioning have indicated that outcomes of QA visits are shared with management and actions moving forward are jointly agreed. Commissioning staff and management have met with the care provider on multiple occasions.

5.5. Interagency communication and case coordination

5.5.1. In circumstances where a number of agencies are involved in managing a high-risk situation, two aspects of interagency collaboration play a key role - information-sharing and case coordination. Both show some shortcomings in this case.

5.5.2. Not all relevant information was shared with Flexserve as the agency providing daily care and support. Despite carrying responsibility for supervising her smoking, they were not advised that she had initiated a fire in her previous flat in 2011. They did not have information about Ms Taylor's history, the trauma and abuse she had experienced, or her overdose in 2010, which they believe could have provided a greater understanding of her behavioural traits and influenced the management strategies used to support her and led them perhaps to question the suitability of the home care arrangement. They were not invited to the ASC review held in July 2017 and no documentation arising from the meeting was shared with them.

5.5.3. Similarly, Homes for Haringey staff in Latimer House were not aware that Ms Taylor had started a fire in her previous flat. While it is clear that Homes for Haringey tenancy/lettings section was aware of this in 2011, when discussions took place between them and the Police about her accommodation, it is possible that the information was not passed to the

housing scheme staff when Ms Taylor took up her tenancy 4 years later. They believe knowledge of her history would have triggered a more proactive approach to risk assessment and management.

5.5.4. In June 2016, when Ms Taylor made a series of 14 phone calls to the police, a mental health marker was added to the call record on 7 occasions. Yet none of the calls resulted in a Merlin report being completed, and therefore no other agencies were informed about the calls. They took place at a time when Ms Taylor was experiencing possible financial abuse and could have helped to provide a fuller picture of her situation at the time. The Police have reflected on the risks posed when the criteria for completing a Merlin report[19] are considered not to be met and no report is made, despite an individual's vulnerability.

5.5.5. Communication and sharing of information around the home fire safety visits was unclear. The housing scheme manager believed that the Fire Brigade had recommended fire-retardant bedding at the visit in June 2016, but the Fire Brigade have indicated that they did not recommend it until 2017. When after the 2017 visit the scheme manager received an email from the Fire Brigade advising her that Ms A did not meet all the criteria for fire-retardant bedding to be provided by the Fire Brigade, no explanation was given, making it difficult to question the decision. Equally, neither the scheme manager nor ASC went back to the Fire Brigade for more information.

5.5.6. A further communication error occurred in August 2017 when ASC sent to the wrong care provider an email requesting that either Homes for Haringey or the care agency help Ms Taylor purchase fire-retardant bedding. Although the error was rectified and the email subsequently forwarded to Flexserve (although Flexserve state they did not receive it), it was not clear from its content that Flexserve were expected to act, and there was no follow up on this matter by ASC.

5.5.7. In contrast, there were some good examples of communication and joint working. BEHMHT kept the GP well informed on her mental health treatment between 2011 and 2015. The BEHMHT care coordinator, the housing scheme manager, Flexserve and ASC worked together during 2015 when Ms Taylor was moving to and settling in to Latimer House. The ASC reviewing officer and the scheme manager worked closely together over annual review, and the OT collaborated with ASC to ensure safe levels of staffing when Ms Taylor was trialling use of the hoist. District nurses were in regular contact with the Flexserve care workers, providing advice on caring for Ms Taylor's pressure areas during their attention to her personal care. The nursing service also made referrals to physiotherapy and occupational therapy for advice on safe transfers.

5.5.8. Some of the other agencies involved worked relatively in isolation. Whittington Health has commented on the absence of collaborative working through multidisciplinary team meetings to discuss her needs and consider

[19] The guidance for the creation of a MERLIN requires one to be created when a vulnerable adult comes to notice for any one of five criteria AND 'there is a risk of harm to that person or another person'. Current policy states that other than the vulnerability criteria there must also be 'cause for concern for the adult'.

that multidisciplinary teamwork could have resulted in more effective management of the risks. ASC Commissioning have reflected that their involvement in Ms Taylor's case could have been more intense had concerns about fire safety been communicated to them. LFB have stated they were unaware of Ms Taylor's use of emollient creams when they undertook Home Fire Safety Visits.

5.5.9. In addition to, and possibly a reason for, these communication failures, a key feature of the case is that at no point was a multiagency discussion involving all agencies convened. This overall absence of case coordination contributed to the absence of holistic overview of risk and of strategies to manage it. No one agency appears to have exercised leadership in taking an overview of her situation and coordinating the efforts of those involved. Thus vital information relating to fire risk was not shared, and omissions such as the failure to source fire-retardant bedding in August 2017 escaped unchecked.

5.5.10. One feature playing into this was the ASC practice of closing a case following annual review, once care and support review responsibilities had been discharged. Thus there was no ongoing monitoring or coordination of the actions of all agencies and no key point of access for other agencies to escalate concerns to – a point emphasised by participants at the learning event.

5.6. Contact with Ms Taylor's family

5.6.1. Ms Taylor's daughter and granddaughter requested that the panel consider whether there were missed opportunities to contact them. The review panel therefore explored with agencies whether, at any points during their contacts with Ms Taylor, they gave any consideration to such contact.

5.6.2. Homes for Haringey was aware that Ms Taylor had a daughter, as well as a nephew who was listed in their records as her next of kin. They also knew, however, that Ms Taylor did not want any contact with her family, and that she felt strongly about this; the absence of family visits was in line with her wishes. Homes for Haringey were aware that at one stage she had made an allegation of financial abuse against her nephew, but later retracted this, saying she had given him money to buy items for her. Ms Taylor did give Homes for Haringey her daughter's phone number during discussions about her final support plan but indicated that she and her daughter did not speak to each other, and therefore it was not thought appropriate to make any contact. Ms Taylor's family have indicated that this was not the true picture – Ms Taylor and her daughter had had periods of being of phone contact for some years, and calls had become more regular and calmer in the year prior to her death.

5.6.3. Flexserve did not have any information about Ms Taylor's daughter, and were not advised by Homes for Haringey that they had her contact details. They have stated they would in any case normally rely on instructions from ASC in terms of managing her needs and would expect that any necessary family contact would be ASC's responsibility to pursue.

5.6.4. Similarly in their contacts with Ms Taylor, the Police were aware that she was receiving health and social care from ASC and health providers. Had this

not been the case, they would have made efforts to identify family or friends to ensure they were aware of her circumstances but given other agencies' involvement they presumed that any necessary family contact would be carried out by those agencies. They were also aware that Ms Taylor had been reluctant to provide details of family members due to estrangement from her family, and on one occasion when contact did take place with a family member (following the 2011 fire) the family member advised the Police that Ms Taylor had irreconcilable differences with her daughter.

5.6.5. ASC, in contrast, was not aware that Ms Taylor had a daughter. She had supplied only her nephew's contact details. Family contact would normally be made only when a client asked for this to be done, or when practitioners consider they should be contacted and the client has given permission.

5.6.6. The LFB did not consider contact with Ms Taylor's family, although national guidance now advises that "*in certain situations, where risks associated with smoking are identified, and it is recognised that residents are particularly vulnerable, it might be appropriate to engage the assistance of relatives, carers or outside agencies to identify potential solutions that could be considered to reduce the risk to the individual as part of a person-centred approach*" (NFCC, p113)[20].

5.6.7. The failure to recognize the true extent of the risks Ms Taylor faced may well have militated against recognition of the value of seeking help from her family. It is not clear whether any explicit conversations took place with Ms Taylor about contacting her daughter, and participants at the learning event considered that Ms Taylor deliberately kept her family away from the professionals with whom she was involved. Clearly there would be difficult decisions to be made about confidentiality, had Ms Taylor withheld permission, but the fact that she provided her daughter's phone number to Homes for Haringey during the later stages of her tenancy indicates that discussion with her about involving her family may have been fruitful.

6. CONCLUSIONS

6.1. This concluding section summarises the learning that has emerged from the SAR and thus provides a context for the recommendations that follow in section 7 of this report.

6.2. Learning event participants who knew Ms Taylor felt strongly that she was a strong-willed woman who had dealt with many difficulties in her life and was pursuing her own choices. It is not the intention of this report, in identifying significant features of agencies' work here, to portray Ms Taylor as a victim of those circumstances. Learning event participants were equally of the view that the circumstances of her case could occur again. It is therefore important to summarise the significant learning in the thematic analysis above, so that it can inform future actions to minimise recurrence of the events that took place here.

6.3. The SAR panel was tasked with addressing key questions relating to:

[20] NFCC (2017) *Fire Safety in Specialised Housing*. Birmingham: National Fire Chiefs Council.

- Assessment and decision-making on care and support, housing needs and safeguarding risks;
- Professionals' understanding of safety and safeguarding risks and vulnerabilities;
- Whether safety/safeguarding risks and needs assessments completed and acted on;
- How mental health and mental capacity were taken into account;
- The level and impact of management involvement;
- Organisational and/or operational difficulties within or between agencies;
- Involvement of Ms Taylor's family in her care planning.

6.4. The summary that follows identifies good practice where appropriate in the above domains, as well as indicating where changes could contribute to more robust risk management. In any SAR, it is important to try to answer "why?" questions and to reflect on whether the particular features of the reviewed case reflect wider systemic issues either within or between agencies. Thus this conclusion focuses on such issues where they are seen to have contributed to events.

6.5. Ms Taylor's care and support needs were assessed and reviewed by ASC, and her daily needs were met by those involved in her care. The housing scheme manager was attentive to her needs, and on occasion took appropriate steps to engage other agencies in addressing concerns that arose, particularly those relating to the security of her finances. She received safeguarding attention in relation to risks from third parties on a number of occasions, (although her own actions sometimes compromised measures to keep her safe).

6.6. However, on the evidence available to this review, it is hard not to conclude that comprehensive and holistic risk assessment, particularly of the risks arising from her smoking, was missing. Nor was her mental capacity to make decisions about health and social care support, and about the risks from smoking, assessed, despite features of her situation that could have given rise to the need to undertake such an assessment. In addition, her mental health was not monitored for a significant period of time. Her family have expressed particular concern about these aspects of agencies' involvement with her.

6.7. The absence of case coordination was a significant feature that contributed to this, and is again a particular concern of Ms Taylor's family. No single agency was sighted on the whole picture. The ASC focus in reviews was solely on her care package, with an absence of wider considerations: housing, risk management, coordination of provision. Flexserve, whose care workers were key to the strategy for managing fire risk by placing cigarettes out of Ms Taylor's reach, have stated that they were not invited to the 2017 ASC review and did not receive any information or report arising from it. Failures of communication and information-sharing between agencies added to the impact of silo-working, where agencies worked within their own remit without a sense of collective ownership.

6.8. Thus risk assessments were incomplete, failing to take account of significant fire risk. Home fire safety visits were undertaken without information about her fire history that could have affected the appraisal of risk, and without consideration of risks from the Airflow mattress and emollient creams. The chosen approach to reducing fire risk relied on Ms Taylor smoking only when her care workers were present, a strategy that was inadequate given her known ability to source and

hide both cigarettes and lighters. Flexserve was aware of the risk but did not escalate concerns about the effectiveness of the strategy for managing it.

6.9. Given conflicting information from the Fire Brigade and Homes for Haringey, and in the absence of written records of advice given during home fire safety visits, this review has been unable to identify when the need for fire-retardant bedding was first identified. If it was identified as needed at the June 2016 home fire safety visit (as claimed by Homes for Haringey), this raises the question of why it was not provided, and why it was over a year before this was followed up with the Fire Brigade by the housing scheme manager. If it was at the home fire safety visit in July 2017 (as claimed by the Fire Brigade, this raises the question of why it was not considered necessary by the Fire Brigade in 2016, when Ms Taylor's circumstances and risks from smoking in bed were the same, and why the housing scheme manager recorded the recommendation in a risk assessment/support plan in November 2016).

6.10. Either way, no action was taken to source the bedding, in either 2016 or 2017. Again the reason for this is unclear. In August 2017 ASC emailed both Homes for Haringey and Flexserve, asking for one of them to assist Ms Taylor in sourcing the bedding. Homes for Haringey responded asking ASC to request Flexserve's assistance with this. Flexserve state they did not receive the email ASC forwarded to them and were therefore not aware of the request. No-one in any agency took responsibility for ensuring that it was acted upon.

6.11. In the absence of comprehensive assessment of fire risk, the risk management strategies employed were limited and insufficient. It seems that no-one worried sufficiently to escalate discussions to the next level – either through Haringey's risk management panel or through a safeguarding referral that could have brought agencies together to share information and engage in collective appraisal of options. Thus no consideration was given to more robust fire risk management strategies that are suggested by national guidance[21].

6.12. But any such more proactive measures would depend on risk being appropriately identified, which in Ms Taylor's case it was not. There can be a number of reasons for this: lack of professional curiosity, exacerbated perhaps by Ms Taylor's own hostility and reluctance; a belief that respecting her autonomy meant not questioning her apparent choices; a culture of case closure; absence of appropriate risk assessment tools; systemic blocks on gathering all relevant information together; application of funding thresholds. All could have contributed to the absence of sufficient levels of concern to escalate risk discussions to a higher level. There is no evidence that Ms Taylor's decisions on smoking was construed as self-neglect and therefore as a safeguarding issue, although in her rejection of safe smoking strategies she was neglectful of her own health and safety.

6.13. Management involvement in case decisions, while possibly in line with routine operational expectations, did not result in review of the effectiveness of the risk

[21] The National Fire Chiefs Council (2017) guidance Fire Safety in Specialised Housing states:"*While it is not suggested that sprinkler or watermist protection should be retro-fitted in all existing specialised housing, it may sometimes be appropriate to consider this measure, or to consider personal protection watermist systems, comprising localised fire suppression within a flat of a highly vulnerable resident, so enabling the resident to continue to live safely in their own accommodation*" (pp31-32).

management strategy or in escalation to forums designed for bringing agencies together.

6.14. Finally, Ms Taylor's daughter and grand-daughter requested that this review consider whether there were missed opportunities to involve her family. ASC, despite its long involvement in providing care and support for Ms Taylor, was not aware that she had a daughter, again raising questions about both the breadth of assessment undertaken and the level of interagency communication. For agencies who did know, in the context of Ms Taylor's reluctance to share too much personal information, and the belief that it was her choice not to have contact with them, it seems understandable that agencies did not pursue this, out of respect for her wishes. However, discussion with her about whether family contact should be made would have been appropriate.

7. RECOMMENDATIONS

7.1. In line with the terms of reference for this review, the recommendations that follow are intended to contribute to improvements in how agencies respond to individuals where there are safety and safeguarding risks, in particular risk of fire. Those relating to fire safety will inform the work of the Haringey SAB's Fire Prevention Task and Finish Group, and it is intended that all will stimulate measures to strengthen future interagency safeguarding practice.

7.2. In addition, some individual agencies have already indicated in their submissions to this review that they have implemented changes within their own organisation. These are listed in Appendix 2.

7.3. Arising from the analysis undertaken within this review, the SAR Panel recommends that the Haringey Safeguarding Adults Board should:

7.3.1. In relation to fire safety:

7.3.1.1. Make arrangements for the implementation of a patient safety alert on the use of Airflow mattresses by people who smoke in bed, to ensure that the risks of such equipment are considered routinely in risk assessment by health providers.

7.3.1.2. Request that the Board's Fire Prevention Task & Finish Group implement the following matters:

a. A single fire risk screening tool that can be used routinely by all agencies to identify level of risk (including risks from health-related equipment) and the threshold for referral to the Fire Brigade, along with a programme of training in its use delivered across all agencies;

b. A mechanism whereby ASC, sheltered housing providers and domiciliary care agencies alert the Fire Brigade regularly about people who are receiving care and support and are confined to their bed, to facilitate regular fire safety checks, advice and review by the Fire Brigade;

c. Provision by the Fire Brigade (following home fire safety visits in supported housing) of written fire safety advice to individuals at high risk, their housing provider and agency commissioning their care and support package;

d. Distribution of LFB guidance on health care products and equipment [22] to all agencies and housing providers and domiciliary care providers;

e. Joint guidance between the Fire Brigade, ASC, LBH Commissioning and providers of supported living on the funding and provision of fire safety measures for high risk clients, including the criteria for installation of sprinklers and personal protection watermist systems;

f. Feedback from Homes for Haringey and ASC on their use of the Community Safety Investment Fund provision from the Fire Brigade, and its impact;

g. Consideration of mechanisms to ensure that the Fire Brigade, when undertaking home fire safety visits, are able to track information on previous fires by name as well as by address.

7.3.2. In relation to risk assessment and management

7.3.2.1. Develop a risk assessment template for use across agencies, to assist in early identification of levels of risk that trigger thresholds for referral to a multiagency discussion forum;

7.3.2.2. Request that ASC reviews its assessment, care planning and review documentation to:

- ensure that it contains a checklist of domains of risk to be considered (including health care products and equipment), with a requirement to evidence fire risk management for known smokers;
- ensure that narrative boxes on forms are completed with required relevant information and cannot be left blank;
- ensure that expectations of care agencies in terms of matters such as risk management and mental health monitoring are clearly specified in care plans and shared across all agencies involved with an individual;

7.3.2.3. Request that ASC revise its review and case closure policies to ensure that the frequency of ASC reviews is determined by risk level rather than routine annual review, and that where necessary service users at high risk retain a named practitioner;

7.3.2.4. Request that Whittington Health Trust review and revise the risk assessment practices by district nursing staff, to ensure that practitioners take account of all relevant information (including

[22] London Fire Brigade (2018) *Fire Safety Advice for Users of Health Care Products and Equipment*.

environmental hazards such as smoking and risks from use of health care products and equipment);

7.3.2.5. Request Whittington Health Trust to strengthen procedures and systems for enhanced supervision and case management oversight for all case where it is known that the individual declines or is resistant to intervention.

7.3.3. Interagency case coordination and communication in complex cases

7.3.3.1. Implement mechanisms for comprehensive and ongoing multiagency review of supported living tenants with complex needs including the allocation of a named case coordinator (to whom the case remains open) with lead responsibility for ensuring key information is shared, and for tracking and coordinating actions across all agencies;

7.3.3.2. Conduct a case file audit across agencies of cases in which individuals who smoke are housebound, to identify how information is being shared across agencies and how case coordination is being exercised. In the light of that audit, to consider how existing systems for multidisciplinary discussion of cases can be developed further.

7.3.3.3. Ensure that LBH Commissioning is invited to safeguarding and high risk panel meetings in order to identify any concerns relating to providers and where appropriate carry out relevant visits to a location in which the commissioned service is being provided;

7.3.3.4. Request the Metropolitan Police to review policies within their call handling system whereby people can be recorded as having vulnerabilities but no Adult Coming to Notice (ACN) or MERLIN records are completed, to ensure that sufficient safeguarding measures are taken in these circumstances;

7.3.3.5. Ensure that ASC implements a mechanism to ensure that care and support providers are routinely and reliably involved in care and support reviews;

7.3.3.6. Consider how best to ensure that full information is shared with providers of both housing and domiciliary care on client-related matters that impact on the health and safety of the individual receiving the provision;

7.3.4. In relation to mental capacity

7.3.4.1. Implement multiagency refresher training on understanding mental capacity and conducting mental capacity assessments, to include evidence from SARs on the significance of mental capacity in cases of self-neglect/service refusal/high risk;

7.3.4.2. Review guidance on triggers for mental capacity assessment in cases where repeated unwise decisions[23] escalate risk to ensure that capacity is explicitly considered.

7.3.5. In relation to the SAB's hoarding and self-neglect policy

7.3.5.1. Review the hoarding and self-neglect policy and procedures in the light of learning from this case to identify areas that might require strengthened guidance to agencies. These could include understandings of what constitutes self-neglect, risk assessment, risk panel thresholds, case coordination, mental capacity, working with unwise decisions, importance of consistent relationship, legal guidance on measure to protect others, advocacy;

7.3.5.2. Conduct a multiagency training needs analysis to identify training and development needs relating to self-neglect, followed by a workforce development strategy based on that analysis;

7.3.5.3. Implement a programme of awareness raising on the revised policy, delivered on a multiagency basis.

[23] The concept of 'unwise decisions' is contained within the principles set out in the Mental Capacity Act 2005, which states (section 1) that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".

APPENDIX 1: ACRONYMS USED IN THIS REPORT

ASC	London Borough of Haringey Adult Social Care
BEHMHT	Barnet, Enfield and Haringey Mental Health Trust
CPA	Care Programme Approach
GP	General Practitioner
IMR	Internal Management Review
LBH	London Borough of Haringey
LFB	London Fire Brigade
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review

APPENDIX 2: CHANGES IMPLEMENTED BY INDIVIDUAL AGENCIES SINCE THE CASE

1. Barnet, Enfield and Haringey Mental Health Trust

(a) BEHMHT are now ensuring that appointment times and dates given on discharge letters, to ensure that the need for follow up appointments is not missed.

2. Flexserve

(a) Flexserve has amended its Fire Safety Policy to review how support can reasonably be given to service users who smoke. This is discussed with staff at staff forums, staff meetings and supervisions since 2017 and is an ongoing practice.

(b) The Fire Safety Policy has been recirculated to all staff members. Ongoing training and retraining takes place within the organisation.

(c) Flexserve uses the LFB form for fire risk assessment to promote uniformity of usage across multidisciplinary teams and referrals will be made to LFB where clients have not been visited by the LFB.

(d) Field supervisors are to follow the amended Fire Policy and report concerns to the office for escalation to LFB.

(e) Flexserve's amended Fire Safety Policy has been provided to the Coroner following Ms Taylor's inquest.

3. Homes for Haringey

(a) Homes for Haringey have put in place more rigorous checks in relation to vulnerable residents. This includes a referral to the organisation's Health & Safety Team for an individual fire risk assessment.

(b) Homes for Haringey have introduced the use of 'tablets' by all support staff and all risk assessment and support plans are carried out electronically. This captures any risks around fire and referrals are automatically sent to the health and safety team for a safety talk and visit. The support staff also complete an individual risk assessment designed by the Fire Brigade. The service have also shared with the Fire Brigade details of the most vulnerable residents. The support plans are now set up with triggers for varied review periods – monthly, 3 monthly, 6 monthly - dependent on the actions generated by the resident's needs.

(c) Staff in Homes for Haringey's two sections - Support and Well-Being Hub and Tenancy Management - all store information on all tenants on 'Sharepoint', which is accessible to key staff. The teams meet monthly to discuss tenancy issues.

(d) Homes for Haringey has obtained £13K from the Community Safety Investment Fund to fund 5 mobile sprinkler systems and has successfully installed one device. Despite multiple efforts, other residents who meet the risk criteria refuse the installation due to the size of the device. Targeted visits by the fire brigade have been agreed in certain cases, and in new lets devices will be installed where the new tenant fits the high risk criteria.

(e) Homes for Haringey wishes to contribute to the Fire Prevention Task & Finish and is committed to ensuring that the guidance provided is the basis for relevant training and implementation, including on multi-agency triggers, information sharing, products and cream, mental capacity and self-neglect.

4. LBH Adult Social Care

(a) All frontline practitioners have undertaken fire safety training facilitated by LFB and this will be part of ongoing training for all frontline practitioners. Additionally, LBH ASC have requested that the LFB produce a factsheet that can be shared with practitioners on home fire risk covering aspects of high risk factors, fire safety visits, timeframes and how and by whom resources such as fire-retardant bedding can be accessed.

(b) LBH ASC have shared the LFB's fire safety assessment with all frontline practitioners.

(c) Assessment and review documents are being revised to ensure home fire risk is clearly identified in its own heading of risk, with appropriate prompts; these will be further updated when we have the factsheet from LFB.

(d) LBH ASC is represented on the SAB's Fire Prevention Task & Finish Group whose remit it is to develop and establish a system for identifying home fire risks to vulnerable adults in order to provide early intervention and prevention.

(e) Changes to the high-risk panel with new panel membership, new terms of reference and new process are currently being finalised. Once completed this will be shared across the service to raise further awareness.

(f) LBH ASC is working with LFB to identify individuals who would be presenting as higher risk due to being bedbound. The LFB Borough Commander has been linked into the ASC performance team to ensure a co-ordinated approach to this. The amount of people able to be identified with the setup of the current record system is limited, however, and ASC is therefore also undertaking changes to the record system (Mosaic) so that bedbound service users and those living alone can be identified at the assessment or review stage, which would ensure much greater reporting accuracy in the future.

(g) LBH ASC has provided LFB with full details relating to how the grant LFB provided to the authority was spent. The next step for both parties is to look at what impact that spending has had to ensure the benefits are maximised.

(h) LBH ASC has made some significant changes relating to mental capacity assessment, which ensure that it is much more embedded in practice and much more visible. Given the issue of cumulative risk and capacity were key to Ms Taylor's case, a practitioners' mental capacity manual is being developed with a focused section relating to the consideration of risk factors and the requirement to sufficiently test that the individual's capacity.

(i) LBH ASC want to ensure that, where annual reviews highlight potential risk, there is sufficient action taken by practitioners to ensure the individual's safety. The new structure of adult social care implemented in 2017 provides a framework in which to ensure timely responses where there are concerns around risk

identified. However, we intend to ensure that our practitioner review manual is updated following the report so that there is clarity on responsibilities of practitioners to ensure co-ordinated and actioned responses to risk when identified.

5. LBH Commissioning

(a) LBH Commissioning has worked with Flexserve and with other providers to support the development of fire safety awareness, particularly in circumstances in which users smoke, are bed bound, or use equipment such as air mattresses or emollients to protect skin. The use of person-centred fire risk assessment is promoted.

(b) LBH Commissioning manage the LBH Appointeeship Team. The team notifies all providers of residential and nursing care when appointeeships are made. Notifications relating to people living in the community are carried out by the social work teams. The Appointeeship Team adds a note to the care records front screen.

6. London Fire Brigade

(a) London Fire Brigade works across all London boroughs to help care partners recognise fire risk to their clients and work with the London Fire Brigade to reduce risk. The Brigade now has an officer solely dedicated to working with the care industry to improve fire risk identification and management.

(b) The Brigade has reviewed its policy on fire-retardant bedding to ensure people have access to it where smoking risk has been identified. The criteria for supplying this free of charge have widened to include anyone that the crew feels is at increased risk of fire.

(c) A general safety/advice note that has gone out to LFB operational staff on health care equipment, covering oxygen, airflow mattresses, emollient creams and incontinence pads.

(d) The Brigade continues to work with care providers and commissioning agents to highlight the dangers of fire. Officers have distributed a fire awareness package to all Borough Commanders to aid them in raising awareness of fire risks amongst those receiving care, and ensure that carers know how to recognise the signs of fire risk and take risk reduction action including a referral for a home fire safety visit. A centrally run training session was piloted for housing providers, carers and risk assessors covering these topics and a rollout of this is currently being considered due to the success of the pilot.

(e) Resources have been developed centrally such as the 'Healthcare Products' leaflet, which covers emollient products, incontinence pads, airflow mattresses and oxygen, and the 'person centred risk assessment checklist' which supports local identification of risk. Letters highlighting these new resources were sent out to 2000 care homes, care agencies, housing providers and carer support charities.

(f) The Brigade's website has recently been updated to include a page for carers and social workers. Information on the website includes detail of how to identify someone that is at risk from fire, advice on telecare systems and assistive technology, links to the person centred risk assessment checklist and advice on fire risk associated with healthcare products.

(g) The Brigade has produced an online fire safety awareness package in conjunction with the Telecare Services Association to provide carers with information on fire risk and what action can be taken to mitigate them.

(h) Consideration is being given to whether LFB is able to commission research into the effect emollient creams have on the effectiveness of fire-retardant bedding.

(i) Locally LFB has brought together Haringey Social Services and Homes for Haringey to share information on the most at risk/vulnerable people in the borough. Following a fire death in 2016 LFB were given a list of bedbound people, who were visited for a home fire safety visit during a 2 month period. Such information provided monthly/ bi-monthly on new people at risk can ensure that they are contacted by LFB, either alone or in conjunction with social services/care providers.

(j) LFB has offered to provide awareness training to care providers and those providing care to vulnerable people in the borough and are rolling out a person centred risk assessment.

(k) In October 2017, as part of their Community Safety Investment Fund, LFB provided
- £10,000 to Haringey Council to fund Careline Telecare smoke detectors and fire-retardant products
- £13,350 to Homes for Haringey to purchase portable fire suppression systems.

7. Metropolitan Police Service

(a) The person who abused Ms Taylor has been found to be someone who exploits vulnerable women, with other victims. A broad view of the risk he presents has now been made available for any officers who investigate him for future allegations of violence against women, so that the risks he presents can be effectively assessed. An intelligence package has been prepared and uploaded to CRIMINT to enable such a risk assessment.

8. Whittington Health Trust

(a) During 2018 the London Fire Brigade have attended district nursing forums to improve practitioners' understanding and gain their support when visiting patients with a risk of fire.

(b) In July 2018 the community services in Whittington re-structured to improve the integration of the community multidisciplinary teams (therapies, mental health, district nursing).