Neutral Citation No: [2017] NICoroner 10	***Ref:*** **2017NICORONER10**
Judgment: approved by the Court for handing down (subject to editorial corrections)*	***Delivered: 28/04/2017***

IN THE CORONERS COURT FOR NORTHERN IRELAND

_____

IN THE MATTER OF

AN INQUEST INTO THE DEATH OF

MARY KATHLEEN FEGAN

_____

Before: Coroner Patrick McGurgan

[1] The Deceased Mary Kathleen Fegan born on 31st December 1930, of Owenvale Court, 607 Springfield Road Belfast, died on 11th April 2012.

[2] Until 29th July 2011 the Deceased resided at her home at 7 Herbert Street, Belfast, with support from her family and a home help service. On 29th July 2011 the Deceased was found by her granddaughter, Miss Nicci Reid, collapsed on the floor of the property. The Deceased appeared to have no recall of the events which had led to this collapse. As a result, the Deceased was taken to the Emergency Department at the Royal Victoria Hospital, Belfast and admitted to Ward 2 F. The Deceased was subsequently transferred to Meadowlands Ward 3, Musgrave Park Hospital, Belfast, on 10th August 2011 for a period of rehabilitation. On 23rd August 2011, the Deceased was referred to Care Management within the Belfast Health and Social Care Trust, regarding a care package to allow her to return home following discharge from hospital as per the wishes of both herself and her daughter. A discharge meeting took place on 30th August 2011 with the Deceased and her family. At this meeting the Deceased's family highlighted concerns that they had regarding the Deceased's safety at home following two previous break-ins and her fall. They were also concerned about the Deceased smoking as she

was becoming more disorientated at home. A package of care was put in place and the Deceased was discharged home on 2nd September 2011.

[3] The Deceased's health began to deteriorate and she became increasingly confused and prone to wandering. During this time the Deceased's daughter was dying. There were also concerns about the Deceased starting fires and burning herself with matches. The Deceased was admitted to Ward D in the Mater Hospital, Belfast, on 23rd September 2011. On the 30th September 2011, Lorraine Moffett, Occupational Therapist, assessed the Deceased and she noted the family's concerns that the Deceased had become increasingly confused in the last number of weeks, that they were worried about the Deceased's safety at home, that she was having visual hallucinations and that she was starting fires and burning herself with matches. She was diagnosed on 30th September 2011 with mixed aetiology dementia and a referral for a psychiatric assessment was suggested. It was agreed with the family that the Deceased should be placed in a residential care home. Although an assessment was carried out, the Deceased's suitability for a residential home was not specifically assessed. The Deceased was discharged from Ward D on 17th October 2011 to Owenvale Court Residential Home. This particular home was the choice of the Deceased's family as it provided a smoking room and offered bingo to the residents.

[4] The Deceased's granddaughter, Nicci Reid, told the Inquest that Owenvale seemed perfect for the Deceased because it was homely and had a community atmosphere. Her evidence was that when the Deceased took up residence fire retardant clothing was neither discussed nor recommended. The Deceased settled well but due to issues with the Deceased and her smoking, she was placed in a room, Room 10, within Owenvale Court, which directly faced the smoking room. Furthermore, her cigarettes and lighters were placed at Reception. The Deceased's family were content with Owenvale Court and at no time were they ever made aware of any issues surrounding the Deceased and smoking.

Medical Assessment:

[5] Doctor Grainne Donaghy, SHO to Dr C Barton, Consultant in Psychiatry of Old Age reviewed the Deceased on the 30th September 2011 and diagnosed her with dementia, either vascular or a mixed picture. Dr Barton's evidence to the Inquest was that the Deceased's suitability for residential care required a particular assessment to be conducted and that he was not asked by the Trust to do this assessment. Neither he nor Dr Donaghy were asked to assess the Deceased's safety regarding smoking or her ability to understand, retain, and follow the policy of the Home as regards not being allowed to smoke in her room.

The St. John of God Association and Owenvale Court:

[6] Owenvale Court was one of a number of residential care homes presented to the family of the Deceased by the Belfast Health and Social Care Trust. At the time of the Deceased's admission to Owenvale Court it was under the management of St John of God Association. St John of God had been operating Owenvale Court since approximately 2002. They also operated two other care homes in Northern Ireland, both in Belfast.

[7] Due to issues with management in the Home, Brother Michael Newman was appointed as the Acting Manager. He remained in this position from mid-2010 until 26th January 2012. At all times, the Deceased remained subject to Care Management review by Belfast Health and Social Care Trust.

[8] In his evidence to the Inquest, Brother Newman stated that he had previously managed a smaller unit which dealt with people with learning difficulties. Brother Newman was a qualified nurse having qualified in 1971 and he held a nursing diploma in geriatric nursing. In taking up his post Brother Newman was required by the Regulation and Quality Improvement Authority (RQIA) to undertake a "Back to Nursing" course, in order to satisfy the statutory criteria for being a Registered Manager, but this had not been completed by the 26th January 2012.

[9] Owenvale Court was a residential care home which was registered to accept only residents who were aged 65 and over, elderly and frail. This was known as Category I. Once these criteria were met and the individual was recommended for a Residential Care Placement by Social Services then Brother Newman would assess the individual, as he did in this case with the Deceased. Brother Newman visited the Deceased in hospital and he considered the assessments and medical reports which pertained to the Deceased. He deemed the Deceased to be suitable for admission to Owenvale Court and felt that Owenvale Court would meet the needs of the Deceased.

[10] During an inspection by the RQIA in 2010 four residents were identified as having developed dementia. At this time Owenvale Court was not certified for accommodating dementia residents. In accordance with the Residential Care Home Regulations (Northern Ireland) 2005 any organisation seeking to vary their category of care must make an application to the RQIA. On the 25th May 2011 the St. John of God Association submitted such an application to include persons with dementia, Category DE, in their registration. A suitable certificate was ultimately granted by the RQIA on 25th October 2011. This was after the Deceased had been admitted to Owenvale Court on the 17th October 2011. Brother Newman explained that he had been operating on the assumption that the certificate would be granted. The certificate that was granted by the RQIA referred to four named individuals only and it did not include Mrs Kathleen Fegan, the Deceased. At this time the RQIA directed Brother Newman to write to the Trust regarding the limited certificate that had been granted, this was not done, nor was this

direction followed up by the RQIA. Brother Newman accepted in evidence that he should have been aware that the Deceased had dementia.

Smoking Policy:

[11] Brother Newman in giving evidence to the Inquest, stated that he was aware that the Deceased was a smoker and that she was pleasantly confused. This was despite a number of assessments referring to her as having dementia. Owenvale Court did permit smoking by its residents but only in the smoking room provided for this purpose and under staff supervision. The Deceased smoked in her bedroom in contravention of the smoking policy. Brother Newman stated that, notwithstanding the fact that the Deceased suffered from dementia, he and other staff members spoke to the Deceased on a number of occasions about smoking in her room and in fact, he decided to place her in a bedroom closer to the smoking room, Room 10. He explained that whenever the Deceased had wanted to smoke, she was required to ask for a cigarette and lighter which were retained at Reception. He believed that she would have been accompanied by a member of staff to the smoking room and supervised whilst she had a cigarette. Some residents appear to have been allowed to keep their own cigarettes and lighters. In addition, residents were able to come and go freely in the Home and therefore could purchase their own smoking materials outside of the Home and return without staff knowing if smoking materials had been obtained.

[12] Brother Newman believed that the smoking policy was working well. I find that it was not.

[13] ARMA Fire Safety Limited was retained by the St. John of God Association to carry out annual fire risk assessments. In an assessment dated the 25th January 2008 the following were highlighted:

[14] Signs of unauthorised smoking in Room 16; in July 2007 a small waste bin had been set on fire in Room 17 as a result of smoking waste, and cigarette burns on furniture and carpet in the smoking lounge. That same assessment recommended that a policy should be implemented to inform any persons purchasing sleepwear or bedding for residents to only purchase flame retardant garments.

[15] In a further fire risk assessment on 29th June 2010 it was noted that there was occasional evidence of smoking in bedrooms. This also recorded that sleepwear standards were not made known to residents and or carers for those who supplied their own sleepwear.

[16] A further fire risk assessment on the 3rd August 2011 again recorded that there was evidence of smoking in bedrooms. It recorded that at this time the sleepwear standards were made known to residents and or carers as it was in the resident's contract. I find that this was not the case and no evidence was given to the Inquest as regards how such a requirement was either

policed or enforced. The Deceased's granddaughter informed the Inquest that this policy was never made known to her. Brother Newman accepted that it was possible that there were residents within Owenvale Court and their carers, who would not have been aware that fire retardant nightwear would be required. In the assessment of the 3rd August, it was considered that the risk to life from fire at Owenvale Court was tolerable. In his evidence, Brother Newman accepted that the ARMA fire risk assessments highlighted smoking as an issue and that the smoking policy should have been more vigorously enforced.

[17] Smoke detectors were placed in each resident's bedroom. No such detectors were placed in the en-suite bathrooms due to the unsuitability of that environment for detectors. I find that this was appropriate.

[18] In his evidence to the Inquest Mr Rooney from ARMA accepted that smoking in bedrooms was a recurring theme in this Home. Mr Rooney also indicated that he felt that the Home was very responsive to the reports. He stated that he did not forward the risk assessments to any other organisation as he was engaged solely by the St. John of God Association and the assessments were their property. Mr Rooney opined that he would prefer if care homes did not permit smoking.

[19] Brother Newman accepted in his evidence that he was not "over the detail" as he should have been as the Acting Manager of a residential care home.

[20] Brother Newman was relieved of his managerial position on the 26th January 2012 and some senior staff were suspended at this time. Mr Cormac Coyle was appointed on an interim basis as the Registered Manager notwithstanding the fact that he was also the manager of the St. John of God Associations' other two facilities. These other two facilities were also under the scrutiny of the RQIA around this time. Following this change of management, Mr Coyle conducted a review of admissions and the competency levels of all agency staff. As a result of the review he identified some 10 residents who may not have been suitable to be residents of Owenvale Court. One of these residents was the Deceased. He was aware that there had been some two or three reports of the Deceased smoking in her bedroom, that she had dementia and that clothing belonging to her had been found with cigarette burns on it. Mr Coyle advised that he spoke to the Deceased regarding her smoking and whilst she appeared to understand what he was saying, he accepted that he had no way of knowing how much information the Deceased either understood or retained.

[21] I find that as soon as Mr Coyle identified that Owenvale Court may not have been a suitable home for the Deceased, her family should have been advised about this. I find that in not doing so an opportunity was missed for

the family to make an informed decision about where the Deceased should reside.

[22] The Deceased's GP, Dr Orang Agahi, informed the Inquest that the Deceased had been assessed as 15/30 on Mini Mental State Examination, which would have indicated that her short term memory was an issue and that it would have been unlikely that the Deceased could have retained facts.

[23] Mr Coyle accepted in his evidence that the issue of the Deceased having dementia and smoking were "red flags" and as a result speaking cigarette detectors were installed in the bedrooms in addition to the other smoke detectors. These cigarette detectors were not linked to any central alarm system. As a result of the staffing issues in the Home, agency staff were employed, but they were not familiar with the residents. Around this time there were some ten reports to the RQIA regarding problems with smoking in residents' bedrooms. Registered Managers were required to notify the RQIA and the Trust by way of a Form 1(a) Statutory Notification of Events form of incidents in the Home. In the two years prior to Mr Coyle's arrival there were approximately 4 smoking incidents reported to the RQIA. After Mr Coyle took up his position there was approximately 1 report every 6 days. In fact, in one two week period there were some 7 smoking incidents reported. Mr Coyle accepted that there had probably been a high number of smoking incidents that had gone unreported prior to his arrival. I find on the balance of probabilities that that was the case.

[24] Mr Coyle agreed that there was a "shocking pattern" of smoking by residents in bedrooms. A manual log recording the number of cigarettes in and out was maintained by staff for the Deceased. Mr Coyle accepted that it was difficult to understand from this log just how many cigarettes the Deceased was being given out on occasions, how many she was smoking and if she was hoarding cigarettes. A monthly audit report prepared by the St. John of God Association dated 28th February 2012 referenced:

[25] "..the very high level of smoking in the rooms which is prohibited in the home but is a practice that seems to persist".

[26] On 7th March 2012 the Deceased was found sitting in bed smoking at around 2am. The cigarette was removed and staff explained to the Deceased that smoking was only permitted in the smoking room. On 10th March 2012, during their 12am night check the Deceased was again discovered sitting on the edge of her bed smoking a cigarette. The cigarette was extinguished and the Deceased was instructed to use the buzzer in future if she needed to have a cigarette. The Deceased was reminded that it was against the rules to smoke in her room. On 15th March 2012 staff smelt smoke in the corridor. On entering the Deceased's bedroom there was a smell of smoke and staff discovered burnt underwear in the Deceased's bin in addition to the Deceased having burnt her trousers. She was advised again to use the smoking room in

future and that she would be escorted there by staff on request. Mr Coyle accepted in evidence that if ever there was a "red flag" the incident on 15th March 2012 was it. The family were not informed of any of these incidents although it was accepted by Mr Coyle that they should have been. It also appears that this latter incident was not reported to the RQIA until after the Deceased had lost her life.

[27] I find that the non-reporting of this incident in particular and not informing the family amounted to grave shortcomings on the part of the St. John of God Association. It also amounted to a further missed opportunity for the Deceased's family to make informed decisions about the suitability of Owenvale Court for the Deceased's residential care.

[28] On Tuesday 10th April 2012 at approximately 11.10pm, Jonathan Simpson, Acting Residential Care Worker at that time, heard the fire alarm go off. Both he and Miss Erin Popely, Care Assistant, ascertained that the alarm had gone off in room 10. That was the Deceased's room. The room was found to be full of smoke and the bathroom door was wide open. The Deceased was standing facing the wall holding onto the towel rail. The Deceased was on fire from head to toe. The fire was extinguished and the Deceased was taken by ambulance to the Royal Victoria Hospital where she passed away the following day, 11th April 2012.

[29] I find that staff acted in both a timely and appropriate manner on discovering the fire.

<u>The Belfast Health & Social Care Trust:</u>

[30] Ms Louise Labrooy, Social Worker, was the Deceased's Care Manager. In her statement to the Inquest she stated that on the 23rd August 2011 she received a referral from Lisa Pepper, hospital Social Worker in Meadowlands requesting a care package for the Deceased. She subsequently received care management Medical, Nursing, Occupational Therapy and Physiotherapy assessments from the hospital.

[31] On 23rd September 2011, Ms Labrooy spoke with Eileen Christie, Mater Hospital Social Worker, who informed her that the Deceased had been admitted to the hospital with increased confusion, falls and visual hallucinations. Updated care management assessments were requested. On the 26th September 2011, the Mater Hospital Social Worker informed Ms Labrooy that the Deceased had been diagnosed with dementia (mixed aetiology) and that she required residential care. As a result, Ms Labrooy contacted Owenvale Court Residential Home and they agreed to carry out a pre- assessment as they had a vacancy. On the 4th October 2011 further care management assessments were received by Ms Labrooy recommending residential placement. The Deceased was admitted to Owenvale Court on 17th October 2011 and on 7th November 2011, Ms Labrooy met with the

Deceased's granddaughter to complete financial assessment forms. It was stated that the Deceased and her family were happy with the placement.

[32] On the 13th February 2012 a Care Review meeting was arranged. This was only partially completed because no family members attended and the Deceased was unwell.

[33] On the 2nd March 2012 a further Care Review meeting was conducted in Owenvale Court by Miss Claire Hossick, Assistant Care Manager and the Acting Home Manager. The family was unable to attend and the Deceased did not attend as she was having her lunch.

[34] A Nursing assessment was then conducted on the 4th April 2012 as part of the re-assessment process of all residents following Mr Coyle's appointment. This confirmed the need for the Deceased to be supervised when smoking and also that her cigarettes and lighter were retained by staff. It is clear from this assessment that the nurse conducting it was unaware of the previous serious smoking incidents and in particular the incident on the 15th March 2012.

[35] The St. John of God Association failed to notify the Trust or the RQIA of the incidents within the required time frame of 72 hours. I find that this was a further missed opportunity as regards the care of the Deceased and highlights the absolute requirement for all staff involved in the care of vulnerable individuals to be fully informed about the needs of those individuals.

[36] Marie Heaney, Co-director, Older People and Physical/Sensory Disability gave evidence to the Inquest. In her statement she described the Deceased as having mild dementia and that the Deceased was a very pleasant lady who required supervision. In her evidence she stated that the Trust had a duty of care to promote the welfare of residents but was not required to conduct inspections. She was of the opinion that the Trust assessment of the Deceased prior to her admission to Owenvale Court indicated that a residential care home environment was entirely appropriate for the Deceased at that time, notwithstanding the fact that the Deceased had a recent diagnosis of dementia. In her view, the Deceased was "much too good" to be placed in a dementia home.

[37] Ms Heaney was of the opinion that there was a perception that the Deceased may have forgotten about smoking whilst she had been in hospital prior to her admission to Owenvale Court.

[38] She confirmed that the Trust and in this case the St. John of God Association had a shared role in relation to the care of the residents. A social worker employed by the Trust remains the key worker and continually assesses if the home is meeting the needs of the resident. Ms Heaney indicated that the Trust is required to review a resident's placement within

eight weeks of admission and thereafter annually. The Deceased was not reviewed within the first eight weeks of her admission to Owenvale Court. Ms Heaney indicated that neither the partial Care Review which took place on the 13th February nor the Care Review which occurred on the 2nd March 2012 identified any concerns in relation to the Deceased smoking. She accepted however that these reviews were limited in nature due to the absence of the family and the Deceased. She further accepted that more steps should have been taken by the Care Manager to engage the family and the Deceased in the process at this time.

[39] I find that insufficient attempts were made by the Trust to ensure the attendance of the family and the Deceased at these Care Review meetings. I find that such important meetings cannot adequately meet the needs of the resident if neither a family member nor the resident, are in attendance.

[40] Ms Heaney acknowledged that in or around January 2012 there were a lot of warning signs in respect of Owenvale Court, particularly following a whistle blowing report on the 26th January 2012 by Ms Rosemary Gilbey, who was at that time, the Deputy Manager in Owenvale Court. Ms Heaney indicated that significant managerial issues had deteriorated and she and a team went to Owenvale Court to talk to the management, and outlined the Trust's significant concerns. An adult safeguarding meeting was called and 21 actions were identified on day one. Decanting the 47 residents immediately was not considered to be a viable option at that stage.

[41] I find on the balance of probabilities that this option should have been more fully considered both at this stage and throughout the process.

[42] A re-assessment of all of the residents was undertaken, staff were interviewed and two residents were removed immediately due to the unsuitability of Owenvale Court in meeting their needs. Further admissions to Owenvale Court were suspended. Legal advice was taken by the Trust in relation to installing the Trust's own manager but the advice received was that that would not be possible. Trust staff were attending the Home on an almost daily basis but it was accepted by Ms Heaney that smoking was some way down the Trust's list of significant concerns with the Home. The Trust sought assurances from the St. John of God Association in relation to the managing of the Home. The Trust indicated that they were not aware of the lack of ability of the management team in Owenvale Court.

[43] I find that the Trust was deriving too much comfort from the assurances being provided by the St. John of God Association at that time.

[44] In relation to whether or not the Deceased had been placed in a suitable home, Ms Heaney explained that approximately 70% of residential care homes would have residents with some form of dementia but that the home would not be classified with the appropriate dementia classification.

Whilst Ms Heaney did accept that there needs to be a demarcation point as to what residents are to be admitted to a home, she did not agree that it would have been whenever the Deceased had a diagnosis of dementia in this instance. Ms Heaney did accept that the Trust relied too heavily on the fact that the Home was registered with the RQIA.

[45] Ms Heaney further conceded that the Trust was unaware that Owenvale Court was limited by the RQIA to having four named residents with dementia. I find that a simple enquiry with the RQIA would have clarified this issue and that it is imperative that whenever the Trust is suggesting homes to families that it is incumbent upon the social worker to know the classification of the home.

[46] Ms Heaney also conceded that the fact that the Deceased was a lady who had dementia and who smoked was not considered at the time of admission to Owenvale Court, represented a failure by the Trust. She also accepted that the smoking risk was not taken seriously enough and addressed as it should have been. In addition to this, it was accepted by the Trust that the re-assessments of the residents which were initiated by Mr Coyle should have been given more urgent focus. Despite the fact the Trust was aware that the Deceased was smoking in her room on occasions the Trust did not take any steps itself to investigate this and relied on the assurances being given to it by Owenvale Court.

[47] Although I accept that the Trust does not have any regulatory role, I find that it is its responsibility to ensure that the duty of care it owes to a resident is being adequately met by the care provider and that on the balance of probabilities the Trust did not do so here.

[48] On the 20th February 2012 Mr Coyle forwarded an email to the Trust and the RQIA seeking guidance on how to enforce a smoking policy with residents who had dementia. It was clear from this e-mail that Mr Coyle was both struggling to enforce the smoking policy and was seeking guidance. The Trust and the RQIA both responded with advice but I find that was insufficient action on the part of the Trust and the RQIA. I find that this was a "red flag" being raised by Mr Coyle which should have been more thoroughly dealt with than by way of e-mail advice.

[49] The Trust did meet with the Chief Executive Officer of the St. John of God Association in order to discuss their concerns and the Trust had a contingency plan in place to rehome the residents in the event that there was a sudden closure of Owenvale Court. It appears however, that the option of decanting the residents was again not seriously considered by the Trust despite stating that it had such a contingency plan in place.

[50] On the 4th April 2012 at a meeting with the St. John of God Association, the RQIA and the Trust, Ms Heaney suggested that a decision was taken for

the RQIA to commence the de-registration process of Owenvale Court. The Trust was in agreement with this decision.

[51] Ms Heaney was of the opinion that Homes should not permit smoking as the risk to life outweighed any other rights that a resident may enjoy.

The RQIA:

[52] In her evidence to the Inquest, Ms Marie Marley stated that she was now a senior inspector with the RQIA and at the time of this tragic event she was an inspector. The RQIA is the independent body that regulates and inspects the quality and availability of Northern Ireland's health and social care services. The RQIA was established in 2005 under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive improvements for everyone using health and social care services. Ms Marley advised that the RQIA is required to inspect adult residential care homes on a minimum of two occasions each year. These inspections may be announced or unannounced and where significant or repeated failings are identified the RQIA may take a range of escalated enforcement actions. These actions include improvement notices, notices of failure to comply with regulations, placing conditions on registration and seeking the urgent closure of a registered service.

[53] Ms Marley was allocated responsibility for Owenvale Court and inspected that Home for the first time in May 2008. In 2010 the Home came under increased scrutiny due to a number of anonymous complaints and reported incidents. The RQIA was informed on the 9th July 2010 that Brother Michael Newman had been appointed as the acting manager of Owenvale Court. The RQIA informed Brother Newman in writing on 13th August 2010 that he did not meet the criteria for being a Registered Manager as detailed in the Residential Care Homes Minimum Standards. On the 28th July 2011 the RQIA received a response from Brother Newman confirming that he was attending a pre-course interview at the University of Ulster and he subsequently enrolled for a Back to Nursing course commencing in January 2012. This was some 16 months after Brother Newman's appointment.

[54] During 2010 the RQIA responded to several complaints made in regard to staff shortages and tension within the staff team. During inspections on 17th December 2010 and 7th January 2011, Ms Marley identified that Owenvale Court was accommodating several residents who had a diagnosis of dementia, Category DE. She therefore requested the acting manager to make an application to vary the Home's registration to include Category DE for the four named individuals that she had identified.

[55] On the 24th January 2012 the RQIA received a call from the deputy manager, Ms Rosemary Gilbey, raising a range of concerns about the standard of care provided to residents. The Home was visited on the 26th January 2012

by the RQIA and the issues identified during that visit were escalated to the Director of Social and Primary Care in the Belfast Trust and the Responsible Person within the St John of God Association, namely Brother Fintan Brennan-Whitmore. According to Ms Marley, responsibility for the placement and oversight of a placement rests with the Trust who commissions the care in a regulated service. The Registered Managers are responsible for delivering the care to meet the assessed needs of the residents in accordance with regulations and minimum standards.

[56] Whilst I find that the concerns identified by the RQIA were escalated to the Trust, the RQIA did not inform residents' family members and again this represented a missed opportunity for the family of the Deceased to make an informed decision about the suitability of Owenvale Court to meet the Deceased's care needs.

[57] In her evidence, Ms Marley advised that Brother Newman was not the Registered Manager because he did not meet the criteria at that time. There was therefore no Registered Manager in Owenvale Court for a considerable period of time. Whilst I accept that this was due in large part to employment issues with the previous Registered Manager, I find that the RQIA should have been scrutinising Owenvale Court more thoroughly. Between 1st April 2010 and 31st March 2011 the RQIA inspected the Home on three occasions and Ms Marley accepted, and I find, that given the issues with the Home at the time there should have been more inspections, albeit that there were six inspections in the following year.

[58] On the 16th April 2010 at a meeting between the Trust, the RQIA and the St. John of God Association, the RQIA were advised that 24 reviews of residents had taken place, leaving some 23 resident reviews to be carried out. Ms Marley confirmed that an unannounced inspection was carried out on the 30th March 2010 and that staffing levels were adequate, notwithstanding that 23 further residents had to be reassessed at that time.

[59] I find that the adequacy of the staffing levels could not and should not have been determined whilst 23 resident reviews remained outstanding.

[60] An Adult Safeguarding strategy meeting was organised for Friday 27th January 2012 and Brother Newman was replaced as acting manager by Mr Cormac Coyle. The Belfast Health and Social Care Trust undertook to carry out a review of the care needs of residents residing in the Home. Eight Failure to Comply Notices were served on Owenvale Court on the 1st February 2012 by the RQIA. All new referrals to the Home were suspended.

[61] Ms Marley accepted, and I find, that enforcement action by the RQIA could have been escalated more quickly. It was not until after the Deceased had lost her life that a Notice of Proposal was issued to cancel the registration

of the Home. This was followed by a Notice of Decision on 14th May 2012 to cancel the registration of Owenvale Court.

[62] Ms Kathleen Fodey, Director of Regulation and Nursing with the RQIA gave evidence to the Inquest. She explained that the RQIA had now revised its website and made it easier for care providers and family members to navigate. It now has a section on raising concerns. She did accept that not everyone would have access to the Internet and therefore every care home makes its inspection reports available in hard copy although the homes are under no obligation to prominently display them. The RQIA reports are not sent to families and the Trust is only contacted if concerns are highlighted. Concerns were raised in this case following Ms Gilbey's whistle blowing report on the 24th January 2012. Ms Fodey accepted, and I find, that statutory notification forms were sent by the St. John of God Association in batches and outside the required 72 hour time frame, and this was unsatisfactory. She further accepted that the RQIA did have the power to apply to a court for an urgent closure order of this Home, but that she felt that the RQIA did not have sufficient evidence to take before a court.

[63] In relation to the issue of smoking in Owenvale Court, Ms Fodey indicated that smoking was one of the issues being raised, but was not one of the overarching issues. These appeared to be in the areas of pharmacy and management. She acknowledged that seven of the eight Failure to Comply Notices served on the 1st February 2012 had been met by the Home. However, she indicated that the RQIA continued with the deregistration process of the Home due to the lack of assurances regarding the ability of the Home to provide safe and effective care for the residents.

[64] On the 6th February 2012 at the meeting between the RQIA and the St. John of God Association, Mr Phelim Quinn of the RQIA, stressed that the Home was now worse despite having had such a high degree of regulatory intervention and that "it continues to get worse". It was also pointed out at that meeting that "the total system of management is failing".

[65] I find that the stepped approach to enforcement that was being followed by the RQIA was inadequate particularly given the significant concerns that the RQIA itself was raising.

[66] Ms Fodey accepted that as far back as April 2008 smoking in bedrooms in Owenvale Court was identified as an issue by the RQIA. At that time inspections were focused on the areas of pharmacy, estates and care. Various inspectors were assigned to these areas but Ms Fodey explained that they did not meet to discuss their reports or findings. On the 24th November 2009 the RQIA was aware that the Home had dementia residents and that residents were smoking in bedrooms. The RQIA did not take any enforcement action at that time.

[67] I find that this represented a further missed opportunity to effectively regulate this Home.

[68] Ms Fodey also accepted that the RQIA was tolerating residents with dementia being admitted to the Home in 2009. She accepted that the Home appeared to be going in the "wrong direction" in terms of its ability to care for the residents by 2010. She acknowledged that, despite Brother Newman being instructed by the RQIA to write to the various Trusts regarding the Home's certification in respect of dementia residents, the RQIA did not direct Brother Newman to copy those letters to the RQIA. This should have been done and it was remiss of the RQIA not to have required same. As it transpired, Brother Newman did not write any such letters. Therefore, the Trust was unaware of the issue surrounding dementia and the Home's classification. It also meant that the families of residents were unaware of the issue.

[69] I find that this was a further missed opportunity by the RQIA as regards the effective regulation of this Home.

[70] Ms Fodey acknowledged that the issues surrounding pharmacy and medication were significant issues for her and that these alone should have prompted the RQIA to consider an urgent closure application being made to court.

[71] The St. John of God Association sold Owenvale Court to another provider in June 2012.

Belfast City Council:

[72] Ms Trudy Stanfield, Senior Environmental Health Officer within the Health and Safety Department of Belfast City Council gave evidence to the Inquest. She stated that Belfast City Council investigated this incident under the Health and Safety at Work (Northern Ireland) Order 1978 and in accordance with Health and Safety Executive's "Reporting Injuries, Diseases and Dangerous Occurrences in Health and Social Care", RIDDOR, (Information Sheet) to ensure that the Care Provider was meeting its obligations under the Health and Safety at Work (Northern Ireland) Order 1978.

[73] She explained that Belfast City Council had not been made aware of the fatality for some two months after it had occurred. She further highlighted that the Home should have contacted the Belfast City Council under the RIDDOR regulations immediately following the fatality.

[74] Responsibility for reporting the incident lay primarily with the St. John of God Association but I find that both the Trust and the RQIA should have reported the fatality to Belfast City Council.

[75] Ms Stanfield indicated that Belfast City Council is not responsible for enforcing fire safety legislation and that having prepared two reports in relation to the matter, there were aspects of those reports that she would now change having heard some of the evidence at the Inquest.

Northern Ireland Fire and Rescue Service:

[76] Mr Geoff Somerville, Fire Officer- Group Commander (Prevention and Protection) with NIFRS, gave evidence to the Inquest. He outlined the role of NIFRS in the prevention of fires and injuries from fire by providing fire safety advice and by enforcing The Fire and Rescue Services (Northern Ireland) Order 2006 and The Fire Safety Regulations (Northern Ireland) 2010. NIFRS is the enforcing authority under this legislation.

[77] In his evidence, Mr Somerville explained that the primary focus in fatalities such as the Deceased's was flammable clothing. He indicated that he would welcome a fire retardant standard similar to the one that is applied to furnishings, applied to nightwear and clothing. He stated that NIFRS is now obligated to inspect some 63,000 premises. Care homes are considered to be high risk premises. Inspectors from NIFRS physically inspect homes looking at all aspects of fire risk. The time typically taken for such an inspection is 2 to 3 hours but there is no restriction on the amount of time such an inspection could take. The fire risk assessments, such as those carried out by ARMA, would be reviewed to see if they were adequate and in the event that a care home had a smoking policy, that it was being complied with. This would be verified by speaking to the responsible person, in this instance either Brother Newman or Cormac Coyle.

[78] In relation to Owenvale Court NIFRS issued a "broadly compliant" letter on the 27th September 2011 following an inspection on the 26th September 2011. Mr Somerville explained that this does not mean that a fire would not start in the premises but if it should start it is less likely to affect occupants beyond the room of origin. This is because measures had been put in place to detect the fire, warn others, limit fire spread and enable other occupants to escape safely. The NIFRS audit would also confirm that management understood what to do in the event of fire.

[79] To help reduce the risks of fires to older people caused by smoking particularly those with impaired mobility or other health issues, NIFRS developed guidance specifically on smoking in 2016 and shared this with the RQIA. This guidance has been issued via the RQIA to all regulated care premises in Northern Ireland and the RQIA have placed the guidance on their website as a guidance resource. Mr Somerville was of the opinion that not permitting smoking in a care home may have the effect of encouraging residents to have "sneaky smokes." This he felt would increase fire risks.

[80] Mr Somerville accepted that inspectors would rely on assurances from the Registered Manager of a Home that policies were being complied with. NIFRS would not be made aware, for example, that senior staff had been suspended in a Home and were replaced by agency staff nor would they be aware of the category of the Home. Furthermore the statutory notifications relating to smoking incidents would not be sent to NIFRS although these forms could be asked for by Inspectors at the time of inspection.

[81] Mr James Crothers, fire safety consultant, was retained on behalf of the Deceased's family, and prepared a number of reports for the purposes of the Inquest. He was of the view that "the very significant risk relating to smoking was clearly apparent, but that sufficiently robust action was not taken to eliminate the risk."

Forensic Science Northern Ireland (FSNI):

[82] Mr Julian Halligan, Senior Scientific Officer at FSNI attended the scene and confirmed that in his opinion the fire in Room 10 Owenvale Court had been confined to the en-suite bathroom and was probably caused by smoking material, either a naked flame from a cigarette lighter or a cigarette. This was supported by NIFRS who believed that the Deceased had been smoking in the en-suite bathroom and that the most likely cause of fire had been the night clothing catching fire after contact with the smoking materials.

[83] A post mortem examination was conducted by Dr Brian Herron, Pathologist. Dr Herron found that the Deceased's brain had "severe and significant neurodegenerative disease with features that may be present in Alzheimer's disease."

[84] Life was pronounced extinct at the Royal Victoria Hospital on 11th April 2012 at 12.30pm. Dr Herron reports and I find that the cause of death was:

[85] 1.(a) Burns

[86] I find on the balance of probabilities that Article 2 of the European Convention on Human Rights is not engaged in the context of this Inquest.

[87] I find on the balance of probabilities that the Deceased had a diagnosis of dementia at the time of her admission to Owenvale Court Residential Care Home on 17th October 2011. I accept that dementia is on a spectrum and that on balance Owenvale Court was initially suitable to meet the needs of the Deceased. However, a proper residential home assessment should have been carried out at the request of the Trust, preferably prior to admission but certainly within a very short time of the admission. This was not done nor was it ever followed up by the Trust and as a result the family was deprived of the opportunity to make a fully informed decision about the suitability of Owenvale Court for the Deceased's residential care.

[88] I find on the balance of probabilities that the Trust was fully aware that the Deceased suffered from dementia at the time of her admission to Owenvale Court. I find that no Care Management Review was implemented within the recommended eight weeks of admission and that the Deceased's Care Manager, Ms Louise Labrooy, did not adequately address the issue of a resident with dementia smoking. There was a mistaken assumption made by the Trust that the Deceased may have forgotten about smoking whilst she was in hospital. There were two Care Management reviews undertaken by the Trust, one in February 2012, and one in March 2012. The Deceased was present at neither of these two review meetings. This was an unacceptable situation that could be improved by ensuring that residents and family members are in attendance at these reviews. I also find that on the basis of the evidence, an annual review following the initial review at eight weeks is insufficient to satisfy the duty of care the Trust acknowledged to the Inquest that it has towards residents. This situation could be improved following urgent review by the Trust.

[89] I find that the evidence suggests that families could make more informed decisions regarding the suitability of a care home that has been identified as suitable for an individual, if the Care Manager in the Trust liaised with the RQIA Inspector assigned to that home to ascertain if there were any issues in relation to that home.

[90] I find that Brother Newman was a well-intentioned acting manager. However, I find that good intentions are totally insufficient by themselves when it comes to managing a residential care home. I find that Brother Newman did not satisfy himself in relation to all of the detail required to effectively manage the Home and that he was out of his depth when it came to managing Owenvale Court. In addition, the RQIA allowed too much time for Brother Newman to enrol on the "Back to Nursing" course. This was not adequately followed up by the RQIA. I find that Brother Newman and the St. John of God Association did not appreciate the risks associated with smoking and dementia. I find that insufficient attention was being paid to the on-going and changing needs of the residents. This is highlighted by the fact that once Brother Newman was replaced by Mr Cormac Coyle his assessment was that Owenvale Court was unsuitable for up to 10 residents and that was before Trust reassessments were conducted.

[91] I also find that Mr Cormac Coyle was well-intentioned when he assumed the role of acting manager. It is clear that he did take immediate action on assuming his role regarding the significant number of issues that he faced, in particular in trying to comply with the regulations in force at the time. However, I find that to have expected Mr Coyle to be able to manage effectively three facilities at the same time, which were in varying degrees of difficulty was an impossible task. This situation should not have been

proposed by the St. John of God Association, nor tolerated by either the RQIA or by the Trust.

[92] I find that it is completely appropriate that the St. John of God Association exited the care sector in Northern Ireland.

[93] I find that it was clear that the Deceased was a determined smoker and that she consistently smoked in her bedroom, in breach of the smoking policy in the Home. I find that the Trust, the RQIA, the St. John of God Association, Brother Newman, and Mr Coyle were all aware of this. The difficulties with enforcing a smoking policy with residents with dementia were raised by Mr Coyle on the 20th February 2012, with both the Trust and the RQIA. I find that the response from both organisations was inadequate. I also find that the issue of smoking in bedrooms in the Care Home was consistently raised by ARMA fire risk assessors, but that no robust action was taken by any of the stakeholders to ensure compliance with the smoking policy. The installation of a speaking cigarette detector in bedrooms, whilst admirable was a questionable policy for those residents with dementia who smoked. I find that speaking with those residents who had dementia about the smoking policy was totally inadequate. In particular, I find that the policy of regulating cigarette distribution in the Home and the supervision of smokers was lamentable. It simply did not work.

[94] In relation to the RQIA, I find that smoking was not adequately considered as a significant risk. The RQIA was evidently distracted by other significant concerns pertaining to the Home. However, given that there were 47 residents in this Home and staff, I find that the risk of fire from smoking should have been a high priority for the RQIA.

[95] I find that the RQIA did not adequately consider all the evidence that it had with a view to applying to a court for an urgent closure order for Owenvale Court. It is imperative that RQIA inspectors cross reference the respective inspections. Too much reliance was placed by the RQIA on assurances being given by the St. John of God Association and too much comfort was taken from the fact that the Trust had a staff member on site in the Care Home on an almost daily basis from the end of January 2012. I find on balance that the decision by the RQIA not to apply for an urgent closure order represented a missed opportunity. A stepped enforcement approach by the RQIA was inadequate. Miss Nicci Reid, granddaughter of the Deceased told the Inquest that the first time she had learnt of the RQIA was in the context of the Inquest process.

[96] I find that proper engagement between regulators, residents and or family members is an important part of regulation and that it was clearly lacking at the time in this case.

[97] Regarding the Trust's decision to stop new admissions once the whistle-blower had raised concerns, I find that that was an entirely appropriate response. The placing of a Trust staff member on site almost daily was also appropriate but I find that she had not been informed at all about residents breaching the smoking policy. This was a further missed opportunity by the Trust to ensure the safety of the residents.

[98] It was also entirely appropriate that the residents were re-assessed but I find that the process was too slow and that the Deceased's re-assessment on the 4th April 2012 was inadequate to determine her suitability to remain in the Home. I also find that there was little or no communication between the Trust and the family of the Deceased regarding smoking concerns and or breaches of the smoking policy.

[99] As regards the Belfast City Council investigation, I find that the two reports produced went beyond the remit of the health and safety investigator. The investigator did not adequately independently test the information that was being presented to her and I was not persuaded about the accuracy of the reports or the effectiveness of her investigation.

[100] Northern Ireland Fire and Rescue Service issued a "broadly compliant" letter to the St. John of God Association following an audit. I find on the balance of probabilities that the issue of smoking in bedrooms was not sufficiently addressed by the NIFRS inspectors during the audits and that the issue of a "broadly compliant" letter to the Home would have led to some complacency on the part of the RQIA, the Trust, and the St. John of God Association as regards fire risks from smoking.

[101] The RQIA advised the Inquest that the Department of Health has indicated that the minimum statutory inspections of two should now be reduced to one. I find on the balance of probabilities that neither 1 nor 2 statutory inspections allows for adequate regulation in this sector. I find that the evidence suggests that regulation could be improved with a minimum of four statutory inspections per year, one announced, and three unannounced. In relation to the announced inspection, the evidence suggests that regulation could be enhanced if residents and their family members are notified by the RQIA as to when the inspection is to take place and they are invited to attend.

[102] I further find that the evidence suggests that RQIA inspections are not sufficiently accessible to everyone who might be interested in accessing them. This situation could be improved if it was a mandatory requirement that all residential care homes display in a prominent place the previous two years' RQIA inspection reports. A welcome pack issued by the care home could include the last two years' inspection reports and the contact details of the RQIA Inspector assigned to that particular care home. I find that a revised website is insufficient for this purpose. The RQIA could also inform the Trust when a care home is being inspected and as a matter of course, the outcome of

that inspection could be sent to the Trust. Any and all concerns the RQIA may have regarding a care home could also be made known to the appropriate Trust.

[103] The evidence further suggests that regulation and safety in this sector could be improved if the RQIA and the Trust were made aware as to when the Northern Ireland Fire and Rescue Service intended to audit a care home. NIFRS could then be provided with details of any concerns that either the Trust or the RQIA may have in respect of that care home to include for example, whether or not there has been a management change and the classification of the home.

[104] In relation to the fire risk assessments the evidence further suggests that regulation and safety could be improved if copies of these assessments carried out by fire risk assessors are sent upon completion to the Trust and the RQIA, highlighting in particular any recurrent themes discovered by the assessor.

[105] I find that on the basis of the evidence regulation and safety could be improved if Care Providers seriously addressed their minds to the suitability of allowing residents to smoke. If a care home is going to permit residents to smoke then the evidence suggests that safety would be improved if a robust smoking policy is in place. Safety would also be improved if smokers were required to wear non-flammable clothing or at the very least a non-flammable apron.

[106] I find on the balance of probabilities that this death was both foreseeable and preventable. If all the stakeholders involved in the care of the Deceased had interfaced more closely together and addressed their minds to the risks of smoking and to the constant breaches of the smoking policy, in particular, if the St. John of God Association had ensured the proper reporting of such breaches and if more urgent action had been taken particularly by the RQIA and the Trust after the 26th January 2012 then I find that the outcome for the Deceased would have been different.