Bi-Borough
Safeguarding Adults Executive Board (Kensington and Chelsea and Westminster)

Thematic Safeguarding Adults Review – Fatal Fires

Authors: Suzy Braye and Michael Preston Shoot
Date: 16/03/2023
Publication Date: 09/08/2023

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1. INTRODUCTION

1.1 Over the course of 2020-22, in response to a series of fatal fire notifications the Bi-Borough Safeguarding Adults Executive Board (SAEB) led a series of actions to seek improvements to fire safety across the Bi-Borough. Two of the notified cases were identified for formal Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014[1]. In addition to reviewing the circumstances in those two cases, the Board's Case Review Group (CRG) also considered it appropriate to review how well the fire safety improvement actions already initiated had become embedded in practice. They therefore concluded that a thematic review, incorporating both the two individual SAR cases and the outcomes of a broader scrutiny of fire safety practice, would be appropriate. This decision was endorsed by the Chair of the SAEB on 14th April 2022. A SAR Panel of senior agency representatives was established and two independent reviewers[2] were commissioned to work with the Panel in carrying out the review.

1.2 The two individuals[3] whose deaths are being reviewed as part of this thematic SAR are:

Name	Date of death	Period reviewed	Circumstances
Mr C Aged 85	14/02/2021	22/11/2020 to 14/02/2021	Mr C died in a fire at his home in extra-care sheltered housing. The inquest recorded the cause of death as I(a) respiratory failure; I(b) inhalation injury and 29% full thickness flame burn and (II) chronic kidney disease and hypertension. The coroner concluded that his death was accidental.
Mr D Aged 61	07/12/2021	21/10/2021 to 07/12/2021	Mr D died in a fire at his home in private rented accommodation. The inquest has yet to take place.

2. THE THEMATIC SAFEGUARDING ADULT REVIEW PROCESS

2.1 The key lines of enquiry for the review were as follows:

1. To what degree has the work undertaken by the SAEB to date in relation to fire safety improvement supported organisational and systems change? How well is fire safety knowledge disseminated through training and workforce development and embedded into practice? What are the remaining gaps?

[1] Section 44 of the Care Act 2014 makes it a duty of the Board to undertake a Safeguarding Adult Review where an individual has died (or been seriously harmed), the death or harm is thought to result from abuse or neglect and there is cause for concern about how agencies worked together to safeguard the individual. The purpose is to identify learning that can be used to improve future interagency practice and prevent future deaths or serious harm in similar circumstances. The Board also has a power to undertake such a review in any case that comes to its notice. In this review, one of the cases is included as meeting the mandatory review criteria, the other is included as a discretionary review.

[2] Suzy Braye (Emerita Professor of Social Work at the University of Sussex) and Michael Preston-Shoot (Emeritus Professor of Social Work at the University of Bedfordshire) are independent adult safeguarding consultants with specialist expertise in learning from SARs.

[3] For publication purposes, the identities of the two individuals involved have been anonymised.

2. What do the circumstances in the two cases under review tell us about the barriers and enablers for staff in managing the care and support needs of people with reduced mobility who continue to smoke despite ongoing risks?
3. What can we learn about the challenges of identifying how reduced functional ability (present in both the individuals) affects smoking risks?
4. How well is mental capacity, including executive function, considered in working with an individual who continues to smoke regardless of the risks involved?
5. What can we learn about the expanding role of Registered Social Landlords in supporting people with complex needs and how can commissioners best support this role? Are there sufficient national standards in place to ensure the fire safety of residents within supported accommodation who choose to smoke within their own homes?

2.2 The following approach has been taken:

a) A review of chronologies, documentation and reports completed by agencies involved in the two cases of Mr C and Mr D.
b) Consideration of agencies' responses to further questions and clarifications on their work with Mr C and Mr D as requested by the reviewers.
c) An audit to evaluate the extent to which learning from the previous fatal fire notifications in 2020 – 21 has been embedded in practice.
d) A questionnaire completed by front-line practitioners working in a range of services across the safeguarding partnership to assess the level of knowledge, confidence and competence in multi-agency risk management processes used to manage fire risks.
e) Co-ordination and facilitation of an event with front-line practitioners, managers and senior leaders seeking to explore the key lines of enquiry through discussion of the challenges and strengths of current practice in relation to fire safety.
f) Meetings with family members and friends[4]: Mr C had no known family or current friendships. Mr D's mother was invited to contribute to the review but did not respond. His close friend did contribute her views through discussions with the SAEB Business Manager and subsequently with one of the reviewers. She asked that she be referred to in the report as his "*friend and loving carer*."
g) Consolidation of the emergent learning into a final report and recommendations to the SAEB.

2.3 The following agencies submitted information to the review on their involvement with Mr C and Mr D. In relation to Mr C, full agency information and reflection was requested, along with answers to specific questions posed by the reviewers. In respect of Mr D, whose inquest has yet to take place, only chronological information was requested, along with factual answers to specific questions from the reviewers.

Adult Social Care (ASC) Tri-Borough Hospital Discharge Team	Mr D: Chronology; Responses to questions
ASC Westminster City Council (WCC)	Mr C: Safeguarding referral; Safeguarding meeting minutes; Safeguarding enquiry report; Record of coroner's inquest; Discharge Summary from Chelsea & Westminster Hospital Mr D: Chronology; Responses to questions; Safeguarding enquiry s.42(1) and s.42(2) forms

[4] Statutory guidance on SARs requires family members to be invited to contribute to reviews.

ASC Westminster Learning Disability Partnership (WLDP)	Mr C: Agency report and supporting documentation
SAEB	Mr C: Record of inquest; SAR referral; SAR scoping meeting minutes Mr D: SAR referral
Care Quality Commission (CQC)	Mr C: Statutory notification and agency report; Penfold Court inspection reports
Central London Community Healthcare NHS Trust (CLCH)	Mr C: Internal review documentation; Agency report; Physiotherapy assessment and manual handling plan; Personal exercise programme Mr D: Chronology; Responses to questions
Chelsea & Westminster Hospital NHS Foundation Trust	Mr C: Agency report; Supporting documentation
GP surgeries	Mr C: Agency report Mr D: Chronologies from two surgeries; Responses to questions from one surgery
Care Agency 1	Mr C: Agency report; Supporting documentation; Summary of contribution to safeguarding enquiry
Imperial College Healthcare NHS Trust (ICHT)	Mr C: Agency report; Supporting documentation
Learning Disabilities Mortality Review Programme (LeDeR)	Mr C: LeDeR report
Care Agency 2	Mr D: Chronology; Responses to questions
London Fire Brigade (LFB)	Mr C: Agency report; Fatal fire report; Report to coroner; Fire safety awareness materials Mr D: Fatal fire report; Responses to questions
Notting Hill Genesis (NHG)	Mr C: Agency report; Supporting documentation; CQC notification of incident; Incident reports, Person Centred Risk Assessment; Support plans; Email correspondence from NHG to Safeguarding Adults Manager; Report to coroner; Correspondence to LFB; Summary of implemented changes
University College London Hospitals NHS Foundation Trust (UCLH)	Mr D: Chronology; Responses to questions
Community Independence Service (CIS) WCC	Mr D: Chronology; Responses to questions
Emergency Response Team WCC	Mr D: Chronology; Responses to questions

2.4 The SAEB provided some additional supporting documentation:

2.4.1 Learning briefings: Fire and Telecare, Emollients and Smoking
2.4.2 Annual report 2020-21 with learning around fire and smoking risks

2.5 Prior evidence of learning from SARs nationally shows that in cases that have had tragic outcomes the answers to questions about why events unfolded as they did are often to be

found within wider domains of the safeguarding system that have an influence on how practice takes place:

- The direct practice domain: how practitioners engaged with the individual.
- The interagency domain: how practitioners from different agencies worked together.
- The organisational domain: how organisational features and systems influenced the work done.
- The governance domain: the leadership exercised by the Safeguarding Adults Board (SAB).
- The policy domain: the influence of national factors such as law and policy on local practice.

2.6 Thus, this thematic SAR takes a systemic approach to learning, seeking broader answers to why direct practice unfolded as it did in the cases in question and making recommendations for further system improvements where necessary.

3. CHRONOLOGY: MR C

3.1 Mr C had a mild learning disability, hearing impairment and a range of complex health needs. He grew up in a children's home. As an adult he lived for many years in a long-stay hospital and on leaving there he lived on the street or in hostels, also spending periods in prison. In 2005, aged 69, he was referred by the WLDP for housing by NHG, and took an assured tenancy in a first-floor, three-roomed flat in an Extra Care sheltered housing scheme with on-site care staff (24 hours/7 days), non-resident management staff and Careline alarm service.

3.2 In his later years, Mr C had poor mobility as a result of hip and knee pain, osteoarthritis and cellulitis. He needed support with daily living and received care and support from the on-site care workers. He had no family and described himself as a loner, with visits from only one friend (which had ceased during the Covid restrictions). He did not socialise with other residents and preferred to receive care from a small group of familiar staff whom he knew well, though he could still at times become short-tempered. He had a positive relationship with a key worker he had known since 2006, who supported him with health appointments and transport. He enjoyed watching TV, doing artwork and (before losing mobility in his hands) sewing, and he loved Elvis Presley. In the past he had used alcohol to excess but no longer did so. He was a heavy smoker, using matches to light his cigarettes.

3.3 The housing scheme had a number of plans in place relating to aspects of his care: customer support, continence support, finance support and risk management. A Personal Emergency Evacuation Plan (PEEP) and a Person-Centred Fire Risk Assessment (PCFRA) and fire risk support plan were in place. Mr C kept stocks of cigarettes and matches in his medication cupboard and staff would give him new boxes and matches whenever he was running low. He smoked around 20 cigarettes a day. His care and support plan dated 8th January 2020 refers to this but identifies no concerns about risks. The fire risk support plan, however, included specific measures:

- In the light of knowledge that Mr C's emollient creams were flammable, he was to be advised not to smoke unsupervised. His bed linen was to be washed daily when creams were used to prevent build-up. The GP was to be approached for an alternative to the flammable cream.

- A metal ashtray and metal bin were provided, and there was an agreement that he would only smoke whilst sitting in his recliner in the lounge and never in his bedroom.
- Staff were to empty ashtrays and check bins on each visit and remain vigilant for any signs of heightened risk, such as carpet or clothing burns.
- He had been encouraged to use a lighter rather than matches, but he struggled with all types of lighter due to his arthritis and continued to use matches.

3.4 The question of whether a Home Fire Safety Visit (HFSV) had taken place remains inconclusive. The housing scheme state that LFB had visited for a HFSV[5], and that Mr C had not been considered a high risk as he did not smoke in bed, his flat was not cluttered and the emollient creams he used were immediately covered. He did not need fire-retardant bedding as he did not smoke in bed. LFB in contrast, state that although they had carried out HFSVs at multiple properties within the housing scheme in which he lived, they had not at any point been asked to make a visit to Mr C's flat and had not done so.

3.5 Mr C had persistent cellulitis and pressure sores, for which he received community nursing visits. Between September 2019 and November 2020 district nurses attended for pressure wound assessment, flu vaccination and ongoing leg care, sometimes several times a week, reducing to weekly in March 2020 due to Covid. While accepting leg care, he occasionally refused treatment of pressure areas. In February 2020 he became angry when a nurse asked him not to smoke during her visit. He could occasionally become angry and abusive when declining care.

3.6 Between 12th and 19th November 2020 Mr C was admitted to ICHT with cellulitis and treated with antibiotics and regular pain relief. He was referred to therapy by the ward team and was seen by an occupational therapist with a plan for a programme to get him back to his baseline of mobility. However, he declined most visits due to pain and anxiety, being unsettled by unfamiliar facilities. The therapy team concluded that Mr C had mental capacity and that inpatient therapy would not be beneficial to his rehabilitation. On discharge he was referred to the CIS and listed for physiotherapy.

3.7 Between 22nd November and 1st December 2020, he spent a further period in hospital with vomiting, dehydration abdominal pain and bowel obstruction. He had an acute kidney injury and a distended bladder. He was treated for severe constipation and was fitted with a long-term catheter. His mobility was greatly reduced, and he was unable to mobilise independently. As an inpatient he was seen by the therapy team every day. The physiotherapist facilitated a joint session with the manager of his assisted living accommodation to assess the best way for him to mobilise. He was also seen by the frailty team who advised on treatment. He did not engage with physiotherapy and occupational therapy at the hospital, but hospital therapists assessed his home environment, and he was referred to the Learning Disability occupational therapist (OT) and physiotherapist. His initial support post-discharge came from the CIS, who supplied a standing hoist and exercises and provided moving and handling advice, though their involvement ceased a few weeks later due to Covid restrictions. District nursing also resumed visits for wound care and ordered a pressure-relieving mattress.

3.8 After hospital discharge his support was doubled from 17.5 hours to 35 hours, to cover 2:1 support four times a day. He received reablement for 6 weeks then the Learning Disability Team took responsibility for his ongoing care package, which involved one support worker from the housing scheme and one support worker from an external care agency. A review of his care and support under the Care Act 2014 took place virtually on 4th January 2021

[5] The date of this visit is not available.

and confirmed the increase of hours to allow the 2:1 visits. This did not include any updated risk assessment following his hospital discharge, despite the change in his mobility, nor was smoking covered in the care and support plan that was issued on 8th January 2021, although on the same date his GP referred him to the smoking cessation service. On 20th January NHG held an internal support plan review at which the Learning Disability Team were also present.

3.9 District nursing visits continued during January, the final visit being on 8th February to assess Mr C for bed rails, when he declined to engage and asked the nurse to leave. The learning disability physiotherapist liaised with the housing scheme at the beginning of February to identify how Mr C was progressing. He was reported to have increased in confidence for transfers using the hoist and was variably compliant with his exercises. It was agreed that staff would continue to support him and that the physiotherapist would review in five months' time.

3.10 Mr C died on 14th February 2021 following a fire in his flat the previous day when, seated in his wheelchair, it is believed he dropped a match while smoking. Staff attended within four minutes and a care worker (together with a decorating contractor at work in the building) extinguished the fire. The LFB, Metropolitan Police and London Ambulance Service (LAS) attended, and Mr C was taken to ICHT, given first aid and transferred to the burns unit at Chelsea & Westminster Hospital, where he was placed on palliative care. This decision reflected the extent of his burn injury, his comorbidities and the fact that he had a 'Do Not Attempt Resuscitation' decision in place. He died the following morning.

4. CHRONOLOGY: MR D

4.1 Mr D was a retired musician who had experienced several strokes, the first reported to have occurred six years previously. He was also known to have received treatment for alcoholism in the past and was a heavy smoker, reportedly smoking more heavily in the months prior to his death. He lived in private rented accommodation and had minimal contact with his family in Scotland but was supported by a close friend, who provided practical assistance with domestic tasks.

4.2 An initial assessment by the CIS in June 2021 (following referral by Mr D's GP for mobility input) noted that Mr D's mobility and function were declining. He was unsteady mobilising with a rollator frame and required assistance for transfers, and for personal and domestic activities of daily living. He was awaiting ASC assessment for a package of care. He was at risk of falls, incontinent of urine and smoking 20 cigarettes a day. His fire exit routes would involve a lift and stairs. Therapy and equipment recommendations included a high back chair, a home exercise programme, removal of rugs due to falls risk, referrals to occupational therapy (to assess bed transfers), a rehabilitation assistant (for practising home exercise programme) and a pendant alarm.

4.3 Mr D later declined occupational therapy assessment and engaged intermittently with physiotherapy, preferring to focus on being re-housed. However, on one visit by a physiotherapist in August 2021, advice was given to reduce smoking and a home exercise plan was completed. He moved to different accommodation[6] in October 2021 and reported an improvement in his mobility, as a result of which he was discharged from CIS. However, by 21st October his GP re-referred him to CIS following a report from his friend that he was not eating and was not feeling well. A Rapid Response assessment found him to be Face, Arms, Stability, Talking (FAST) positive for signs of a neurological event, with increased

[6] This involved a move from the Royal Borough of Kensington and Chelsea to Westminster.

left sided weakness and slurred speech. London Ambulance Service was called and Mr D was admitted to UCLH.

4.4 On 27th October 2021 during a visit to his accommodation, social workers observed ashtrays, but this did not result in a formal fire risk assessment or discussion with Mr D regarding his smoking habits.

4.5 This further stroke impacted seriously upon his mobility and resulted in significant left-sided weakness. He was referred to ASC for care and support on discharge and while awaiting confirmation of the arrangements underwent a period of in-patient rehabilitation. No information was listed on referral to the rehabilitation unit and it appears that the hospital social workers did not know that he was a heavy smoker. During assessment he answered ‘no’ to questions about whether he smoked or drank alcohol. There were concerns about possible safeguarding needs given a noted history (2019 and 2020) of experiencing suspected coercion and financial abuse and he was given advice about staying alert.

4.6 He was discharged home on 12th November 2021 to the care of his friend with a care package of four calls a day starting 3 days later. The rehabilitation unit discharge summary contains no reference to smoking. He had been assessed by the reablement team as not being suitable for any further rehabilitation in the community, but a referral was made for community physiotherapy to consider mobility and transfer needs at home. A lifeline alarm was also set up. The plan for a key safe had been abandoned as the landlord would not consent to its installation. To gain entry a key was left at a local corner shop using the Key Nest system.

4.7 Two days after starting the home care service, the care agency asked the hospital social worker to arrange further mobility assessment due to Mr D’s observed difficulties during care episodes, indicating that the current care package was insufficient for his needs. There was disagreement about who should undertake an assessment. The Home First Service declined as it was too long since discharge and advised referral to the Rapid Response Therapy Team via the GP. The Rapid Response Team, however, considered that any reassessment relating to the care package should be done by the social worker. The hospital social worker referred Mr D to CIS on 22nd November and subsequently completed a case transfer summary with a recommendation for a six-week community review.

4.8 The district nursing service undertook a home visit on 18th November 2021 for blood samples and flu vaccination. They subsequently asked the GP to refer Mr D to the memory team and also raised concerns about fire risk due to Mr D’s smoking, requesting a smoking cessation referral. District nursing records indicate that the district nurse believed that Mr D lacked awareness of smoking risks. No referral to the LFB for a home fire safety visit was sent. The referral to the memory team was subsequently declined by that service as it was considered Mr D’s presentation was likely due to post-stroke cognitive impairment and that further time should elapse before referral to the memory service.

4.9 A care plan completed by the care agency on 19th November identified high risk of fire as a result of Mr D smoking. He was to be encouraged not to smoke in bed. Water was to be placed in ashtrays where he would place cigarette stubs. The care agency stated that it referred the fire risk to LFB, but LFB has no record of having received a referral.

4.10 On 29th November 2021 the CIS Home Therapy Service undertook an initial assessment. It was noted that Mr D was able to follow simple instructions and was able to express some preferences but appeared to have cognitive impairment and short-term

memory issues. Mental capacity was not further assessed, although it was noted that a referral to the memory service had been made and that he could be re-referred in six months' time. Mr D reported he was smoking 30 cigarettes and drinking two bottles of cider per day. The therapist explained to him their concerns about the manual handling and high falls risk but queried whether he was able to retain this information or whether there was a fluctuating cognitive state. It was noted that Mr D was awaiting an urgent assessment by the Neuro-Rehabilitation team. An internal same day referral transfer to the CIS Rapid Response Team was made, requesting an urgent occupational therapy assessment as Mr D did not have the required equipment in place to ensure safe transfers and manual handling, and was at high falls risk. An Datix Incident Form was raised relating to the initial home therapy assessment that identified concerns about lack of equipment in situ from the inpatient rehabilitation unit on discharge.

4.11 A CIS OT and healthcare assistant carried out a joint urgent home visit the following day. No significant needs were found with regards to manual handling risks or equipment, which stepped down the concern from the previous day's assessment. The therapist noted Mr D's needs as follows:

- Footwear: Mr D was wearing socks and the therapist recommended slippers to improve grip.
- Bathroom: Equipment was offered but declined by Mr D, explaining he preferred to strip wash.
- Seating: the high back chair in situ was reviewed and Mr D encouraged to use it, but he explained he preferred to sit on the sofa.
- Bed: a hospital bed was offered for ease of care and for days when he was more fatigued. Mr D declined as he preferred to sleep in his own bed.
- Smoking: There was a discussion about smoking cessation.
- Safety: The therapist asked Mr D what he would do in an emergency; he reported he would use his mobile phone and be able to call 999.

Following this assessment, the therapist sent an email to the GP to request a new dosette box to support carers to prompt and manage medications and asked the GP to provide information regarding smoking cessation as Mr D was interested in pursuing this. They also called the care agency to discuss any concerns regarding care; none were raised. They also checked the care agency was aware to contact ASC if adjustments were needed to the package of care. They then called the neurological rehabilitation team administration to check that the referral was accepted, and that Mr D was on the waiting list as high priority (but no timescale was given for when he would be seen).

4.12 Telecare was installed on 1st December, but the system was not linked to the smoke alarms and heat detectors that were already fitted.

4.13 On 2nd December 2021 a telephone appointment took place between Mr D and a smoking cessation advisor, but the advisor found it hard to understand Mr D due to speech issues he was experiencing. The same day Mr D's referral to CIS Home First Therapy was closed with advice given to the care agency to escalate to ASC if further support was required.

4.14 On 6th December Mr D's close friend advised the GP that Mr D was weak, feeling bad and had worsening speech issues. When contacted, Mr D maintained he was fine but

struggling to walk, was housebound and hadn't gone out for two years due to feeling weak. Records suggest that a home visit by a GP was planned.

4.15 The following day, fire broke out in Mr D's flat. It was identified by a passer-by noticing smoke coming from his flat window, and at the same time by neighbours being alerted to a smoke alarm. It is not clear whether he was wearing his link alarm. The emergency services found Mr D in bed. He had sustained 30 – 40% thickness burns, especially to his head and right side. He was placed in a medically induced coma and was air-lifted to hospital where he died later that same day. The Fatal Fire Report by LFB concluded that unsafe use or disposal of smoking materials was the most probable cause of this fire. The LFB Borough Commander's Fire Fatality Report concluded that a metal ashtray on the side of his bed would have been difficult to use because of its position and Mr D's limited mobility. Beside his bed was the remains of a small plastic bin and it is likely that cigarette stubs had been disposed of therein. He was not wearing his pendant alarm in bed. His mobile phone was under a pillow and was consumed in the fire. He had been unable to call for assistance.

5. THEMES ARISING FROM THE CASES OF MR C AND MR D

This section sets out learning arising from review of Mr C's and Mr D's circumstances, organised within the five safeguarding domains: direct practice, interagency working, organisational features, SAB governance and national policy.

5.1 Domain 1: Direct practice

5.1.1 ***Good practice:*** There are elements of good practice in both cases. Mr C's needs and preferences were well understood and well catered for. A wide range of plans was in place in his extra care housing, covering many aspects of his care including fire risk management. Healthcare was provided when necessary, occupational therapy and physiotherapy offered, and equipment provided. His care and support package was increased in response to his changed needs following hospital discharge. Mr D had been appropriately safeguarded when coercion and financial abuse had been suspected. Given he had a history of declining assessments and treatment, a focus was placed on building trust. On his discharge from hospital the care provider noted risks from smoking and gave him advice on managing those risks. District nursing referred him for smoking cessation advice. Shortcomings are nonetheless evident in both cases.

5.1.2 ***Recognition of fire risk****:* In Mr C's case there was simply insufficient recognition of the increased fire risk following his hospital discharge. No agency considered the impact of his loss of mobility on the risks from smoking. No discussion took place prior to discharge. His fire risk management plan was not updated. The ASC core assessment in January 2021 took place without assessment of his home environment and the care and support plan did not refer to smoking or fire risk. The suitability of his accommodation was not reviewed. There was no discussion with the care providers about his smoking and no apparent consideration of enhanced risk management measures that might be needed. There is no evidence that fire risks from smoking were discussed directly with Mr C during this period.

5.1.3 In Mr D's case, there were missed opportunities to assess the risks of fire from smoking. Some practitioners did not know he was a heavy smoker. Others accepted

his answers or did not follow up on what they had observed in terms of his smoking. Others focused on smoking cessation advice. His dislike of wearing the pendant alarm was not risk assessed. The need to place water in ashtrays was recorded but no additional mitigations were put in place.

5.1.4 ***Mental capacity:*** There is no evidence that consideration was given to Mr C's mental capacity. His autonomy of decision-making about smoking was respected without his understanding of risk, recognition of the potential outcome of a fire, or ability to act to keep himself safe in the moment being tested through assessment under the Mental Capacity Act (MCA) 2005. Such assessment should be a crucial step in any circumstances similar to those of Mr C. In Mr D's case there was some uncertainty and concern about cognitive impairment, but even so his ability to act in the moment to keep himself safe when smoking was not evaluated.

5.1.5 ***Additional features of direct practice:*** In Mr D's case, despite his rehabilitation provision he was not assessed at home before discharge and although he was subsequently seen at home by district nurses, home therapy and occupational therapy, some urgent assessments were not completed before he died. There does not appear to have been a review of the actual suitability of his accommodation despite his decreasing mobility, despite assessment that he required a rollator frame and supervision to assist with transfers and would require close supervision and rail support to manage stairs.

5.1.6 ***Family perspectives on practice:*** The telephone contacts with Mr D's close friend were hugely helpful in providing a picture of Mr D as a person and the reviewers are grateful for her contribution. The perspectives she shared are most relevant to the direct practice domain, and they are therefore included here.

5.1.7 She described Mr D as "*gentle, very quiet, soft, talented, generous, kind and loving*" and as a "*wonderful friend*", observing that they were "*like brother and sister.*" She had become a close friend after he had returned from living in Thailand, where he had gone after his musical career with his band had ended. She was a back-up singer and they had worked together on making music. She said that his initial stroke "*shattered him*" and he became a recluse, not allowing anyone to support him other than accepting the help that she provided. He would self-discharge from some treatment episodes after his first stroke. She took him to all his hospital appointments and helped him with activities of daily living, such as cleaning his flat.

5.1.8 She said Mr D was also very stubborn and often discharged himself from hospital; she always had to encourage him to accept help. She also mentioned that when he was located on the 6th floor the lift was not working and she couldn't move him, and he couldn't get out and about and that was when he was at his lowest. He was such a talented song writer but had withdrawn from the world after his stroke and disabilities, not wanting anyone to see him in that state and having got to a point where he didn't want to get out of bed. He had told her that he "*didn't want anyone to see him but her, as he only felt safe with her and didn't feel safe with other people.*"

5.1.9 She described how he was a chain smoker and had always smoked in bed. He would strenuously object if she tried to stop him, saying that smoking is "*all I have.*" He would not follow advice as smoking was "*his one pleasure left.*" She described the level of his disability, how he would have to struggle to turn himself in bed and how he could

not get up unaided. She had not been offered a carer assessment despite the level of support that she was providing daily. They had considered applying for a two-bedroom flat together so that she did not have to travel each day to support him, and they had tried to complete the necessary paperwork, but she thought that services had been too slow to support them both. She knew that he had been provided with an alarm, but she understood he had been told that he could remove it at night when in bed.

5.1.10 She shared that prior to his death, she had booked his mother into a hotel close by for three days and that she and his mother had cared for him as he had begun to self-neglect in terms of his personal care following his stroke. He wasn't changing his clothes, he didn't want people to see him in that state, he had let himself go, and he told her "*he wanted to die*". She expressed that his mother was shocked to see him in that state and together they cared for him, washed him and helped him.

5.1.11 As usual, the evening before he died, she had supported him and unusually he had asked her not to leave, but she had had to go home. She felt *"It's like he had a premonition something was going to happen".* Without prompting she offered the following information: "*I didn't want to raise the alarm and blame Westminster, but they told him to take his neck pendant alarm off when he was in bed in case he might press it by mistake but if he had triggered that button he may not have died, and the Fire Brigade would have come earlier. The people across the road, his neighbours and the offices that knew he was disabled raised the alarm. I didn't want to make a big fuss or blame anyone. I cried for months after he was gone. Carers need to make sure no smoking in bedrooms this is the learning, but I don't want to create any big problems with Westminster.*" She had attended the funeral in Scotland and believed that the cause of Mr D's death had been recorded as due to smoke inhalation and Covid-19. She also said that she had been provided with counselling since his death from a hospital.

5.1.12 It is important to note that some of the comments of Mr D's close friend are not in line with the information that was contained in his care plans, which included for carers to check and prompt him to wear the alarm. The reviewers understand that the standard protocol is for people to be told to wear the alarms in bed, but for people to be aware that following accidental activation the monitoring centre would respond as if it's an emergency and call to check on them. If the person doesn't answer the phone, they will receive a visit from a response officer/key holder. Owing to this, people will often take off their pendants at night. Nonetheless the advice that is, or should be given, is to ensure the alarm is kept close by at all times, in case of emergency. Mr D's ability to access his pendant in an emergency should have been the focus of a functional assessment.

5.2 Domain 2: Interagency working

5.2.1 In Mr C's case, there is evidence of good interagency collaboration between ASC and Health learning disability teams, hospital-based staff and extra care housing provider staff. There were clear communications and good follow up to his hospital discharge. However, there were significant gaps in how well the interagency system came together to consider his needs going forward. The ASC Learning Disability Team did not attend the hospital discharge meeting and have reflected that it would have been valuable for them to have done so. Significantly, the interagency discussions that did take place did not feature consideration of Mr C's smoking and the resultant fire risk,

particularly in the light of his impaired mobility. Information-sharing about core assessments and risk assessment was poor between the ASC Learning Disability Team, the extra care housing provider and community healthcare staff; not all those involved in his care and support held the full picture on his situation. In addition, in the period between his discharge and his death it would have been entirely appropriate to request a HFSV, given the change in his health. mobility and dexterity, regardless of whether or not one had taken place previously. The absence of attention given to fire risk during this period meant that no agency made such a request.

5.2.2 In Mr D's case, the care provider's care plan identified high risk from smoking but neither the provider nor LFB have a record of a referral being made for home fire safety advice, raising a question about whether all services have a direct pathway to refer to LFB for HFSVs. More broadly, there was no multi-agency meeting convened to pull together information relating to the different assessments that were being conducted or requested. Instead, there is evidence of referral bouncing regarding whose responsibility it was to respond to the care provider's request for reassessment of the care package. Information about his smoking was clearly available but either not shared or not accessed from his records.

5.3 Domain 3: Organisational features

5.3.1 Both men died during a period in which the work of the agencies involved was radically affected by the Covid-19 pandemic. While not underestimating the impact of those challenges, it does not appear that they significantly affected the services provided to Mr C and Mr D. Only the district nursing service in Mr C's case has indicated that Covid restrictions brought about a reduction in the frequency of nursing visits during 2020 and no evidence of negative impact of this reduction has come to light.

5.3.2 Other organisational features did, however, impact on how practice unfolded. In Mr C's case, following his death the CQC carried out an inspection of the extra care housing provider's compliance with regulations relating to its registration with the CQC[7], including those under which fire safety is addressed. The inspection raised concerns, finding breach of regulations 12 (safe care and treatment) and 17 (good governance). The extra care housing provider subsequently implemented improved measures for identifying and managing risks from smoking for all tenants and a further inspection by the CQC in August 2021 identified significant improvements to risk management and to management oversight. The extra care housing provider had made significant changes in how risk is identified and mitigated, including identification of tenants at highest risk of harm due to fire and working with the LFB, the local authority and health teams to review and manage those risks. There were improved processes for ensuring that the relevant checks had been carried out and how information about risks was passed between shifts and between the care team and the housing team.

[7] The Care Quality Commission (CQC) is the independent regulator of healthcare, adult social care and primary care services in England. It registers regulated activities as specified in the Health & Social Care Act 2008, and inspects, rates and monitors those services. Personal care is a regulated activity and the care provided by the scheme in which Mr C lived had been registered with CQC since 2010. Fire safety risks are considered under regulations 12 (Safe care and treatment) and 17 (Good governance) of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014.

5.3.3 In Mr D's case, systems and processes within agencies are also significant. The Discharge to Assess (D2A) form did not have a section on smoking, so there was no prompt to consider measures that might need to be in place once Mr D returned home. The interim care and support package of four daily visits contains no reference to smoking. The Telecare referral record contains the entry 'no' to the question 'is there a risk to client from smoke in the property?' and while Telecare was installed it was not linked to the smoke alarms and heat detectors. Closure by a hospital social worker with a recommendation for a community review after six weeks was signed off by a manager, but it is unclear by what process this review would happen. Finally, it is evident that individual practitioners and managers carry the trauma from the outcome in this case, raising questions about how well agencies support staff to manage the lived experience of losing someone with whom they have closely worked.

5.4 Domain 4: SAB governance

5.4.1 While the SAEB had already, in response to previous fatal fires, implemented a plan of action to secure improvements across the interagency partnership, the outcomes in the cases of Mr C and Mr D indicate that further assertive leadership is required. The focus here will need to be on the following actions:

- Measures to embed fire safety awareness in routine, daily practice across all agencies, supported by ongoing monitoring through audit of the effectiveness of these measures. This requires establishing the principle that fire safety is everyone's business, regardless of professional role or agency remit.
- Guidance to ensure that fire risks assessment and management plans are updated routinely following a change in circumstances (such as hospital discharge or significant change in health or functional ability).
- Improvement to recording and sharing of fire safety advice given by LFB on HFSVs, to ensure that advice is given in writing, shared across all agencies involved and flagged for action by all practitioners.
- Improvement to agencies' understanding and implementation of mental capacity assessment, including the significance of executive function[8], where individuals continue to smoke in circumstances that place them and others at high risk of harm from fire.
- Provision of expectations, guidance and pathways for convening multiagency discussions in such cases.
- Provision of training and guidance on raising important but difficult discussions with individuals about risks to life.

5.5 Domain 5: National policy

5.5.1 The tragic outcomes in the cases of Mr C and Mr D raise important questions that have national significance. Essentially these relate to whether and how a correct balance can be struck between the right to self-determination, on the one hand, and the duty of care (both to the individual and to others) on the other. How should providers of services respond to these competing imperatives of autonomy (the right to private and

[8] An individual with impaired executive function may be able to give a rational and persuasive response to discussions about how they would keep themselves safe when smoking but be unable to carry out those self-protective measures in the moment of actually smoking – in effect being able to talk the talk but not walk the walk.

family life) and protection (the right to life) where individuals to whom they provide a service are at high risk of harm? There is no standard answer to this question, the correct balance has to be struck in each and every individual case, but there is potentially a need for further guidance, for example on the *process to be followed* in making that difficult decision, including the significance of mental capacity, the importance of shared interagency strategy and how to determine the weight attached to each of the competing principles. Equally the powers of housing providers (and others) to restrict activities that lead to fire risk where the risks to the individual and to others are extreme require clarification so that there is shared understanding.

5.5.2 One example here is that HFSVs require the person's consent. Is there a gap in law relating to when the person refuses consent but is living in flats/buildings where other residents will be at risk as a result of that refusal?

5.5.3 A further potential gap in law relates to training on fire risk. This is currently not mandatory for care workers in registered services. Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires providers to assess the appropriate training for care workers to receive to carry out their role, and it is for providers to determine what constitutes mandatory training. There is no suggestion here that in Mr C's and Mr D's cases the appropriate training had not been provided – indeed the CQC's inspections of the extra care housing service in Mr C's case found that the requirement was being met - but in the broader context the SAB's leadership in ensuring that fire safety awareness is embedded in practice (see 5.4.1. above) would be strengthened by a legal mandate on training.

6. THE AGENCY AUDIT

6.1 The audit questionnaire was designed to serve two purposes. The first was to review how agencies have embedded the learning that emerged from fatal fires in the Bi-Borough during 2020-21. The second was to consider where there might be outstanding learning and further actions required. To answer these purposes, organisations were invited to answer eight questions and then to identify future priorities.

6.2 The questionnaire was sent to senior managers in each organisation to secure information from relevant teams:

- ASC
- Block homecare providers
- NHS Trusts
- Care providers
- GP surgeries
- ICHT
- NHS Integrated Care Board (ICB)
- Supported accommodation schemes
- LAS
- Metropolitan Police
- Extra care housing providers.

28 responses were received, some from different services within one organisation. Some organisations also attached supporting evidence, including induction and training programmes, handbooks, safeguarding bulletins, policies and procedures, guidance on

mental capacity assessments, 7-minute briefings, case studies on reducing risk of fatal fires and risk assessment templates.

6.3 Question 1: Do staff have regular mandatory fire safety awareness training to ensure they can identify fire / smoking risks with the adults who they work with, whether they live in their own homes, supported or extra care accommodation or care home environments?

6.3.1 It appears that training has focused more on workplace safety but less on fire safety assessment and advice for people in their own homes. Respondents reported some concerns about the focus of the training on offer.

We have virtual Fire Safety Training, which is mandatory, however, this is generic and not specific for customer or client assessment. This is part of the general training for staff and required to be completed annually. Objectives are to identify risks and to reduce risk however it is only related to the office environment. On completion staff receive a certificate and training is saved on our portal.

All staff attend mandatory fire awareness training, but this is related more to the organisation and staff's responsibility. At this time there is no training available for staff for fire training relating to patient's safety and, therefore, no monitoring either. The team request this training is provided. And with reference for what would be appropriate for different professional roles.

Staff receive fire training in regard to building evacuation procedures and using basic fire extinguishers.

6.3.2 There is (e)training, most often mandatory and with requirements to update and refresh, but limited information in some services on the number of staff accessing what is mandatory. By contrast some providers were able to provide details of the number of staff who had received initial and/or refresher training. The emphasis on training followed partnership development work after several fatal fires, with occasional references to 7-minute briefings having been disseminated. All three GP practices reported that their staff are trained in fire safety awareness via the North West London (NWL) learning hub training platform. That fire safety training is mandatory for their staff and is renewable yearly. All three practices maintain training logs with a target of 100%. All practices reported that they are compliant with this target. Some providers distinguished between training programmes provided for care staff and for managers.

In response to the learning from fatal fires identified in 2020, LFB delivered four face-to-face 1-hour training sessions from Sept – Dec 2020 offered to all operational ASC staff. 306 (78%) of staff attended. Since then, fire awareness training has been delivered via an e-learning package owned and managed by LFB. It is advertised in the ASC Learning and Development weekly bulletin to promote training opportunities. This training is mandatory and is on the list of mandatory training to be completed annually as a refresher. It is the responsibility of managers to check if staff have completed this training.

It has not been possible obtain data on numbers of staff who have accessed this training, because the package is owned by LFB. This was discussed with LFB on a number of occasions between November 2021 and January 2022, but LFB advised they are unable to provide this information.

All our care workers receive Fire Awareness training as part of their induction training, with annual refreshers thereafter. The training is provided by our in-house trainer and covers emergency procedures in case of fire, identifying risks and staff responsibilities that are required to reduce the risk of fire.

We have asked a number of central Metropolitan Police departments and have been unable to establish whether any fire safety training is given. We must therefore infer that this training is not provided to police officers and is certainly not mandatory.

All staff are given fire risk training when they are employed by the company and before they are sent out to work. We offer fire safety awareness training online as well as fire safety training within our induction training. Our field care supervisor is a train the trainer on fire safety and conducts our face-to-face fire safety training. We use an online training company who supply our online fire safety awareness training. Staff that have the fire safety training receive a certificate once completed. Training is mandatory for every staff … and we do refreshers every year.

Having completed these modules staff are able to take all the necessary steps to prevent fire in the scheme workplace and deal with it effectively, should it occur. Additionally, they will also have gained an understanding of common residential fire safety themes such as landlords' legal obligations, current facts and statistics, fire risks and how fires can start or be prevented. The course additionally signposts promotional material available to assist in fire safety discussion with residents.

6.3.3 There were occasional references to concerns identified by respondents as a result of reviewing the training that is provided.

I understand risk of fire is not specifically included on the health needs assessment /risk assessment completed with patients and our learning is that it needs to be on risk assessments for [the service's] district nurses and therapists to support care planning and safety, especially for bedbound/patients with reduced mobility who smoke/have oxygen/air mattress/uses emollients. Smoking is a category that is included on risk assessments. I have asked the community matron to dip-sample 10 cases where the patient smokes and is bedbound/has reduced immobility and has air mattress and/or oxygen and/or uses emollient cream and will report this back.

6.3.4 Future priorities with respect to training were identified by several audit respondents. Some priorities related to being able to evidence what priority is given to fire safety training, and the number of staff who have been trained. Where figures were not available for the number of staff accessing initial and refresher training, the future focus emphasised consistent recording, for example in supervision notes. Less prominent, but no less important, is the use of supervision and audit to ensure that the knowledge and skills acquired through training do transfer into actual practice.

In the absence of being able to obtain organisational data about the numbers of staff that have completed LFB e-learning, it is recommended as an interim measure that line managers evidence that staff have completed the training and annual refresher via supervision and appraisal processes. This data is therefore kept and reviewed at a team level. A longer-term recommendation is that LFB need to identify how they can provide data on numbers of staff who have undertaken this training.

Awareness for local authority staff that this is an annual essential training. Awareness that this should be discussed and planned and recorded as part of supervision.

6.3.5 There were also priorities identified with respect to the focus and content of training on offer. For others the expressed priority was to ensure that fire risks are assessed and that assessments transfer into support planning.

The training focuses on the hospital-based environment and general fire safety and does not include any specific training on assessment of risks in a patient's home.

The current training package should be reviewed jointly by LFB and ASC in terms of content and method of delivery – i.e., would face to face training be more effective?

The fire officer in the conduct of this audit expressed an interest in this and did indicate a commitment to review the outcomes of this review in consideration of any changes in update of the training. The tension appears to be the statutory nature of the training and content that includes explicitly issues with reviewing fire safety risks for people at risk of neglect and abuse.

There are some contacts that are routinely not in a patient's home so some thought to be given to the processes for such checks and assessment.

6.3.6 It was also acknowledged that reviews of service provision and providers should include a focus on fire safety. This included making amendments to documentation and embedding fire risk assessment in all recording systems.

For fire and safety monitoring to be included in service review and quality assurance process.

Fire assessment questions to be added to nursing / therapy assessment questions. To check if clinical system can alert practitioners when [a] patient is recorded as being a smoker [or] accelerant in use i.e., oxygen, emollients, air mattress.

6.4 Question 2: What evidence is there as to how the learning from the training in relation to fire safety is being understood and applied?

6.4.1 One GP practice reported that GPs do not do referrals to LFB themselves but do signpost any patients of concern to their designated Care Navigator for onward referrals to services that can provide care and education; this includes LFB. The practice stated that as part of completing this audit tool, they confirmed with their Care Navigator that they do make referrals to LFB where appropriate. The practice stated that they have now realised that the process of referral to LFB is not covered in their mandatory fire training and wonder whether this would be beneficial going forward.

6.4.2 Some agencies test practitioners' knowledge at the end of fire safety training, giving some confidence that the information provided in the training has been understood.

E-learning has a test at the end; face to face training also has a test and staff are asked questions throughout the training to test their understanding.

Following the training care workers have to answer the series of questions, which assesses their knowledge and skills in regards to fire safety.

6.4.3 Some agencies reported that prompts on fire safety were now contained within templates and electronic recording systems, partly as a result of training and partly in response to the reviews of practice prompted by requested for scoping information relating to Mr C and Mr D.

The ASC electronic recording system Mosaic has prompts embedded within the assessment, review and support plan documentation to prompt consideration of fire risk assessments and referrals to LFB for home fire safety checks where relevant. The prompts were initially implemented in April 2019 with updates implemented in March 2022, with the aim of making the process more robust in light of the SAR referrals for Mr C and Mr D.

6.4.4 Some services reported an increase in awareness and referrals to LFB, and robust assessments with supervision oversight, although one service reported that although referrals are monitored the data does not evidence any increase following fire safety training.

Assessments and reviews have evidenced that workers are more vigilant of fire risks and referrals to LFB have increased. There's an increase in referrals for smoke alarms.

Training outcomes are monitored and evaluated by focus groups, post training job performance, supervisions and spot checks, client feedback and "voice of customer". Classroom based induction training is signed off by the qualified trainer.

There is some evidence that the increased focus on fire safety has meant more conversations with our facilities team about ongoing fire safety/prevention work. Feedback from teams has been positive about the effectiveness of the training and senior managers continue to work with teams to ensure feedback from the training is used to inform future training.

Due to the training, staff have reported that they are more aware of fire risks and will look at the client's fire risk assessment in the folders in their homes. Staff have also reported that due to the training, they are also more aware of fire risks in their own home and personal environments.

There has been an increase in consideration of LFB referral especially when hoarding/self-neglect arises in Datix incidents. Safeguarding review the incidents and will contact the team if a fire risk assessment has not been considered.

There is no evidence that fire safety training has led to increased awareness.

6.4.5 Not all services where training is provided monitor evidence of its impact on practice, however.

Information about this is not compiled or reported.

We are not able to evidence that the number of cases identified to have a fire risk has increased as a result of the mandatory fire training.

Current training focuses on fire safety risks within acute hospital building. As a consequence, there are no learning outcomes relating to risk assessments, support plans and referrals to LFB that might be assessed. Following this audit and eventual publication of this review, safeguarding leadership within the trust will develop a plan to challenge existing training with a view to extending learning outcomes to include fire safety risk assessment and other elements of support planning.

6.4.6 Audit respondents also reflected on priorities for future development and recommendations for their individual services. Thus:

It is acknowledged that whilst an amount of work has been undertaken since March 2020 to raise awareness and support practice in this area, more work is required to embed fire risk assessment principles more robustly in practice. As continuous improvement, we will be adding measures to the Bi-Borough schedule of audits to specifically consider effectiveness of practice in this area.

We concentrate on making sure that the training is delivered, and we need to improve monitoring of its effectiveness. There is no formal way of doing this. Need for continued raising of awareness, development of a monitoring system and embedding of changes in the assessment forms.

Smoking risk may not always be considered when a patient is being discharged by a hospital and it would support joined-up care if this was added to discharge assessment templates.

For providers to evaluate how they will monitor and evaluate effectiveness of training.

Referrals to LFB to be recorded.

6.5 Question 3: How do staff actively consider fire risk and undertake appropriate assessments in partnership with other agencies involved? Are all immediate risks to health and from fire identified and addressed?

6.5.1 Respondents provided evidence that assessments are conducted and reviewed but some expressed concerns that staff have to be reminded and that fire risk assessments are not prominent enough.

Staff do multi-disciplinary risk assessments as needed. I have found that they need to be reminded and guided by managers about this issue still. Documents are reviewed at the annual review of needs. Fire risks are still not prominent enough. The teams do use the [the borough's] multi-agency self-neglect and hoarding policy. I believe there is reasonably good understanding of this.

Assessments identified as unsafe if [the] client is smoking on the bed and there is no fire safety bedding or if the client is at risk of leaving cooker or gas on. As part of the self-neglect and hoarding, fire risk is assessed. All assessments are reviewed within the year. If a review is needed sooner than this, it can be brought forward.

Documentation reviewed does not reflect sufficient awareness. There is some evidence of considering risks re: cooking for example and smoke detectors or induction cooker and other equipment would be considered and set up.

However, other risks such as smoking, are either not mentioned or mentioned without evidence of risks considered.

We complete fire risk assessments at the start of every package of care, which identifies risks, rates it and advises of risk reduction measures. It covers all electrical appliances, portable heaters, lighting, unsafe smoking, [and] use of emollient creams. It is reviewed at least once a year and sooner if required depending on a service user's changing needs.

Fire risks are included in assessment, care planning and person-centred risk assessments, care tasks. Unless warranted these are reviewed on annual basis. Risk assessments are also conducted upon discharge from hospital etc. Each risk assessment and care plan is personalised, fire risk is rated for example, where client smokes at home/in their bed risk is scored as High. Clear instructions are provided to staff around fire and emergency actions that they should take. Risk assessments includes "Mobility in case of fire". This clearly states that in case of fire staff are to be aware that person will/or will not require equipment for mobilizing. Fire safety referral to LFB is included in the assessment. Risk assessment includes whether the service user/power of attorney consents to a referral to be made … Personalised care plans are reviewed once a year.

Local authority Care Act assessments have a risk section where fire risk should be considered and there is a prompt box for the assessor to consider referral to LFB for fire risk assessment. This should be reviewed at least annually when undertaking Care Act reviews.

There is a resident Fire Risk Assessment that should be completed at least annually or as required taking in all of risk factors mentioned. Once increased risks are identified our procedure is to involve our internal Health and Safety team and external partners as necessary.

[The service] utilises a three-step approach to person-centred fire risk assessment for people we support. This incorporates the LFB person centred checklist as its first step, acting as a screening assessment to identify those people who may be at increased risk. Those identified then have a person-centred fire risk assessment completed and (where identified factors may affect evacuation) a PEEP to specify the evacuation plan... The documents cover a wide range of risk factors (e.g., unsafe smoking/cooking/heating, use of emollient creams, self-neglect etc). The guidance documents for the assessment state that these must be reviewed whenever a relevant change to a person's circumstances occurs, and annually as a minimum. Teams are aware of safeguarding reporting protocols and the requirement to raise alerts in cases of self-neglect/hoarding.

6.5.2 There were clear expectations about recording but also concern about consistency of referral patterns and the adequacy of recording referrals to LFB.

All referrals to LFB are recorded on client's file. As part of the assessment process, there are prompts for staff to make referrals to LFB and record these referrals. This is on the FACE[9] assessment form and self-neglect and hoarding form.

[9] Functional Analysis of Care Environments

It's not possible to track referrals to LFB as they are documented as free text.

On the Mosaic system, there is a record of referrals to LFB as part of the assessment process. I am not aware of this being part of the [service's] assessment process; however, it could be recorded in a progress note if it has taken place.

One GP practice has a Patient Care Plan template which ask whether patient smokes. Should a patient answer yes to that question, the patient would be offered a referral to smoking cessation clinic. Where evidence of self-neglect is reported or seen, it is recorded in the patient's GP-held medical record. The practice reported that GPs do now record that emollients are flammable. The care plan is then reviewed annually or as a patient's circumstances/health conditions/level of need change, or they are discussed in the weekly practice Multi-Disciplinary Team (MDT) meeting. Where a patient has been referred to LFB for a fire safety risk assessment, this would be recorded in their medical record.

There are a number of electronically recorded discharge assessments that help to identify any fire risks. The 'Discharge Needs-Based Assessment' and 'Early Discharge Notification' question whether patients smoke, drink alcohol, use drugs and where they live to allow discharging professionals to make a decision about the risk of fires using professional judgement. If a LFB referral is made it would be recorded on the assessments. All fire risks are documented within the D2A process by the referring therapist.

6.5.3 Some assessment templates have been updated to include an explicit focus on fire risk assessments, reflecting immediate learning from the death of Mr D. However, assessment documentation is inconsistent in the focus given to fire risks.

We used the embedded D2A which, following the death of Mr D, we updated to include more specific fire safety questions relating to smoking and change in person's physical function. But we are changing our forms post D2A which formally ended in mid-September… We now use the FACE assessment/Review document and are updating the questions in this form to reflect the full range of prompts, so will include the prompts listed.

D2A process does not seem to include specific person-centred fire risk assessments. However, having spoken to staff, they and their managers are keen to include the assessments and we are looking at developing links/QR code stickers that prompt staff to make a referral to LFB. The records include smoking/use of emollients/self-neglect … working on templates that again prompt staff to ask and act when there is a risk/changes to mobility or mental capacity for an individual who lives alone. The timeframe for review of fire assessments is not documented but care plans are reviewed monthly so there is the opportunity to consider changing risk/need.

6.5.4 There was concern that referral is more likely when risks are high, and that staff lack confidence to challenge a person when consent is withheld for a referral.

I think staff are completing risks assessments and referrals to LFB where there are known high risks to smoking or fire. I don't think the referrals to LFB are being completed routinely, and also if someone declines a referral, I am not confident that staff feel confident to challenge on this.

6.5.5 Respondents picked up the theme of risks and the inconsistency in assessment documentation in their recommendations for future priorities for service development and practice improvement. The expressed objective was to develop a system-wide response to home fire safety. Some respondents committed their service to change. Thus:

Would be good to embed fire risk assessment into Mosaic and make it compulsory.

In partnership with colleagues in other departments we are currently implementing additional prompts and links to fire risk assessments/referral to fire brigade within all of our documents. There will be a mandatory requirement to respond to prompts (practitioners will not be able to progress without these being completed as part of the assessment/support planning process). Specific fire risks will be part of the prompts. There is a need to ensure that the fire risk identified in any assessment/review document is copied through to the support planning documents.

We do not currently record which fire risk assessment reviews may lead to cases being referred to LFB – we will look into how this could be incorporated into our monitoring.

Need to ensure all [our] services consider risk, especially podiatry services where emollients are used, and that risk assessment is completed/reviewed and shared by therapists to GP/DNs.

Review LFB referral process. Review hoarding policy.

Awareness raising of the need to consider fire risk at Care Act assessments and reviews and following procedure to mitigate including use of technological interventions and referral to LFB. Awareness raising of the protocols for hoarding.

6.6 Question 4: Person-centred interventions/mental capacity: How are the person's views and wishes captured? And how are these understood and used to assess level of risk?

6.6.1 Clear commitment emerged to person-centred practice and to completing risk and capacity assessments where indicated.

MCA practice is well embedded in the service with skilled assessments taking place regularly and in cases where needed. Formal assessments are recorded on our system and embedded into it.

Adults' as well as the families' views are recorded as part of the assessment. When in doubt, formal MCA assessments are carried out and recorded. If necessary, a Best Interest decision is made.

In every case we consult with our service users/their relatives to establish their views and understanding regarding fire/smoking risks so we can implement risk reduction measures. Where necessary we complete mental capacity assessments and share our findings with the local authority.

The adult's views are included within the environmental risk assessment section of the service user risk assessment.

Flexible and creative practice: An example of this is a young autistic gentleman which [the organisation] has been supporting over the last few months who has displayed very complex and challenging behaviour. One of the ways we have adapted to ensure we are able to creatively communicate with the young gentleman is by the use of picture exchange communication calls generated by office staff. Practitioners recognise the need for reasonable adjustments (Equality Act) and make them.

Care plans and risk assessments are person cantered. The agency works in line with the MCA; it protects and empowers people who may lack capacity. Agency works with service users, their next of kin, Lasting Power of Attorney (LPA) and any other external practitioners such as GPs. Copy of LPA is obtained, where it has been established that client lacks capacity and formal assessment is carried out. Agency works with local authority and requests copy of the assessment - this is shared where available. This is included in care plans and service user risk assessments.

As part of the physical health information gathered on SystemOne, smoking is discussed and smoking cessation support is offered. Where risks relating to fire and smoking, such as smoking in bed, are present, staff record discussions with patients in the progress notes and offer support if continuing to smoke by offering to procure smoke retardant bedding/referral to LFB. The risks are recorded in a risk assessment in SystemOne as well as the risk management plans. The team work in a holistic and systemic way and address the concerns of carers and they are included in the care planning process, respecting the client confidentiality also.

High fire risk registers demonstrate that the service refers residents to smoking cessation support as well as discussing this periodically and in detail. Further, there are occasions where [the service] has gifted residents with smoking aprons and fire safe materials, for example, metal ashtrays and bins, where the resident is unable or unwilling to source these items themselves (for example, the resident cannot afford to buy the items that make everyone safer). There are also examples within [the service] of misting towers being installed (where funding has been secured), as well as pendants and warden call.

6.6.2 One GP practice stated that since the fatal fire incidents under review occurred, the practice team has discussed the importance of completing fire risk assessments for patients who may lack mental capacity on their lifestyle choices. They would continue to ensure that all patients who declare that they smoke who are on their “Learning Disabilities Register” or “At Risk Register” will continue to have their smoking status reviewed annually and would be offered referral to smoking cessation service. They stated that Care Navigator will continue to liaise with external agencies where appropriate.

6.6.3 In one provider response there was appropriate focus on repetitive patterns and executive functioning.

Concerns around executive capacity are referred to safeguarding teams. For example, cumulative decisions which are unwise and impact on an individual’s health and wellbeing are subject to trend analysis using daily care records and any concerning patterns of self-neglect (which may be due to lack of executive functions) are referred to local authority safeguarding teams for a multi-disciplinary response.

6.6.4 However, some respondents reflected that evidence is hard to obtain on inclusion of fire risk in capacity and care and support assessments.

> *Evidence about conversations on fire risks and inclusion in support plans is limited in my experience. We have used a small number of misting towers. We continue to try to engage people where they refuse support. Evidence is hard to obtain. It would be in supervision notes and notes on mosaic.*

> *Not sufficient evidence available that any of these points are considered in relation to fire risks/smoking or other issues that could pose a risk of fire to the individual or the wider community.*

> *We complete mental capacity assessments routinely regarding change of accommodation, and being able to participate in a safeguarding process, but not routinely about going home or risks regarding smoking.*

6.6.5 A particular challenge is confidence in addressing fire risk with people assessed as having mental capacity. Moreover, some provider respondents expressed the view that completing mental capacity assessments was neither their role nor responsibility. One service commented that mental capacity training does not currently include the assessment of capacity in relation to actions that create fire risk.

> *If person has full capacity, this is the area I think we need to work on to ensure that actions are taken, and staff are more confident.*

> *Within the conduct of this audit, it has not been possible to determine the experience of staff in working within the MCA with people where [there is] fire safety risk in particular.*

> *As it is not within our remit to determine capacity, we would forward concerns to the local authority, as well as health practitioners involved in the individuals care and support to evaluate their level of capacity. We continue to forward concerns to the local authority, as well as health practitioners involved in the individual's care and support to evaluate their level of capacity.*

> *Cases involving fire safety risk were not included in MCA training sessions.*

6.6.6 The focus, including when using advocates, tends to be on care and support needs rather than on the specific question of smoking.

> *We do use advocates to support with decision making and could include smoking but tends to be more about care and support/change of accommodation.*

> *Care Act advocacy is involved in the context of Care Act assessments. Independent Mental Capacity Advocates (IMCAs) are referred to in cases where service users might lack capacity and do not have relevant others to be consulted when making best interest decisions.*

6.6.7 This section of the audit generated several priorities for future practice development and service improvement. In relation to advocacy, one respondent suggested that a system needed to be developed in order to monitor the number of referrals for advocacy. Another focused on awareness-raising and training:

Improve the awareness and understanding of fire risks and risk to health from smoking (causes/implications), including mental capacity assessment training specifically around areas of fire risks and health implications and how to approach this with individuals, to include case studies to promote learning.

6.6.8 Another reflected on the importance of assessments of care and support needs and of executive functioning in a person's home environment:

It is difficult for hospital social workers to identify many of the risks that would be seen on a home visit as they only see the resident in hospital and mostly have only what the resident or next of kin tells them. If serious risks are identified then home visits are often undertaken but this is usually in relation to environmental factors such as hoarding, utilities not working, blitz cleans, bed bug infestations, all of which need to either be assessed or resolved before the person goes home.

6.7 Question 5: Risks to others: How is the safety of others within the premises considered as part of risk assessment process?

6.7.1 Agencies recorded a clear expectation that risk to others would form part of assessment and support planning, and that this would involve collaboration with housing or other practitioners, and referrals to LFB. Thus:

Hospital Health and Safety relating to environment, equipment and materials is a key part of training and management of the organisation. Consideration of safety issues for other patients is included in health and safety planning and is undertaken on a case-by-case basis. Incidents are reported within the clinical risk management system and responded to within departments and divisions with the oversight of health and safety governance arrangements.

During our initial assessment we look not only at fire risk to our service users but other individuals in the building. This includes identifying risks, rating them and advising on risk reduction measures.

6.7.2 Some concern was expressed, however, that evidence of risk to others might not be recorded or, indeed, referred to LFB. Thus:

It would be interesting to review [this in] referrals to local authorities / fire and rescue service.

This area [is] of vital public interest [and] need[s] to be strengthened particularly when someone has capacity to decline a referral for example to LFB.

6.8 Question 6: Support for practitioners and managerial oversight: Are practitioners well supported to manage complex cases involving ongoing fire/smoking risks?

6.8.1 Respondents emphasised the use of supervision and reported on management oversight and scrutiny of practice. Some also reflected that gaps had been found in recent audits. There was some reference to the use of complex case panels, but this was not widespread, and the multiplicity of routes could be confusing. Some concern was expressed that there is insufficient recording of supervision discussions and decisions.

Staff are supported to manage complex cases through constant communication with managers as well as field care supervisors. If there are

any issues or concerns that should arise, steps are taken to ensure that all and any fire/smoking risks are managed. Our organisation has policies and procedures in this area, accessible to all staff. We also ensure that all guidance relevant is included within the care plan and risk assessments. We are continuously monitoring ongoing practice with smoking/fire risks. Our staff are advised to report any changes or concerns regarding client safety and this in turn leads to further assessments being carried out. All assessments that are carried out are reviewed by management to ensure that all possible risks and control measures are evidenced. Our organisation ensures that adequate reflection regarding identified risks and actions that are required are evidenced throughout not only the fire risk assessment but also through the environmental risk assessment which also details the level of risk as well as actions to support in the prevention of these risks to the client's safety.

Practitioners are supported by line managers and senior managers. Where multi-disciplinary meetings are arranged which includes LFB, housing and any other professionals. Where necessary complex cases are referred to the Review Monitoring Board for advice. The number of panels can be confusing and recent work has been done to review and work out the best place to discuss cases.

This is done via supervision and also practice forums for challenging behaviours. Manager input is on Mosaic. Recent case audit shows some gaps in this, and further training may be needed.

Policies are in place - external audit of [the organisation's] governance was positive - but where teams are stretched, they do not always think of policies. Access to safeguarding team has supported discussion/referrals.

No sufficient evidence of discussions in supervision or as part of ongoing case management of discussions in relation to fire risks. Complexities in other areas of someone's life are discussed and risk assessed regularly (e.g., personal care/transfers/behaviour of concerns/risks to themselves and others), however, there seems to be a lack of awareness around complexities when looking at fire risks.

6.8.2 There was an expectation that self-neglect and hoarding procedures would be used alongside safeguarding and discharge policies as forms of support. Some audits had been completed to monitor usage, alongside oversight of recording.

The case may also progress via the self-neglect and hoarding pathway if required. Recent partnership work is being done with housing in order to review the multi-agency self-neglect and hoarding policy. All advice and directions are recorded on case notes and meetings are minuted.

Practitioners are supported via regular supervisions and MDT discussions, as well as self-neglect/hoarding procedures. Local guidance encourages practitioners to bring cases for daily MDT discussion. {The organisation's] supervision and appraisal policies identify any areas of training, further development or support. There is evidence of regular supervision and records are maintained. There is also evidence of MDT discussions in service users' notes. Reflection is part of supervision and MDT discussions as a tool to explore in depth the risks and strategies to address them.

6.8.3 Nonetheless, respondents were sufficiently concerned about the effectiveness of organisational support for fire safety practice that several priorities for practice and service improvement were identified. Thus:

> *Further embedding of good practice around identifying risks/discussion of these with individuals and corresponding risk assessments/capacity assessments/referrals to LFB if needed/appropriate. Managers across Community Learning Disability Teams to ensure that the topic of complex case management in relation to smoking/fire risks is covered within supervision and case recorded.*

> *The complex discharge team will attend to the outcomes of this thematic review and consider an action plan to improve focus on fire safety. The outcomes of the review will be taken to the Trust Safeguarding Committee to develop key development priorities in respect of policy, guidelines and other priorities as appropriate.*

> *We have recently developed a significant analysis process and will be using this to look at any incidents to allow for further learning.*

> *More training and support from line managers is recommended. Too often junior staff are exposed to these complex cases in the frontline. They may sometimes lack awareness, confidence or unaware of their responsibility to escalate potential risks to managers.*

6.9 Question 7: Multi-agency communication and information sharing: How does your agency ensure effective partnership working when supporting adults experiencing high and ongoing risks in relation to fire/smoking?

6.9.1 Fire safety/smoking was seen by some as the responsibility of community-based staff, and particularly of social workers. Some concern was expressed about the expectation that ASC practitioners are routinely expected to lead in the multiagency context.

> *Fire safety remains more of a community therapy/social work issue. Patients with restricted mobility tend to have social work involved and we would expect them to complete any fire risk assessments, especially since we no longer carry out access visits for discharge.*

> *Social Workers need to take the lead in MDT working and have to drive this. This can lead to fatigue if they are the only ones doing this, which is the case. Other parts of the system expect social care to organise and chair this work.*

6.9.2 There were references to using the duty to enquire (section 42, Care Act 2014) or the self-neglect and hoarding pathway to ensure a MDT approach. The management of referrals in adult safeguarding, however, was seen as a challenge at times when a safeguarding route is not seen as appropriate for the issues identified.

> *Should a case meet Section 42 criteria, then it will be progressed to safeguarding or self-neglect and hoarding route. This involves multi-agency working and all concerns of risk are escalated appropriately which professionals are aware of. Once a case is progressed to a safeguarding enquiry or via the self-neglect and hoarding policy a MDT is held, and all professionals involved as well as other agencies who may be able to provide support are invited to the meeting where clear actions and time frames are agreed. Minutes of the meeting are shared. Actions and time frames are*

reviewed within 28 days and updated until risks are reduced. The safeguarding enquiry is chaired by the local authority; however, the investigating officer will be from the most appropriate agency involved, e.g., health, LFB or social worker if appropriate.

Managers maintain clear communication with social services, commissioners and other partners in relation to individual risk cases in this area. Safeguarding concerns are raised as necessary by managers in relation to risk to people supported due to self-neglect, hoarding etc. Area managers collate and record all safeguarding concerns within their area, liaise with local authorities and track the outcomes.

ASC staff have to screen out the issues that are not safeguarding but that have been badged as safeguarding. These clog up the system.

6.9.3 There was recognition that closer scrutiny of how agencies work together to manage fire risk is needed, especially around inclusion of fire risk in information-sharing and partnership working.

This is a challenging area of work which requires closer scrutiny. We are reviewing policies and procedures at a partnership level in order that cases are managed more effectively and efficiently.

There is not sufficient evidence of information sharing and partnership working in relation to fire risks. Whilst there is evidence of very close partnership working with a variety of stakeholders in relation to many other issues and complexities when working with people with learning disabilities, fire risks and discussions/sharing of information around these with key partners / agencies is not evidenced.

While working in the D2A period we had daily meetings with NHS colleagues and actions were recorded on a shared tracker. However, prioritisation for these discussions are about barriers to discharge and setting up care and less details about fire risks.

6.9.4 Several respondents identified future priorities for this area of practice. These priorities included the need to work with referrers of adult safeguarding concerns to avoid unnecessary referrals, and to amend documentation in order to provide mandatory prompts and to remind practitioners of the need to complete fire risk assessments and provide evidence of referrals to LFB. This would need to be accompanied by clear and regular audits, and mandatory training.

Safeguarding leadership will work … to initiate a development plan to enhance the existing safeguarding documentation to more explicitly address issues involving fire safety risks.

Recommend more Multi-Agency Safeguarding Hubs (MASH) or High-Risk Panels are established, with clear Terms of Reference and accountability. Some boroughs have weak frameworks.

Information sharing between heath and all agencies needs to be more robust. Standardised assessments in North West London [would help] to support ongoing assessment and audit.

6.9.5 These priorities for practice development and service improvement, however, would have to navigate a pressurised workplace context:

> *Creating the right environment for a safe discharge takes time and the social care teams need to feel confident and assertive to communicate this to NHS – this is difficult for staff and managers in a climate whereby length of stay for residents is heavily scrutinised and individual cases are escalated to senior directors for responses.*

6.10 Question 8: Commissioning: Are commissioners and contract managers familiar with standards of fire safety to then apply to commissioning or agreeing terms of contracts/services?

6.10.1 Both commissioners and providers confirmed that contracts included references to fire safety. Key provisions included the requirement that staff are competent and able to meet the needs of residents and that providers will ensure the safe operation of buildings, and the provision of training, including on fire safety awareness. Some contracts were under review, but other common requirements focused on health and safety and fire safety policies and procedures, fire risk assessments and fire evacuation strategy and practice, alarm testing and PEEPs, and engagement with LFB.

> *[Standards of fire safety] are looked at in a variety of methods - at Procurement, through service compliance visits, through contract monitoring - where staff training/health and safety [are] picked up as standard agenda items.*

> *Annual reviews are undertaken in the form of Fire Risk Assessments as well as site visits and health and safety checks which are embedded into the contractual arrangements. In depth reviews undertaken as part of procurement exercises. Feedback from tenants and service providers. Contract monitoring undertaken on quarterly basis.*

> *Services have been focusing on identifying risks, particularly with those residents that smoke, and establishing risk mitigation activity as relevant. Services are mindful of the smokers they have in services and any risks they might present. Within [the borough] this has led to misting towers, fire blankets/aprons have been put in place with those with identified risks.*

> *The service specification requires care providers to carry out a risk assessment in accordance with health and safety legislation. In addition, care providers are required to have policies and procedures in place to support their staff to observe and report any potential environmental hazards and concerns. Any incident related to fire is raised by the provider with relevant stakeholders. Social workers will address these concerns in care review meetings. The service is provided in the service user's home. The contract recognises that the service user may decide to live with an element of risk. As part of our site visits to care agency offices, commissioners check staff training records to ensure all carers have had induction and refresher training.*

6.10.2 Some concerns were expressed that mechanisms for the maintenance of standards were not widely known.

> *The 'Provider Concerns Process' is not a process that is well known or has been embedded within practice. However, whistleblowing and serious incident reporting is within services. Providers are also encouraged to talk to local*

authority officers (commissioning/safeguarding) about service challenges to ensure a collaborative approach.

6.10.3 Fewer future priorities were identified in this section of the audit. However, one commissioner respondent commented that consideration would be given to developing a Fire Audit Template with a maturity scale of measures for providers to complete periodically. Several providers expressed one same priority, namely:

An area for clarification is who is responsible for signing off on fire safety of a building (especially where this is a bed-based service). How often should this happen? What qualifications/experience are needed in order to provide such as sign off. Could we have a whistleblowing route for staff/service users/residents/family to raise fire risk concerns?

6.11 Respondents' concluding comments

6.11.1 Several respondents included additional reflections in their audit response, highlighting additional barriers that must be overcome in order to promote and ensure home fire safety – in effect showing the extent of the challenge of implementing change.

6.11.2 A common finding in SARs is that agencies did not have a complete picture of a case, of the information available about risks and the responses to them. Often this is linked to different practitioners recording on separate systems. Allied to this concern was another, namely the challenge of working across local authority boundaries and having to navigate different system requirements.

As there are two systems for patient records (SystemOne and MOSAIC) which are not uniform, there is some work to do to scope the contents, benefits and drawbacks for each system, mindful that not all patients are required to be recorded on both systems. The Royal Borough of Kensington and Chelsea (RBKC) have more dedicated fire safety risk assessment fields to be completed.

The benefit of hindsight must change practice as we cannot ignore the number of fires across London that have resulted in the deaths of adults at risk who were bedbound/limited mobility. Ensuring all services have access to information and D2A considers and documents questions / actions regarding fire and smoking.

Social care teams in the hospitals work across three boroughs meaning practitioners complete many different work steps on Mosaic …. purchasing care from across three different reablement teams for example, each with its own referral route, and transfer process, into long term care, placements, and safeguarding processes. Staff are being asked to do this at a significantly different pace to their community or reablement colleagues. As there are many different scenarios, practitioners have a lot to remember about process and I think this tends to take their time and priority as well as completing the actual tasks required to problem-solve barriers to discharge.

6.11.3 There were other references to the need to develop systems to ensure and promote practice standards.

Systems of audit are not yet as embedded as they could be. [This] rests with Heads of Service and managers to continue to work with staff to recognise risks and manage.

I think staff need to have the embedded prompts in all their paperwork to ensure that all areas are considered.

6.11.4 There was also some acknowledgement of the pressurised context within which adult safeguarding is situated. The focus here was twofold. There was acknowledgement of workloads. There was also recognition of the complexity involved when having to balance (in relation to individuals assessed as having mental capacity to take particular decisions) human rights as set out in the European Convention on Human Rights - the right to private and family life (article 8) with the right to life (article 2), and the need to determine the balance to be struck between these rights when different individuals are likely to be affected.

Change in level of need is assessed through discharge planning processes. Existing risk assessment should be taken into account for discharge but pace and volume of work, I'm not confident that the existing risks are clearly evident on all cases. For example, a warning indicator for FIRE would help to enable staff to see what is already on file.

In my experience when I have reviewed files there is evidence that not enough time is given to reviewing the history of the person prior to the admission to hospital. This is often because we are being asked to restart the care or discharge the person either the same day or the next day. I want the system to flag high level risks that are easy for practitioners to see.

We have had a lot of changes to processes over the last two years and more recently with reverting back to our own Standard Operating Procedures after two years of D2A NHS led processes. We are including more authorisations processes including a Hospital Discharge Challenge Panel, so mindful there is a risk that social workers are being asked to complete more 'paperwork' and not keeping up with the variations to changes.

The complexities are balancing Article 8 of the Human Rights Act with a public interest concern.

If a patient has capacity and refused a referral to LFB for assessment, we would not progress the referral. We would however explain the rationale in terms of their safety and the need.

Safeguarding vulnerable people with fire and smoking risks is a huge challenge. Most patients coming into the acute pathway lead complex lives, with comorbidities like drug, alcohol, criminality etc. ... If they have capacity to make their own unwise decisions on how to conduct their lives, professionals need to be equipped with the political will and confidence to challenge them. They would use legal knowledge to apply environmental, housing, tenancy regulations with the help of other agencies to enforce compliance if the risks involve the public and the community.

6.11.5 There was also a timely reminder that home fire safety should be but might not yet be seen as a whole system responsibility.

Staff are asked to ensure that residents' discharges are safe and prompt, and are experienced in considering individual risk assessments around going home with falls risk, risks to hoarding, not accepting care, risks of fire from behaviour related to dementia and hoarding - as these are also the concerns of the MDT

in hospital, so need to ensure that smoking and use of emollient fire risks are fully understood by all working in health and social care, and that the fire risks not just seen as the social worker's responsibility. Practitioners need to be able to escalate the smoking or fire risk in the MDT and feel assertive in stopping the discharge if they are not confident the risks have been minimised.

It is critical that the Integrated Discharge Pathways Model works in concert with multi agencies (especially GPs) to ensure protective measures are in place and importantly regularly monitored.

The link between smoking and fire injury awareness needs revisiting across professions as there are several scenarios where this might be picked up. Medical assessment, nursing assessment, therapy assessment, pharmacy assessment, cognitive assessment….

6.12 Throughout the audits was recognition of the importance of learning from this thematic review and from other SARs, locally and regionally, where individuals had died or sustained serious injury as a result of fire in their own homes. There was recognition also that training had to be accompanied by organisational-level change to promote, embed and monitor practice, alongside ongoing support for practitioners from managers and workplace supervisors.

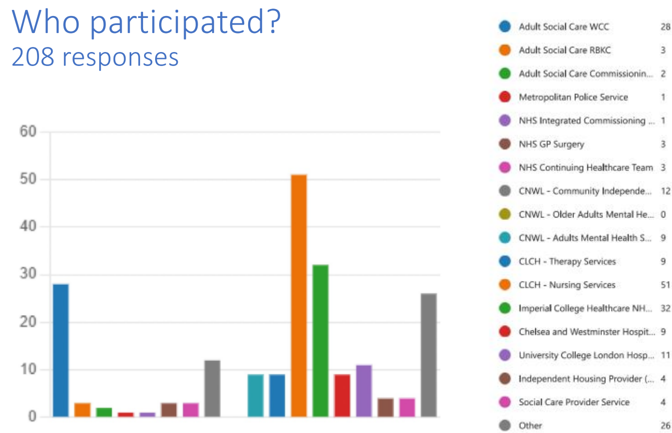
7. THE PRACTITIONER QUESTIONNAIRE

7.1 The final element of learning from the diverse approaches used in this thematic SAR is that arising from the practitioner survey. The questionnaire invited practitioners' views on a range of fire safety questions. The template was sent to agencies across the partnership, with decisions on how it would be further distributed to staff in those agencies left to the discretion of the agencies themselves, in order to allow for the diverse structures and staffing patterns in place. This section reports on the findings emerging from the 208 responses received.

7.2 It is perhaps this mode of distribution that resulted in very different levels of participation, with the highest number of responses received from CLCH nursing services. There were multiple responses also from WCC ASC, ICHT and Central & North West London NHS Foundation Trust (CNWL). At the opposite end of the spectrum, only four responses were received from social care provider services, the same number from independent housing providers, 3 from the RBKC ASC and one from the Metropolitan Police (Figure 1 below).

7.3 Without knowing exactly how many staff were invited to respond, too much should not be read into these figures. It is important to note, however, that the survey results cannot be claimed as representative or comprehensive in any way. At best they provide a snapshot of some practitioners' knowledge and awareness of fire safety and by doing so they identify some important themes to inform thinking on how levels of understanding and application in practice can be further developed.

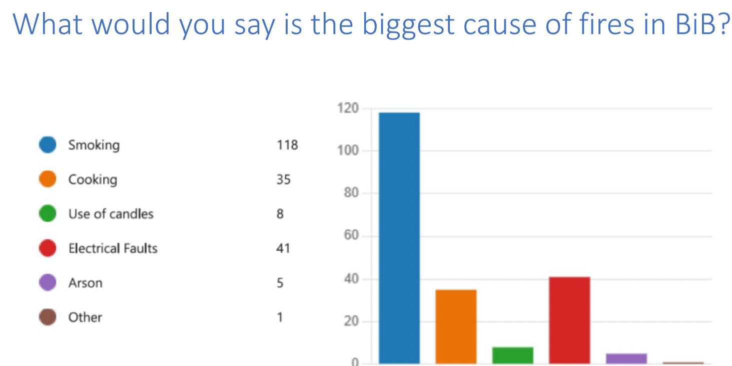
Figure 1



The 'other category included LAS, specialist teams in CNWL, further homecare provider services, RBKC housing, Community Learning Disability specialist services and Age UK.

7.4 Of those who responded, 57% identified smoking as the biggest cause of fires in the Bi-Borough, exceeding by some margin those who identified electrical faults (20%) and cooking (17%) as the biggest cause (Figure 2 below). In actuality, the biggest cause of fires is indeed smoking, but the following two causes are reversed, cooking being the second most frequent and overloaded electrical sockets the third:

Figure 2

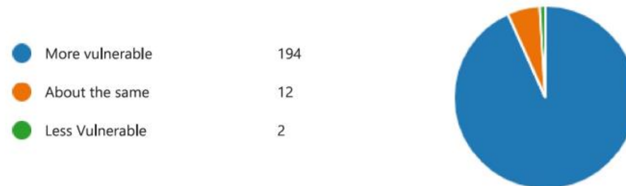


The answer given in the 'other' category was 'a combination'

7.5 Almost all respondents (93%) identified that people with care and support needs would be at greater risk of injury or death in a fire than those without such needs (Figure 3 below). The reasons given included the potential for less understanding of risk and /or ability to respond to it, reduced perception of fire having broken out, limited mobility, support needs and poor mental health.

Figure 3

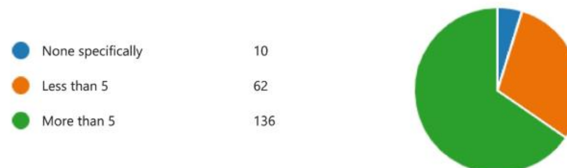
How would the vulnerability to injury or death of a person with care and support needs compare with the vulnerability of a person without those needs?



7.6 A large number of respondents (65%) could identify more than five specific sources of fire risk for someone with care support needs (Figure 4 below). Commonly mentioned were electrical sockets, appliances and faults, open fires, heaters, cooking, bathing, smoking, hoarding, candles, emollient creams, home oxygen, use of materials that are not fire-retardant, poor mobility and memory issues. While some of these clearly apply across the population, the impact is potentially increased by the person's care and support needs.

Figure 4

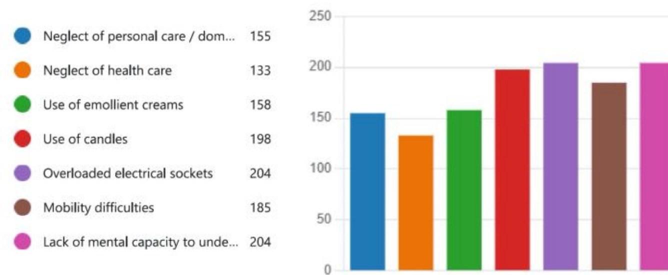
How many specific sources of fire risk can you identify for someone with care and support needs?



7.7 There was widespread recognition of features in the lives of people with care and support needs that could present a heightened risk of fire, with 98% of respondents recognising heightened risk from both overloaded electrical sockets and absence of mental capacity to keep themselves safe. Use of candles was recognized by 95%, mobility difficulties by 89%, use of emollient creams by 76%, neglect of personal care or the domestic environment by 75% and neglect of healthcare by 64%. This does indicate a need to refresh understanding of how common practices (such as the use of emollient creams) or common domestic circumstances (such as hoarding) by their very nature present a heightened risk of fire and/or of negative consequences from fire.

Figure 5

Do you think any of the following present a heightened fire risk?



7.8 Practitioners identified the likelihood of them taking a range of further actions in respect of fire risks they might identify (Figure 6 below). The most likely action was to talk to the individual and to monitor, closely followed by noting the observation in records, immediately reporting the risk to a supervisor, requesting a home fire safety check by the LFB and warning colleagues. Additional actions proposed were:

- Referral / discussion with another agency - social services, GPs and housing providers.
- A safeguarding referral.
- Contact with family members.
- Update to risk assessment.
- A professionals' meeting/discussion.

Figure 6

How likely are you to take the actions below in respect of any fire risk you identify?

7.9 In terms of tackling risk at the root cause by assisting an individual to stop smoking, 59% of respondents had at some point in their practice offered to refer someone to smoking cessation services (Figure 7).

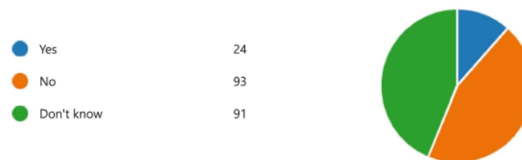
Figure 7

Have you ever offered to refer someone for help to stop smoking?

7.10 The question of whether agencies have the power to stop someone smoking in a supported accommodation or sheltered housing tenancy revealed very diverse views (Figure 8). 44% of respondents simply did not know. 45% believed that it is not possible to stop someone smoking, whereas 12% believed that it was possible.

Figure 8

Are you able to restrict or stop someone smoking in a sheltered housing or supported accommodation tenancy?

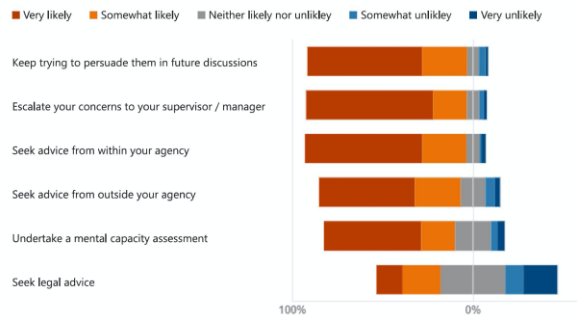


There were concerns here about invasion of privacy but also about risk to others. Key factors were thought to be the need for consent, the relevance of mental capacity, the nature of the tenancy agreement, the provision of designated smoking areas, whether restriction could be applied in public spaces and the need for additional risk management strategies.

7.11 Faced with the question of what to do when an individual does not engage with fire prevention measures, escalation to a supervisor or manager was named as a very likely action by the highest number of respondents, closely followed by persevering with persuasion to the individual, seeking advice from within the agency, undertaking a mental capacity assessment and seeking advice outside the agency (Figure 9). Respondents thought they were much less likely to seek legal advice.

Figure 9

If a person does not engage with fire prevention measures, what would you do?



Additional actions proposed included the provision of additional smoking advice and discussion of potential risk outcomes, attention to fire prevention and safety measures to ensure good working order, discussion with family or friends, escalation to housing, social services, GP, safeguarding or environmental health, specialist fire and rescue advice on additional risk mitigation measures, mental capacity assessment, multidisciplinary meeting, use of a yellow/red carding system in relation to adherence to rules, increased care and support with fire safety written into the support plan, legal advice and clear records of discussions and decisions.

7.12 Testing the extent to which LFB's HFSVs had been requested, respondents were asked to identify whether they had ever made such a referral and, if so, how they had made it (Figure 10). Slightly less than half the respondents (48%) had made a referral to LFB, with use of a referral form or a phone call the most common ways of making the request. A lack of feedback on the outcome of visits was noted.

Figure 10

Home fire safety checks

Have you ever made a referral to London Fire Brigade for a home fire safety check?

Yes	100
No	108

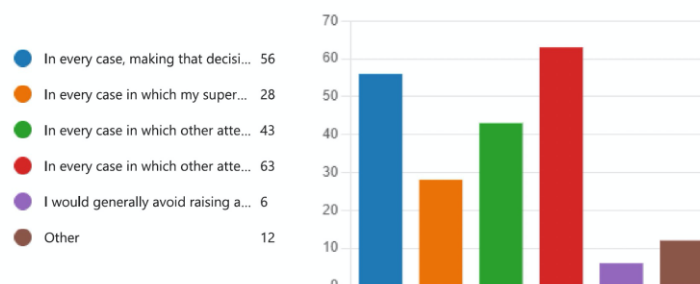
If so, how did you make that referral?

Phone call	28
Written referral form	38
Request raised through your su...	7
Other	36

7.13 In relation to raising safeguarding referrals on fire safety, this was by no means a commonly pursued action. The most likely circumstances in which a safeguarding referral would be made were those in which other attempts to keep the person safe had failed, but even here only 30% of respondents would pursue this. 27% indicated that they would make a safeguarding referral in every case, with a further 21% saying they would refer in every case in which other attempts to keep the person safe had failed. A number of

respondents indicated that supervisor approval of the referral would be required before they could make it.

Figure 11

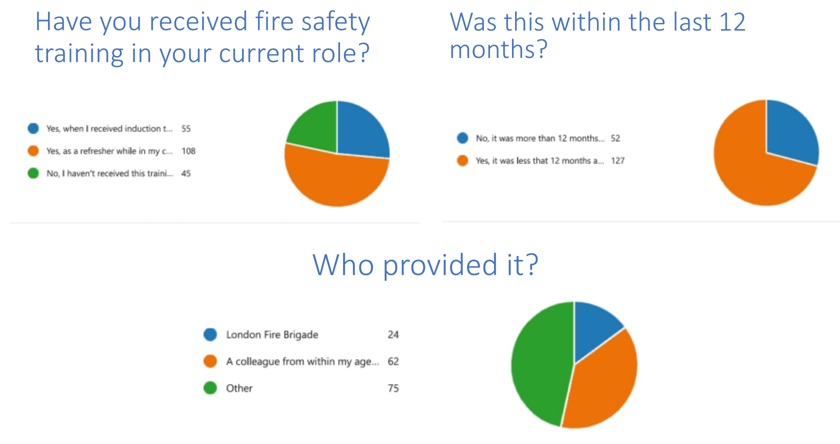


Answers to the ‘other category included calls for clarification on when referral would be warranted, referral where risk is significant and the manager disagreed with the referral, discussion with adult social care, discussion with safeguarding team, discussion with agency safeguarding lead, where warranted by reasons for non-engagement, if there is self-neglect or neglect of others, if they lack capacity.

Additional comments on the use of safeguarding included reference to a lack of safeguarding response if the individual has capacity. Respondents called for more guidance on fire risk response routes – whether a safeguarding pathway, a self-neglect and hoarding pathway or other avenue was advised. Greater visibility of fire officers, engaging with staff and residents, was thought to be helpful in promoting awareness among tenants/residents. The inclusion of gas safety measures in thinking on risk was believed important, as were clearer guidelines on PEEPs / stay-put guidance, and how to weigh the public interest concern of risk to others. There were calls for a fire risk protocol to be devised, backed by a fire risk forum that could be convened for discussion of challenging cases.

7.14 Finally, respondents were asked about their fire safety training (Figure 12). Over three-quarters (78%) had received training in their current role, either at induction or as a refresher, with this being within the last 12 months for 61%. But almost a quarter of respondents (22%) had not received fire safety training in their current role. For only 12% had the training been provided by the LFB; a colleague within their agency was by far the most common provider (30%), but it is clear that a range of providers had been involved, with 36% indicating ‘other’ as the source of the training. E-learning pursued on an individual basis was by far the most common mode of delivery (47%). Adding e-learning as a group to this figure shows the strong reliance on e-learning, which accounts for 62% of the training experiences reported.

Figure 12



Answers in the 'other' category included a variety of online providers, the employer, the agency's fire officer, trainers from outside the organisation.

Answers in the 'other' category included online, e-learning and face-to-face.

Additional comments on training expand this picture. Respondents commonly reported that fire safety training in NHS trusts covers only safety in the office/clinic/hospital and does not consider fire safety in the patient's own home. This was also a concern expressed in the audit, as previously noted. Given the high numbers of health-based respondents in the survey, this potentially significantly reduces the number of respondents who have received home fire safety training.

In terms of mode of delivery, reliance on e-learning was not popular. It was commonly described as less effective than in-person sessions, where questions could be asked, and clarifications sought. Real-life case examples were favoured, with respondents calling for greater inclusion of these in the training received. Also advocated for inclusion was information on further resources that can be accessed and on referral pathways for further assessment of individuals about whom concerns remain unresolved.

8. THE LEARNING EVENT

8.1 The SAEB and the reviewers invited practitioners and managers from a number of key agencies across the partnership to attend an online event. Attendees included senior leaders from senior management and commissioning, operational managers and practitioners with experience from the front line. The aim was to carry out a 'temperature check' on the strengths and weaknesses of fire risk management practice across the organisational layers and to ensure that priorities for change have the commitment of all those on whom their success will depend.

8.2 There were 115 attendees, including 50 from local authorities (split almost equally between WCC and RBKC), 47 from the NHS (including CNWL, CLCH, ICHT, Royal Brompton & Harefield and West London Trusts and North West London ICB) and 18 from other agencies (including NHG, the Metropolitan Police, LFB, LDN London and Octavia Trust).

8.3 Participants received a briefing to read prior to the event, including an outline of the rationale for the SAR, the approach being taken, and the chronologies relating to the two individuals Mr C and Mr D. At the start of the event, the reviewers shared some of the early themes emerging from review of those two cases, and also presented summary findings from returns of the agency audit and the practitioner questionnaire. There then followed a series of facilitated discussions on two key aspects of fire risk management in Bi-Borough:

- What is working well, and what makes that possible?
- What still needs to be improved, and what gets in the way?

Discussion group 1: A selected number of practitioners and operational leads, drawn from across the agencies, participated in a facilitated discussion of what helps and what hinders fire risk management in their experience. All other participants observed the discussion and used the online chat facility to enter their own contributions and comments.

Discussion group 2: Senior leaders, strategic managers and commissioners participated in a facilitated discussion reflecting on what they had heard and identified what priority actions could be taken to remove the obstacles to good practice. All other participants observed the discussion and used the online chat facility to enter their own contributions and comments.

Discussion group 3: All participants joined break-out rooms for a short, reflective discussion on what they have heard, facilitated by members of the SAR panel, who then gave feedback to the whole group and submitted their notes to the reviewers.

8.4 Those attending, whether as practitioners or as operational/strategic managers, were not asked to comment directly or answer questions specifically on their own involvement in the fatal fire cases. The focus was instead on what, at a more general level, their experience of working with fire risk enabled them to say about the facilitators and barriers to the achievement of positive outcomes.

8.5 Discussion group 1: Practitioners and operational managers

8.5.1 Practitioners in discussion group 1 acknowledged that the seriousness of what had occurred in the fatal fires had prompted much reflection and that there had been a

collective willingness to seek improvements. Although some had already been implemented, there remained a long way still to go.

8.5.2 In terms of what was working well, there had been an increase in guidance and communications on fire safety and a growing awareness of its importance. There were some good working relationships between agencies, including with Telecare, and better understanding of who to contact to seek help. ASC practitioners could send a referral email to LFB via a form in their Mosaic record system, which could then be uploaded to the case record. A mandatory risk assessment form in Mosaic had helped to develop a culture of identifying risk, and practitioners had developed skills in asking difficult questions about smoking or use of candles. Other agencies too were amending templates to embed smoking assessments.

8.5.3 In terms of the need for improvements, some practitioners felt that more confidence was still needed in asking difficult questions without appearing to challenge or interfere. It was thought that more detailed prompts were needed on assessment templates in order to support practitioners with the questions to be asked – for example, whether the individual was able to react to a fire alert. Flags or markers on records where fire risk had been identified were suggested. There was a view that although staff knew to refer to LFB, feedback on the outcome of referrals – for example the nature of the advice given – was lacking. From a provider perspective there were calls for better communication with them on the outcomes of risk assessment and referrals to LFB. If feedback is given, it is given verbally, without written record. The potential for duplication and gaps in referrals to LFB was of concern, with a view that strong, undivided responsibility was important. Information-sharing was a theme expressed by others too, with suggestions for creation of a standard template to be used to notify fire risk and management measures to all involved, including GP surgeries, housing support and specialist teams such as alcohol services.

8.5.4 Practitioners felt they needed better understanding of what options exist for alternative fire prevention measures where the individual declines a home fire safety visit referral, raising the difficulty of knowing what could be done if risk remains unmitigated.

8.6 Discussion group 2: Senior leaders

8.6.1 Senior leaders recognised that barriers to best practice in fire safety remain. In relation to hospital discharge processes, hospital-based staff do not always know who among community agencies is involved with an individual. They would tend to use the GP as a key point of contact, but the GP surgery may not have up to date information or be aware of the individual's circumstances in the community. They emphasised the importance of early notification to ASC when an individual is admitted and of better coordination of discharge pathways. Social workers in the hospital context do not routinely undertake home visits and often experience difficulties making onward referrals into the community before the patient goes home. Rapid sharing of care plans should take place within 72 hours of discharge. Linking with key contacts and effective communication was key and there was recognition that community-based agencies, including LFB, could more routinely be invited to discharge meetings. Strengthening multidisciplinary relationships was a key priority, with a suggestion that learning could be transferred from responses to discharge during the Covid-19 pandemic, where things were seen as having worked well. The absence of feedback from LFB on the outcomes of home fire safety visits was seen as a real gap – LFB needed to be a more central player in multidisciplinary teamwork around individuals living in high-risk fire safety circumstances.

8.6.2 There was also discussion about the content of fire risk training, which in hospitals does not cover fire risk in domestic premises, even though community-based staff attend. More broadly on training, there was a need to broaden the focus, moving beyond identifying risk to enable better understanding of the context.

8.6.3 There was recognition, however, of the pressures that staff are under in the context of hospital discharge and a concern to ensure that managers are not expecting staff to take on a level of responsibility that they should not have. What is it legitimate to expect them to observe and act upon?

8.6.4 Risk to others in areas of multioccupancy housing was recognised as an important consideration.

8.6.5 In relation to mental capacity, there was thought to be a gap in the legal framework between individuals' rights and the provisions of the MCA. It was important to recognise the importance of the individual's lived experience and of the place that smoking has in their life – it may be one remaining pleasure. It was suggested that assessing mental capacity in the context of the individual managing fire risk from smoking should be a focus in MCA training.

8.6.6 There was recognition that system changes were needed to support standardised, consistent approaches to fire risk. Fragmented commissioning was thought to be a problem. Participants also discussed the need to strengthen the monitoring of improvement actions in order to gather evidence on their impact.

8.7 Breakout room discussions

8.7.1 Discussion in the breakout rooms gave participants the chance to consider whether the material presented and the views expressed in the two facilitated discussions reflected their own experiences.

8.7.2 Participants broadly recognised the issues that had emerged from analysis of the two cases – the risks and shortcomings identified were familiar, and it was felt they indicated a need for ongoing training for all staff. Particular reference was made to the fact that existing training in some agencies addresses only fire safety in the workplace building rather than in domestic environments. A call was made for a bespoke fire safety training package to be designed, for use by all agencies, featuring the key learning that needs to be conveyed – some of which is identified below. It was thought important that any agency that does not currently provide training to their staff should do so.

8.7.3 Some of the discussion groups acknowledged the tension between the need to respect the autonomy of someone who wishes to smoke, on the one hand, and the need to protect them and others from negative consequences of fire, on the other. The lifestyle choice of those receiving care and support was considered important, but equally it was thought that risk to others should have a higher profile in assessment.

8.7.4 Some practitioners (for example those in mental health services) observed that fire risk thinking is not embedded fully enough in their daily thinking or practice. There was mention also of the need for fire risk to be more routinely considered as part of care and support assessment/planning and carers' assessments. More focus on case studies in training was called for, so that the skills of practice in relation to assessment and management of fire risk could be rehearsed.

8.7.5 There was felt to be a need for greater clarity about pathways through which staff should raise concerns about safety from fire risk – there was some feeling that safeguarding may not be the right pathway if the concerns were not explicitly seen as arising from abuse and neglect. In addition, it was thought that the boundary between the safeguarding pathway (under section 42 of the Care Act) and the self-neglect pathway was not well understood, nor was it clear at what point the self-neglect pathway could or should trigger a safeguarding response. At the same time, there were calls for guidance on how information could and should be shared across agencies – when an agency becomes involved, it is not always clear to practitioners what has already taken place through other agencies. One proposal was for a Fire Risk Panel to be created, similar to the Hoarding Panel, to consider high-risk cases.

8.7.6 The need for more confidence in the processes and timescales for fire risk assessment and equipment provision was raised, as well as for better understanding of what might constitute a full safety check as opposed to risk-reduction actions they could themselves take. The pressures on hospital discharge timings made this an important consideration. It was thought vital to have a single discharge coordinator who could liaise with all agencies involved.

8.7.7 District nursing staff called for more training for junior nursing staff, along with a process for triggering reassessment when new needs or risks arise. Currently this was thought not to be embedded in practice. They commented too that they are not always aware that a person they are visiting is at fire risk as a result of smoking and called for use of a common record template across agencies on which this information could be recorded and more easily shared. Care workers too were not always aware of what fire risk assessment had taken place or what risk-management measures were in place. Concerns about communication channels and information-sharing were commonly expressed, recognising the difficulties posed when agencies did not have access to each other's information about risk. Here it was noted that the outcomes of fire safety home visit by the LFB were not always shared with other agencies. Housing providers were seen as key participants in multiagency collaboration – it was felt that they sometimes missed out on discussions relating to individuals, but equally that it can at times be difficult to secure their engagement.

8.7.8 Professional curiosity about fire risk was believed to be vital for practitioners from all agencies. This would mean not assuming that someone else has asked those questions but asking them oneself, regardless of primary agency function and professional role. These were recognised as difficult conversations and there was some uncertainty about whose responsibility they were. As in discussion group 1 (practitioners and operational managers), there was a perception that agencies relied on ASC to come up with a solution – an expectation that social workers should have all the knowledge and are to blame if something goes wrong, even though they would not see themselves as expert in this area. OTs were seen as well placed to look at environmental hazards, but it was noted that staff shortages were particularly acute here and impacted on availability for assessments. More broadly, however, some consensus emerged that these difficult conversations should be seen as the responsibility of each and every practitioner involved. Practical measures were also seen as important: care workers not just observing that smoke alarms are in place but checking their function by pressing the test button; practitioners having greater awareness of fire safety equipment that is available. There was a suggestion that those

responsible for commissioning services that go into people's homes, including NHS services, could more explicitly build fire safety training requirements into contracts.

8.7.9 There appeared to be some difficulty for some care providers in accessing electronic systems required for fire safety measures to be implemented.

8.7.10 Mental capacity was recognised as a pivotal consideration in determining what risk management measures could or should be put in place. Participants called for better understanding of executive function, why and how it could be damaged and what the consequences for decision-making were likely to be. Equally, there were concerns that even the basics of capacity assessment were not being well addressed, and suggestions that fear of getting it wrong could explain why sometimes practitioners don't engage with the need for assessment. Additionally, there were calls for greater clarity on what measures could lawfully be taken when someone assessed as having mental capacity on specific decisions related to smoking refuses to recognise or to manage the risks. It was seen as vital to grapple with the complexities of mental capacity and important to make assessments as multidisciplinary as possible.

8.7.11 Finally, it was believed there should be some recognition that it may not be possible to mitigate all risk of fire – that risk may remain even when it is recognised and shared, and all possible mitigations have been implemented.

9. CONCLUSIONS

9.1 Amid all the efforts made to meet Mr C's and Mr D's needs, there was one glaring omission – attention to fire safety. Even when risks from smoking were noted, this did not lead to appropriate action, particularly following their discharges from hospital with severely impaired mobility and dexterity. It is hard to know whether this omission resulted from lack of knowledge and awareness in the practitioners involved, or from a reluctance to stray beyond what they understood their professional role to be, or a reluctance to engage Mr C or Mr D in difficult discussions, or failure to recognise the significance of mental capacity, or a belief that nothing could be done to curtail autonomy. It was, however, a collective omission that ran across a number of agencies. Other layers of the system are likely to be playing a significant part also: failures of information-sharing between agencies, an absence of training in fire risk management, a missing step in hospital discharge processes, an absence of triggers on assessment proformas and templates to prompt engagement by staff with the challenge of addressing the risk.

9.2 Thus, the way forward cannot be confined to calls for improved and more widely available training – important though training is in giving staff key information with which to build their awareness and understanding. It is at the organisational and interagency levels that systems change is needed to ensure that staff are able to transfer their learning from training into their daily practice: supervision, assessment, pathway processes. IT systems can play a part – for example making it impossible to complete an electronic record without entering data about fire risk or promoting information-sharing through shared access.

9.3 Equally it is about establishing a culture of shared ownership. Fire safety is not confined to any one agency, it has to be embedded across all agencies, overcoming any profession-based or agency-based assumptions about where roles begin and end, and pushing for collective responsibility.

9.4 Assessment under the MCA 2005 should be a much more routine step in practice where an individual is placing themselves at high risk of serious injury or possible death. That neither Mr C nor Mr D underwent capacity assessment is a glaring and serious omission. Sustained development work is required here to ensure that mental capacity receives full attention across all agencies.

9.5 Looking more broadly at the learning from the audit, practitioner questionnaire and learning event, at which the focus was less on the two cases and much more on how fire safety is being pursued across a range of agencies, a number of key findings emerge. At the level of direct practice, these relate to practitioners' knowledge, skills and confidence in fire safety, and their ability to place fire safety in a prominent position in the context of what they see their professional role to be. Put succinctly, home fire safety must be everyone's business. Awareness of the different sources of fire risk and skills in expressing concerned curiosity are important here. As summarized at the learning event, practice should be characterised by "see, think, act." So too is the inclusion of executive functioning in mental capacity assessments and in risk and care and support assessments also – "show me" or "demonstrate" should be the approach adopted. Reliance should not be placed simply on what a person says.

9.6 At the organisational and interagency levels, the findings relate to how the structures, systems, policies, guidance and governance methods that agencies have in place are able to promote and evidence best practice in fire safety. Focusing firstly on how agencies work together, the use of multi-agency risk management meetings, especially at points of transition such as hospital discharge or deteriorating physical health, is a core component of best practice, building a team around the person and wrap-around care and support. A priority that emerged during the concluding part of the learning event was the importance of managing risk collaboratively. One of the priorities identified by participants when summing up the learning event was greater use of joint visits with the LFB. All decisions and referrals, and their outcomes, should be recorded.

9.7 Access to legal advice and to supervision will be important, especially when practitioners are having to consider how to balance one person's right to private and family life against another person's equivalent right, or a person's right to private and family life against a right to life.

9.8 At the organisational level, supervision and management oversight, especially of complex and challenging cases, is essential. However, this will be more effective when those involved are acting within clear frameworks for best practice. This will include assessment templates, co-produced with LFB, that offer practical guidance, the questions to ask: "show me where …" and "show me how …" It will include clear guidance about the pathways to follow, when to refer adult safeguarding concerns to the local authority, when to request home fire safety visits from LFB, and when to activate a panel meeting.

9.9 The audit and the questionnaire clearly identified the importance of training and the types of training being offered. Some respondents to the audit were able to identify the take-up of initial and refresher training accessed by their staff. However, not all agencies had been able to record the number of their staff accessing training, especially e-learning, and concerns were expressed both about the reliance on e-modules and about the focus of the learning offered. A greater focus on home fire safety training was requested by those whose training does not currently include this. It was also suggested, in concluding remarks from discussion groups at the learning event, that LFB could have a more

prominent role still in the provision of home fire safety training across all services, and that the focus should be extended by the Board to registered social landlords and housing practitioners.

9.10 The audit especially revealed a clear commitment to the provision of training and the questionnaire offered some evidence of its impact. This commitment to workforce development must be accompanied by a focus on workplace development, seeking to ensure that the context for practice enables best practice. The Board also has a mandate to seek assurance about the impact of training on practice through, for example, audits of home fire safety and adult safeguarding concern referrals. Revisiting home fire safety in subsequent learning events, enabling a renewed appreciative enquiry and temperature check, might provide some further assurance that the learning from this thematic review has resulted in practice development and service improvement.

10. COMPARATIVE SAR ANALYSIS

10.1 Other SARs have highlighted similar themes to the findings identified in this thematic review. Picking up one concern identified in the audit questionnaire responses – that of a lack of awareness and understanding of fire risks in the home - other SARs have identified this also[10]. Reflecting on key findings from review of Mr C's and Mr D's circumstances – concern about the adequacy of risk assessments - the importance of ensuring that these are completed collaboratively, shared and reviewed when there are changes in a person's circumstances has been identified elsewhere also[11]. Related to this is the importance of updating care plans following home fire safety visits and risk assessments, with explicit reference to recommendations and responsibility for care coordination following these visits and assessments[12].

10.2 Some SARs remind practitioners to assess the suitability of a person's accommodation when there has been a change in their health and wellbeing and an increase in the likelihood and significance of risk, including of fire[13]. They remind practitioners and managers to consider the impact of excessive alcohol consumption[14], and to ensure communication with family members and friends who are offering care and support[15].

10.3 A common finding relates to the absence of multi-agency risk management meetings and a multi-agency safeguarding response[16]. Such meetings are particularly useful when a person might refuse a home fire safety visit but where another service, acting on advice from fire service colleagues, might be able to assess fire risks and able to engage in conversation with the person about options to mitigate the observed risks[17]. Such meetings

[10] For example, SAR Harry (2022) Waltham Forest SAB; Fire Task and Finish Group Report (2022) Sutton SAB.
[11] For example, SAR Harry (2022) Waltham Forest; SAR EF (2021) City of London and Hackney SAB; SAR WWF (2017) Wandsworth SAB.
[12] For example, SAR EE (2019) Sutton SAB; SAR EF (2021) City of London and Hackney.
[13] For example, SAR EF (2021) City of London and Hackney SAB; SAR Harry (2022) Waltham Forest SAB; SAR EE (2019) Sutton SAB.
[14] SAR Harry (2022) Waltham Forest SAB.
[15] SAR EF (2021) City of London and Hackney SAB.
[16] SAR Harry (2022) Waltham Forest SAB; SAR EF (2021) City of London and Hackney SAB; SAR EE (2019) Sutton SAB.
[17] Fire Task and Finish Group Report (2022) Sutton SAB.

are also indicated where there is a risk not just to one individual but also to others living in close proximity[18].

10.4 There are reminders in SARs that work to assess and mitigate risk is often long-term and requires the building up of relationships of trust and continuity[19]. The work also requires legal literacy in terms of ensuring that one person's Article 8 rights (the right to private and family life) are balanced against the same rights of other people living in close proximity, and that Article 8 rights are weighed in the balance with Article 2 rights (the right to life)[20]. Such legal literacy might require practitioners to challenge the individuals with whom they are working with respect to their recognition of fire risk. The need to assess mental capacity is also potentially engaged here, with a particular focus on executive functioning - whether the person is able to use and weigh relevant information about risk and safety in the moment.

10.5 Recommendations in the SARs referenced here include the need to build awareness and to improve pathways for responding to fire risk. They include the need to enhance and embed awareness of guidance, and to scrutinise landlord responses to ensure home fire safety. They also include the need to embed HFSVs in hospital discharge planning and person-centred assessments, and risks from smoking in training on mental capacity assessments.

10.6 Finally, SARs have occasionally pointed out the limitations within the Regulatory Reform (Fire Safety) Order 2005 in relation to fire safety within private dwellings and suggested that this concern should be raised regionally and nationally[21].

11. CHANGES ALREADY IMPLEMENTED BY AGENCIES

Agencies rightly have not waited to make changes and have provided information to this review on those developments.

11.1 Adult Social Care (ASC)

11.1.1 ASC have worked jointly with the LFB to design and deliver bespoke training sessions held between September to December 2020 to 91% of staff across the Bi-Borough. Since then, mandatory fire safety awareness training has been delivered via an e-learning package owned and managed by LFB.

11.1.2 ASC have also supported more awareness raising amongst staff including dissemination of SAEB learning briefings on fire risks and use of telecare and use of emollient creams.

11.1.3 Funding was secured to support the free installation of telecare-enabled smoke detection systems for residents in Kensington and Chelsea, in alignment with the policy for Westminster residents.

[18] SAR WWF (2017) Wandsworth SAB.
[19] SAR EF (2021) City of London and Hackney SAB; Fire Task and Finish Group Report (2022) Sutton SAB.
[20] SAR WWF (2017) Wandsworth SAB.
[21] For example, Fire Task and Finish Group Report (2022) Sutton SAB.

11.1.4 A number of updates have been made to the ASC assessment templates used by community and hospital social work teams. These have included changes to the ASC information database, Mosaic, to:

- Build mandatory prompt questions regarding fire and smoking risks into all FACE overview assessment, review and care and support plan templates.
- Implement a mandatory fire risk safety checklist from February 2023, as an additional tool to support routine consideration of fire and smoking risks in all cases and to ensure enhanced consideration is given to making home fire safety visit referrals to LFB.

11.1.5 The D2A form to support hospital discharge arrangements during Covid, introduced in August 2020, included the same prompts around fire risks. From September 2022 the D2A process has ended with a return to business as usual via use of the FACE Overview form and work has also been completed to ensure the referral form from the hospital team to reablement services includes information about fire risk assessment.

11.1.6 The ASC Hospital Discharge team have been working with partners in the discharge system (NHS Trusts and community partners Home First CNWL and Reablement) since February 2022 with the aim of developing an improved model of discharge for people going home from hospital. The aim of the model is to promote a single pathway out of the Tri-Borough hospitals for all residents with new or increased care. This has supported work to ensure that the coordination function that sits within the hospital hub completes the comprehensive checklist that includes fire risks. There is a new discharge planning tool, which is being trialled, which makes it incumbent on the social worker to consider specific areas of risk and ensure information is shared consistently with other agencies involved in the discharge. The proposed model also involves a post discharge assessment and triage function within 72 hours of discharge at the adult's home. It will mean greater oversight of risks at home for those adults with complex needs.

11.1.7 Quality assurance work took place in 2022 to analyse the data regarding the number of referrals ASC have made to LFB requesting a HFSV. This has included audit activity to dip sample a number of cases to check that referrals are followed-up between the ASC worker and LFB. As continuous improvement, a schedule of audit activity in this area is planned for 2023.

11.2 London Fire Brigade (LFB)

11.2.1 Training has been delivered to ASC in both RBKC and WCC and 91% of ASC staff are confirmed to have received the training; this equates to over 350 people. The training is to be shared with private care homes and associated providers.

11.2.2 In reporting their involvement in the fatal fire to the CQC and the local authority, LFB provided recommendations for immediate or follow-up actions that they considered were required.

11.2.3 A post incident visit was completed by the Westminster high-rise task force to review PEEPs for smokers and residents with mobility issues and make referral to the Westminster fire safety manager for consultation on supplying misting units to residents where such units were identified as necessary.

11.2.4 During a Fire Safety Inspection following the incident involving Mr C, it was noted that smoke detection and audible warning devices were present in both the residential areas and the common areas, which is not compatible with the unit's 'stay put' fire

evacuation policy. (An alarm sounding in all residential flats could encourage residents to self-evacuate placing them at risk). Works were scheduled to remedy this during 2021.

11.3 Notting Hill Genesis

11.3.1 At the time of Mr C's death, PCFRAs and Support Plans were reviewed annually, or in the event of a change of circumstances. This has now been revised down to a period no longer than six months for tenants who both smoke and use emollient creams, or after a change of circumstances such as hospital discharge.

11.3.2 Immediately following Mr C's death, learning was shared across all NHG extra care services. An action plan was implemented, to include:

- An internal quality assurance project to review all processes that ensure high quality care and enable it to be evidenced. New and improved processes have now been implemented across all NHG extra care services.
- A high fire risk register for care and support services was created and is reviewed bi-monthly by the Regional Business Manager and Extra Care Manager. This is then reviewed by the Assistant Director for Care and Support who reports to the Director of Care and Support on key risks and mitigations.
- A monthly audit was started of all actions related to high fire risk customers.
- PCFRAs and PEEPs were reviewed for all customers, resulting in the provision of fire blankets, provision of misting towers for three customers, encouragement to smokers to use lighters/appropriate technology, LFB visits for all high-risk tenants and provision of fire-retardant bedding, smoking aprons (use of which is monitored and recorded in the handover checklist), updating of the PCFRA form to include risk of incontinence aids and storage, no smoking signs put on bedroom doors to remind them, increased fire safety information discussed with customers in a range of formats.
- The handover form has been enhanced to record completion of fire safety actions e.g., when laundry is completed, ash trays emptied, bins emptied.
- Floorplans have been updated to include specific details of tasks staff are expected to undertake during individual care calls.
- The medication changes book is updated on the day of the change by the Care Coordinator, identifying any changes to prescribed creams.
- Enhanced laundry records monitor laundry tasks and laundry is increased to twice per week to prevent cream build up.
- Post hospital discharge, any changes to risk or care needs are updated within support plans and risk assessment.
- The extra care housing scheme where Mr C lived has followed up with ASC to get the most up to date care plan and to ensure that smoking and other high risks are highlighted in those plans.
- The hosing scheme has also followed up with ASC if there is any question about an individual's capacity to understand the fire risks to ensure that capacity assessment is completed.
- Regular checks take place, including weekly walk-around site checks involving four flat visits to high-risk customers who are smokers, all smokers' pull cords checked weekly and records kept, four spot checks per week made by senior staff, two service-based file audits every month.
- Fire safety training has been reviewed to include the risks from emollient creams.
- Regular requests to GPs are made to prescribe lower risk emollient creams.

- A Fire Safety Workshop has been held with senior care staff and housing staff across extra care services and separate workshops on fire safety have been delivered to front line staff (including housing staff).
- Workshops have been held with senior staff to confirm changed control measures and ensure that all key learning is disseminated to drive quality going forward.
- Fire scenario workshops have been held with front line care staff, the senior team and housing staff.
- Escalation is made to ASC when tenants refuse to follow fire safety actions.

12. RECOMMENDATIONS

The recommendations arising from the learning in this thematic review have been co-produced with the SAR panel members who have supported the review throughout. It is recommended that the SAEB takes action to:

12.1 Review essential content of training on home fire safety and the balance between e-learning and other modes of delivery.

12.2 Use the practitioner questionnaire regularly to track training transfer, the impact and outcomes of single service and multi-agency training on home fire safety.

12.3 Collect case studies of good practice and outcomes relating to prevention and/or mitigation of fire risk for use in training.

12.4 Engage with private and social landlords to raise awareness of home fire safety and of adult safeguarding, for example by ensuring that they are included in training offers and familiar with pathways into multi-agency meetings.

12.5 Review the availability of risk assessment tools and templates across all agencies to seek assurance that the risks of fire are foregrounded.

12.6 Seek assurance that all care and support, rehabilitation and hospital discharge assessment and review documentation profiles risks associated with fire and requires practitioners to complete these sections.

12.7 Strengthen available guidance for practitioners and providers on the importance of expressing concerned curiosity with patients/service users on smoking and other fire-related risks in order to determine how to balance the right to private and family life with the right to life, and respect for autonomy with prevention and safety. While the balance to be struck will be unique to each individual case, guidance on the *process* of decision-making would be helpful in order to support practitioners and providers in reaching defensible decisions in individual cases. In addition, guidance for housing providers on the extent of their powers to restrict smoking will be valuable.

12.8 Strengthen guidance on mental capacity assessment with specific focus on including executive function when focusing on a person’s ability to understand, retain and use or weigh information about fire risk and action to stay safe in the moment of smoking.

12.9 Work with partner agencies on information-sharing at key points of transition (such as hospital discharge and changes in physical capabilities). This requires robust communication channels that can access information from the different recording systems in use across agencies. It also requires work to strengthen the validity of assessment data

shared from one context (for example hospital) in the context to which the individual is transferring (for example the home environment). The goal must be to ensure that practitioners and operational managers have as complete a picture as possible of assessments, risk and what work is necessary to mitigate risk.

12.10 Seek assurance that housing providers and support practitioners are included in multi-disciplinary and multi-agency meetings.

12.11 Engage with LFB on the provision of feedback on the outcomes of referrals for home fire safety visits and on the need for fire safety advice to be provided in writing.

12.12 Establish with partner agencies a fire risk panel or, alternatively, ensure that existing panels include fire risk in their action planning.

12.13 Seek assurance from partner agencies that post-incident support is available to practitioners and operational managers.

12.14 Share the findings of this thematic review with the London SAB and with the London regional network of SAB chairs, to prompt collation of findings from across the London region, with a view to using the pathway for escalation of concerns to the national network for SAB chairs and thence to government departments.

12.15 Track practice change and service development as a result of this thematic review and earlier work on home fire safety and hold annual learning events to complete a temperature check of fire safety practice and identify areas for further work.

Appendix 1: Glossary of acronyms used

ASC	Adult Social Care
CIS	Community Independence Service
CLCH	Central London Community Healthcare NHS Trust
CNWL	Central North West London NHS Foundation Trust
CQC	Care Quality Commission
CRG	Case Review Group
HFSV	Home Fire Safety Visit
ICHT	Imperial College Healthcare NHS Trust
LAS	London Ambulance Service
LeDeR	Learning Disabilities Mortality Review
LFB	London Fire Brigade
MCA	Mental Capacity Act
NHG	Notting Hill Genesis
OT	Occupational Therapist
PCFRA	Person-Centred Fire Risk Assessment
PEEP	Personal Emergency Evacuation Plan
RNKC	Royal Borough of Kensington and Chelsea
SAEB	Safeguarding Adults Executive Board
SAR	Safeguarding Adult Review
WCC	Westminster City Council
WLDP	Westminster Learning Disability Partnership
ULCH	University College London Hospitals NHS Foundation Trust