# Safeguarding Adult Review

# “Liam”

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## 2 Introduction

"Liam", not his real name but the name chosen by the family to personalise documents and reports.

Liam was a 47-year old man, who was described by two of his children as 'an amazing support system', a positive role model and a 'very loving dad'. From a young age, he had been self-sufficient. Even when he became severely disabled and reliant on carers for many aspects of daily living, he maintained a positive outlook on life and valued what independence he had. He was intelligent, motivated and fought for what he believed in.

Sadly, Liam died following a fire in his home in August 2021. The alarm was raised by his neighbour, who heard his screaming. At the time of his death, he had a substantial package of care due to severe mobility issues and health/ social care needs linked to advanced Multiple sclerosis. He resided in rented accommodation and was understood to have capacity in respect of a decision to continue to smoke, though it isn't clear what information he was offered to reduce risk. It is understood that his carers' usual practice was to leave lit tea-lights by his bed to enable him to smoke. The risk that this practice posed was not identified by carers or other professionals and as such ISAB agreed this met the criteria for a mandatory SAR review as an adult with care and support needs died and there were concerns regarding the way in which agencies worked together to reduce the risk of harm.

## 3 Wider context

Tragically there have been numerous SARs into fire deaths nationally[1]. LFB data report that, in 2021 there were 50 fatal fires in London. The factors that influence the chances of a fire casualty becoming a fire fatality are complex. Some of the main contributors include:

- how able the person was to respond to the fire (i.e. were they mobile; were they awake; were they impaired by drugs or alcohol);
- how early the fire is discovered;
- how quickly the brigade is called;
- the materials involved in the fire;
- the size and construction of the room/building;
- the proximity of the victim to the fire;
  as well as the arrival time and response of the brigade.

Most of the people who die in fires are usually over 65, men are slightly more likely to die in fires than women. Around 74% of fires (based on the average over the ten years to 2021) were of accidental motive. Whilst most fires start in a kitchen, these fires are less likely to

[1] The National SAB Chairs repository identifies 40 Safeguarding Adults reviews undertaken between 2019-22 where fire contributed to the harm suffered. Some of these will be thematic reviews, including multiple fire deaths.

be fatal. Most dwelling fires with fatalities happen in a living room, followed by the bedroom. However, in some of these incidents, the living room was also being used as a bedroom. Over the last five years to 2021, bedrooms and living rooms resulted in 32 and 39 percent respectively for all fatal fires in dwellings.

The predominant source of ignition at fires where there is a fire-related casualty is smoking-related. This source of ignition accounts for 27 per cent of all fatal fires, with a further 16 per cent involving matches and candles. The proportions for dwelling fires are similar at 28 per cent, and 16 per cent respectively. The next highest identified source of ignition was naked flame (11 per cent of all fatal fires and 9 per cent of fatal dwelling fires). Heating and cooking equipment accounted for less than ten per cent each as the source of ignition for fires where there are fire related fatalities (including in dwelling fires).

**Chart 12: Fires with fire related deaths in dwelling fires by location of fire start, five year average to 2021**

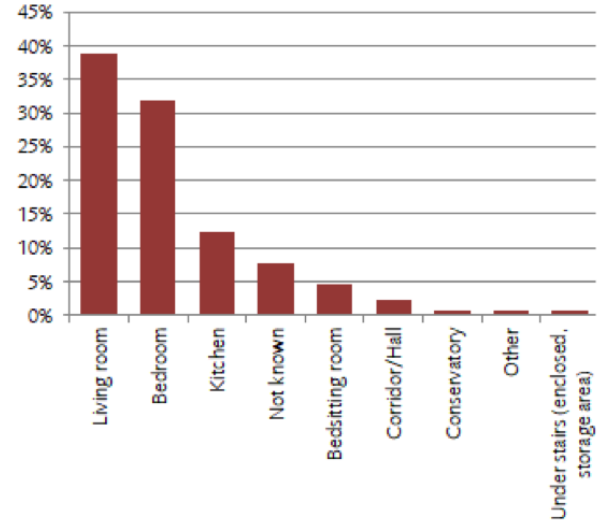
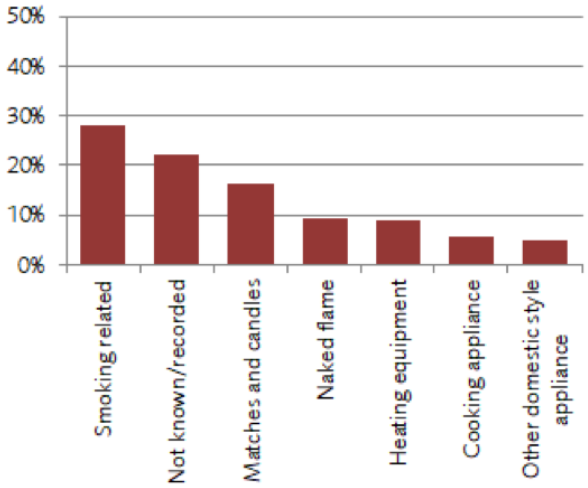



**Chart 13: Top seven source of ignition for fires in dwellings with fire related fatalities, five years to 2021**




Over the last five years, 10 per cent of those who died in fires were aged between 0 to 15 years, 49 per cent of fire fatalities were of people within the 16 to 64 age range, 39 per cent of fatalities were of those aged 65 and over and two per cent were unknown.

The proportion of older people who die in fires is higher than the proportion of that age group within the population for London. Around only 12 per cent of Londoner's are aged 65 and over. [2]

Much is already known about how agencies should work together and with adults at risk and their carers to reduce risk,[3] the SAB wish to review Liam's case to better understand how local partners can work more effectively across Islington to identify adults with care

[2] https://data.london.gov.uk/dataset/fire-facts--fire-deaths-in-greater-london

[3] For example, National Fire Chiefs Council 'Identifying vulnerable persons at risk from fire' and https://www.nationalfirechiefs.org.uk/write/MediaUploads/NFCC%20meetings/2020/September/Item_04_-_Appendix_1a_-_Person_Centred_Framework_-_Core_Components_of_the_HFSV.pdf

and support needs who are at greater risk of harm from fire and pro-actively offer support to reduce that risk.

## 4 Demographic of Islington

The following data was taken from the State of Equalities in Islington Annual Report 2021[4]

People aged 65 and over living in Islington make up 9% of Islington's resident population in 2021. This means the borough has a relatively young population: 12% of the population of London and 19% of England are aged 65 and over.

In November 2018, there were 7,520 beneficiaries of Pension Credit, a means-tested benefit for older people, in Islington. This represents approximately 40% of pensioners, compared to 25% in London and 17% nationally.

Older people make up a significant proportion of Islington's social housing households and pensioner households also have a considerably lower income than the rest of the borough.

Based on figures from the 2011 Census, the proportion of the population aged 65 and over in Islington (11.8%) who are unpaid carers is greater than in any other age group, except residents age 50 to 64.

34% of Islington's 60+ population are living in income deprived households. This is the 4th highest proportion of 60+ persons living in income deprived households relative to all other London Boroughs and the 5th highest nationally.

Men in Islington who have reached the age of 65 can expect to live a further 19 years, while women in Islington who have reached the age of 65 can expect to live a further 21 years.

Men living in the worst-off areas of Islington who have reached the age of 65 can expect to live 3.7 fewer years in good health than their counterparts living in the best-off areas of Islington. There is not a significant difference in healthy life expectancy at the age of 65 among women living in the worst off and best-off areas of Islington

This data puts into context those more likely to die in a fire compared to the demographic of Islington. 9% of the population is over 65 and it is they who are more likely to die in a fire. 34% of those are in income deprived households, increasing the risk further.

## 5 Scope of the review

The scope of the review is in two parts.

1. A specific review into Liam's case to identify any learning that can be identified that could prevent a similar incident from occurring in the future.

[4] https://www.islington.gov.uk/-/media/sharepoint-lists/public-records/communications/information/adviceandinformation/20202021/20210311stateofequalities2021.pdf?la=en&hash=ADFF42B574549E55955F36777E0D5AF584649841

2. A comprehensive review of partner agencies and commissioned services' usual practice to identify opportunities for cross sector working to reduce risk and ascertain any additional barriers to preventing future harm from fire for adults with care and support needs.

More specifically, the review explored whether fire risk management is robust across partner agencies, with particular focus on indicators of high concern such as smoking, hoarding, loss of mobility, learning disability or mental health. The review considered the following:

- Is fire safety training mandatory for all social care, health, housing and probation staff responsible for care management or review responsibilities? Do those courses include fire person-centred risk assessment checklist?
- Whether carers routinely consider fire prevention, review/ tri-age level of risk and escalate (using s42 processes) where routine care planning interventions have not removed/ reduced risk?
- Whether commissioners have sufficient standards in place to ensure environmental health/ gas safety officers, care or health providers visiting people's homes recognise risk and escalate this appropriately if, despite interventions and preventative advice, risks remain high.
- Whether multi-agency risk management processes in Islington are well understood and used effectively to reduce risk to prevent safeguarding concerns and fire risks. Consider if these reflect local policies (e.g. hoarding protocol) and new powers under the Fire Safety Act 2021 and incorporate wider personal responsibilities owed by the adult at risk to encourage pro-active fire safety practice.
- Whether a public health approach to risk mitigation could improve practice by supporting staff working with those who self-neglect or wish to continue to smoke despite very high risks, by offering smoking cessation support and the enforcement of 'safe smoking' policies.

## 6 Methodology

In regard to Liam specifically, the following partner agencies involved in his case completed Individual Management Review's (IMR) and chronologies. These were reviewed by the Independent reviewer to identify learning.

- Care provider
- Local NHS trusts
- Housing Provider
- Fire service
- LA Adult Social Care
- General Practitioner (ICB)

In regard to the comprehensive review of partner agencies and commissioned services' usual practice, an audit tool and associated guidance was used to collect data from respective partners in respect to the scope of the review. Details of the partners audited and the element of the review that relates to them is detailed within the report below.

A "lunch and learn" event was held for practitioners and managers with a questionnaire undertaken during the event to determine the understanding of safeguarding principles and fire risk awareness by practitioners, the results being used to contribute towards this report.

A Safeguarding Adults Review Core Group, the membership consisting of leading members of the ISAB, provided oversight of the review process, monitored the distribution, return and collation of IMR's, chronologies and audit forms.

A review panel was established, overseen by the ISAB core group, which contributed to the report and scrutinised information submitted, and ultimately reviewed the report prior to submittal to the SAR Core Group and ISAB for approval.

## 7 Legal Considerations

There were, at the time of writing, on-going independent parallel investigatory processes. The Coroners Court to establish Liam's cause of death and a Care Quality Commission investigation of the care provider into their involvement in Liam's case, neither of which have concluded.

The purpose of this review is not to hold any individual or organisation to account but rather to inform and improve local inter-agency practice by acting on learning and developing best practice in order to reduce the likelihood of similar harm occurring again. It is therefore not appropriate for this report to comment on the outcome of these parallel investigations.

The final report will be published, though it has anonymised personal information and, to respect the integrity of the ongoing coronial process, made no findings of facts with respect to issues before the Coroner. Following the completion of this report, ISAB partner agencies will agree an action plan which will be monitored by ISAB's Prevention and Learning sub-group, reporting to the ISAB. The impact of those actions on practice improvement across partner agencies will be reported within the ISAB annual report.

## 8 Involvement of the family

Liam's family were contacted to be part of this review and the independent reviewer and the Safeguarding Adults Board Manager and independent Chair, met with them to explain the purpose of the review and to discuss their concerns. It was explained to them, as stated above, that there were parallel investigations and coronial investigations which are independent and separate from this review and that this review is purely to identify learning from Liam's case and not to hold individuals or organisations to account.

This meeting also gave Liam's family the opportunity to describe who he was and the type of relationship they had with him.

## 9 Liam's Background

Liam was a 47 year old single man who lived in rented three roomed ground floor flat.

His family that are known to the reviewer, and with whom he had contact were a daughter from an previous partner, an ex-partner with whom he had a son, and a son from another relationship.

It is also known that Liam had another two children with whom he had some, but limited contact.

Account from his ex-partner said that Liam had siblings but was isolated. He had to be very self-sufficient from young age and had brought up his siblings. He wanted to retain his independence and he didn't want to be a victim. When he was diagnosed with multiple sclerosis he didn't want this to impact on his children. Although there was family around, he was fairly isolated. He was always smiling, always trying to be positive and never wanted to talk about himself or of his illness. Instead, he talked about the future and going on holiday.

His daughter said that her dad was an amazing support system for his children. He made them feel that nothing was impossible. He never dwelled on the bad and always looked for solutions. He was an inspiration to them, was a happy person, resilient and knew how to put a smile on someone's face and shared happiness with family and friends.

His sons described their father as a motivational person who would 'never let you dwell on problems'. One son explained that their dad also had a stammer similar to his. His Dad's attitude to his speech impediment motivated him as his dad had encouraged him to never let the stammer stop him. They also said that their dad taught them a lot and that he was 'a very loving dad to me and always there for me'. He was as a good man who was funny and had a lot of friends.

At the time of his death, he had a substantial package of care (4 visits a day and waking nights) due to severe mobility issues and health/ social are needs linked to advanced Multiple sclerosis which was diagnosed in 2004.

## 10 Summary of Liam's care

Liam had significant care needs related to the deterioration in his health and physical condition as the result of the Primary Progressive Multiple Sclerosis (MS). This was diagnosed, in 2004[5].

He self-referred to Islington Adult Social service in September 2009 reporting that he needed assistance with Activities of Daily Living and housing and mobility issues as a result

[5] GP notes within IMR

of living with MS. He was given contact details for Disability Action for assistance with on-going issues and Benefits Agency to receive advice on what benefits he could claim. He was also followed up with an Occupational Therapy assessment. From October 2014 to August 2021 Liam was in receipt of one home carer to support him at home 7 days a week[6] (this was after directly appointing them himself).

In February 2017 ASC undertook a review of his care arrangements. This discussed reinstatement of his direct payments and identified that he smoked in his bedroom and that a smoke alarm should be fitted in his bedroom. Following the review, ASC made a referral to London Fire Brigade (LFB) for them to carry out a home fire safety visit (HFSV). It was noted in the referral that he had two smoke alarms; one in the kitchen and another in the corridor.

The LFB made six telephone calls to Liam in February 2017 to arrange a HFSV but there was no answer on each occasion. Instead the local fire station were tasked to visit him to undertake one and confirmed in a letter to inform Liam. They visited once in March 2017 but he was not available. They phoned him again and left an answerphone message. This was followed up again by another visit to his address but again he was not available. The referral was then suspended and a confirmation letter sent to Liam asked him to contact the LFB to arrange a visit. In July 2017 after no contact was made the referral was marked as cancelled.

At this time he received a care package that supported him day (10am-5pm) and night (11pm-7am). At his request, Liam was left alone for 5 hours a day to which he referred to as his “down time”. He also had a standing sling with ceiling track hoist to help with transfers (which he used against the advice of the Occupational Therapist (OT))

Liam also had Telecare installed to call for help if he needed. This was in the form of a pendant alarm and was not connected to the smoke alarm.

In April 2017 Liam sourced his own wheelchair from the internet and refused a review with the current NHS wheelchair service but was later reviewed in September 2019 at the Peckwater Centre.

In November 2017 it was recommended that Liam have a ceiling track hoist installed in the bathroom.

In December 2018 another review of his care arrangements identified risks of falls and that he had capacity to make decisions about his care and support needs. The record notes say that he did not have any friends of family to support him and he relied heavily on his carers to support his activities of daily living.

[6] Adult Social Care IMR

In April 2019 Liam had significant works in the house to install automated front and rear doors and windows.

After a change in social workers in 2020 a review of his care identified concerns about manual handling risks with only one carer and he consented to having a care package of two for two hours a day to help him with his personal care, assisting him to get ready for bed or dressed in the morning. The remaining times his care was provided by a single carer.

In July 2021 in an ASC review the social worker stated that Liam looked well and stable and was happy with his current care services and new arrangements of direct payments. During COVID he was not going out but was attending hospital appointments for treatment. It was also noted that he had family but did not like to talk about his private life. It also noted that there were no concerns about Liam's decision making abilities and that he had capacity.

There was no record of smoking or fire risks in either of the ASC reviews in December 2018 or July 2021.

# 11 Part one – Specific issues related to Liam

## 11.1 Bedtime routine

The care agency confirmed it was usual practice for Liam to have a carer present during the night. However, it is understood, from the fire investigation report, that Liam would only allow certain carers to work with him and as such did not allow the carer stay the night the fire occurred.

The fire investigation report also states that it was established practice, apparently instigated at Liam's request, that the evening carer had a bedtime routine to enable Liam to have everything he needed to hand whilst in bed. This involved having his smoking materials on top of a trolley, a lit tea light so Liam could smoke. Other items on the trolley were his mobile phone, cigarette box, containing several 'hand rolled' cigarettes, his lighter, telecare alarm fobs and three further tea light candles[7]. The care agency reported Liam used a paper taper to light his cigarettes from the tea light, but this is disputed by his family.

The care agency have confirmed to this review that they identified his continued smoking as a risk within their risk assessment in January 2021. However, there was no evidence submitted to this review that the specifics of this night-time routine was risk assessed. This should have been identified as a high risk, one which the carer or a risk assessment should have highlighted as such to the local authority and relevant partner agencies, including the London Fire Brigade. It is understood that this forms part of the ongoing Coronial and CQC investigations. If it is found that Liam was left to manage his smoking in this way, it is the reviewers view that this increased the risk of a fatal fire rather than reducing it.

Given that this was reported as his routine, this raises the question as to whether the carer was given the appropriate training to identify fire risks in the home and consequently the risks associated with the bedtime routine. An initial risk assessment was completed by the care provider on the 19th September 2014 and mentioned that he smoked and "handles smoking in a safe manner", "no hazard identified" and "no action is required". This was reviewed in January 2017 and states no change to the plan was required. Smoking is a hazard and considering Liam's immobility further control measures should have been identified to reduce the risk, or if already implemented (examples being the use of flame-retardant bedding, supervision whilst smoking, ceramic tea light holders), that this is noted. That fact that it wasn't suggests the assessor was not aware of the fire risks.

The care provider asserted risk assessments were conducted annually (save for 2020 because of pressures associated with the Covid Pandemic). This can be after a certain period, preferably in conjunction with ASC reviews (yearly) or if there are significant changes to the service user's health or mobility. There is evidence that Liam's declining health triggered adaptations to his home in 2019 and an increase in his care package to

[7] LFB Fire investigation report

enable double-handed care in 2020. However, it does not appear that those changes prompted a review of his usual bed-time routine and smoking arrangements. Whilst it is good practice to undertake regular reviews it is crucial that those assessments are used to inform the delivery of safe care.

For the purposes of this review the care provider completed an Audit which stated that all staff undertake an induction training program which consists of modules relating to care services, health and safety, first aid, food hygiene and fire safety and is refreshed annually. Since Liam's death, stand-alone fire safety training is also provided to staff which includes smoking and candle use. However, it is unclear whether other fire risks in the home such as the use of emollients, oxygen therapy, air mattresses and ways to mitigate them are covered within this training as specific learning objectives.

Recommendation 1

The ICB and LBI provide assurance to the ISAB that Fire Safety in the home training for all provider care staff is included as a mandatory training need within commissioned services.

### 11.2 Overnight care

On the night of the fire the care agency reported Liam had refused his overnight care which was part of his agreed care package. This is disputed by his family. ASC had no record of Liam refusing carers to stay overnight in ASC accounts and were not aware he would not be receiving care that evening.

The care provider stated as part of this review that on a few occasions, Liam rejected the sleepover carer but when this happened previously, they were usually able to provide a replacement upon being informed by the carer.

If Liam had wanted a carer to leave, the correct procedure was for the carer to leave, but immediately inform their agency office. The agency would then inform ASC Emergency Duty Team (EDT), who would then establish the reason for the shift being cancelled or ended early and either approve the cancellation or arrange for another carer to be sent to Liam. EDT would realise from the notes on the system that Liam would be highly vulnerable being left on his own overnight and take appropriate action.

At the Coroner's first inquest hearing, a neighbour had reported that it was not the first time that a carer had left the property in the middle of the night. This information was not known to ASC. Unfortunately, the neighbour was unable to give specific dates when this had occurred, so it had not been possible to cross-check against care log records. It is possible that Liam was being left alone at night and that the bedtime routine may not have been a one-off occurrence, as this will be explored more forensically within the outstanding parallel investigations and for that reason a finding of fact is not made here. The purpose of this review is to explore what relevant partners need to do differently to prevent further

harm. If an adult with care and support needs have significant fire risk factors, especially if they are immobile, it is crucial that carers responsible for providing care notify the commissioning authority of any refusal of care or gap in care provision or unwillingness to adopt fire safety measures that would safely reduce that risk. It is very likely that, if instances of the carer leaving had been reported to ASC, it would have established if this was a regular occurrence so a review could have been carried out as to if Liam received adequate night time care and an agreement reached to ensure he was provided safe night time care that would allow him to smoke whilst supervised, therefore negating the need for the unsafe bedtime routine.

It is relevant to note the oversight role of ASC in the process of identifying whether Liam was indeed receiving the care as per the care provider contract. As part of assuring service providers, the ASC Contracts Team conduct regular audits or reviews of up to 5 random service user files or daily logs. The team review the care and support plans to ensure they are detailed, personalised and include clear outcomes. They also review daily logs to ensure they are detailed, personalised and completed and are up to date. For homecare, they sample the Electronic Call Monitoring (ECM) data for call times. They only do direct comparisons or investigate further if they find issues with the support plans, daily logs, or ECM data. The current assurance process is designed to be a proportionate assurance measure that should work alongside annual reviews and the responsibilities of care providers to provide safe care. By its nature, a random sample will not pick up all those people who are most vulnerable or at risk. However, refusal of care is a specific issue in Liam's case and should initially be picked up as part of care planning and reviews but, it should also be part of the assurance process. Therefore, the inclusion of refusal of care and safeguarding risks within audits should ensure any issues or trends of such are identified. As such the report makes the following recommendation:

Recommendation 2

That ICB and Local Authority commissioners amend their care provider assurance processes to ensure that care providers confirm any refusal or gaps of care are notified to the commissioning authority in accordance with care plans and that any fire or safeguarding risks have been appropriately addressed or referred in line with s42 Care Act 2014.

The report notes that as a result of Liam's case and as part of the Provider Concerns Process (PCP) ASC suspended the allocation of new packages of care to the care provider until relevant assurances had been received.

### 11.3 Smoking

Liam's smoking is at the heart of this review.

The risk associated with smoking was identified in an ASC review 2017 and referred to the LFB for a HFSV. Unfortunately, this was not completed, the reasons for this are discussed further below.

Ideally, following the principal of "making every contact count" those who knew Liam (i.e. carers and those who cared about him) would have flagged with him the increased fire risk which arose because of his immobility, coupled with his smoking and particularly the way in which he managed this when carers were not supervising him.

Chronologies show that ASC carried out two reviews, one in December 2018 and another in June 2021 where smoking and fire risks were not identified in the assessment. It is understood that carers were also present at the review in 2021 and did not mention if Liam smoked, though it is understood that their internal risk assessments did identify this. In between these, in 2019, University College London Hospital (UCLH) Physiotherapy services visited Liam and identified he smoked cannabis. Neither agency shared concerns regarding the fire safety risk with the local authority, either through the social care review process or via a safeguarding alert. These were missed opportunities as it would have enabled practitioners to work with Liam, the care provider, the LFB and his landlord between 2017 and the time of the incident four years later in August 2021.

In addition, there were 8 visits to Liam's home from either a District nurse or Physiotherapist in the 18 months prior to his death where Liam's risk fire risk due to his smoking should have been identified. The ASC IMR states:

*"Under the Care Act Assessments/Reviews are a dynamic process involving a current interaction between a social worker and the person in need of care and support and are based on current needs and views expressed by the service user at that time rather than reflections of past conversations"*

In terms of assessing risk, this is a shared responsibility, owed by all 'relevant partner' agencies and forms part of the preventative safeguarding function. Ultimately as set out below, adults with capacity have autonomy, but where (as in Liam's case) additional factors, such as immobility, makes it much less likely that he could protect himself from harm this should be explored directly with him. Practitioners and family members would benefit from a wider understanding of the support LBF can offer to reduce risk whilst respecting the adult's choice and the importance to them of maintaining control over decisions. Where safe arrangements cannot be agreed with the adult, practitioners and family members should know to use multi-agency risk management processes (including under s42 Care Act) to better understand the risk, options to reduce that risk and any preventative legal powers that might be available across partner agencies and those involved in providing accommodation and care to the adult.

Recommendation 3

Practitioners should routinely ask about smoking where there are additional risk factors, such as the use of emollient creams, immobility etc. If unsafe smoking practices are identified by any ISAB partner agency, landlord or provider the ability of the adult at risk to protect themselves from harm should be explored. It should also prompt discussion about the availability of smoking cessation support and steps required to mitigate fire safety risks. The adult's capacity to understand the risks and protect themselves from harm must be carefully recorded.

The ASC IMR also states:

*"Liam did not discuss or identify smoking as an issue during this time and he had capacity to understand the nature of risks as well as to communicate in full issues that were important to him"*.

In cases where the likelihood of a fire is high or very high, in other words, a fire is likely at some point, agencies involved should convene a Multi-Disciplinary Team (MDT) review and, if necessary because risk mitigation steps are not agreed, escalate through the relevant safeguarding channels (in line with s42 Care Act 2014). This escalation can be considered without a person's consent considering the likelihood of a fire occurring and high risk of injury or death and where there is a vital or public interest, which makes it necessary to seek a multi-agency response.

Adults have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding, the Care Act allows these rights can be overridden in certain circumstances[8]:

- Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.
- The law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality.

In Liam's case, there were opportunities prior to his death where practitioners did not identify the risk of fire and therefore escalate his case for a MDT review or reported to ASC. The combined risk due to his smoking and immobility could have been considered as life threatening, and if a fire started, there was an immediate risk to him (because of his immobility) and to other members of the public in the building therefore referring without his consent would be appropriate.

[8] https://www.scie.org.uk/safeguarding/adults/practice/sharing-information

Data shows that if someone is frail (or has reduced mobility), smokes and drinks or uses drugs (prescribed or not), they are more likely to die in a fire. These should be triggers or a "red flag" to instigate an MDT discussion or meeting to discuss all the issues and risks and to establish a way forward and if one cannot be found, escalate upwards. If the risks identified involve fire then the Fire Brigade and housing provider must be part of the meeting.

Since Liam's death, Islington Safeguarding Adults Board (ISAB) has introduced the Creative Solutions Panel (other borough's may call it a High Risk Panel).

The need for this panel arose as a result of several serious cases in Islington that involved people who were not compliant with traditional service delivery, were complex and did not respond well to the standard interventions. The SAB felt that these cases would have benefited from multi-agency creative thinking to devise potentially innovative and creative approaches to mitigate the risks.

The SAB considered various models of addressing these complex or 'rising risk' cases. Having weighed up the advantages and disadvantages of various models, the SAB agreed to set up the Creative Solutions panel.

The panel is accountable to the Safeguarding Adults Board and comprises a core group of senior managers and commissioners from partners such as public health, adult social care and mental health. It is a deliberate mixture of multi-agency senior managers and commissioners to promote co-operation, build relationships of trust and better support the management and mitigation of risk. The aim is to provide an additional multi-agency, multi-disciplinary response, which can agree bespoke packages of care, enable better risk sharing and risk management between agencies, and aid better outcomes for people than could be achieved when 'usual care' or the usual safeguarding responses have been unable to reduce risk.

Recommendation 4

Where the risk of a fatal fire is medium or high, (for example, the combined risks of a chair or bedbound service user, smoking and emollient creams) or where there is a risk to other members of the public, failure to agree with the adult appropriate risk mitigation arrangements should automatically triggers an MDT meeting, between the adult at risk, any family or informal carer, paid staff providing direct care, ASC, LFB and any Landlord to establish ways to mitigate the specific risk of fire. If the MDT cannot identify methods or resources to mitigate the fire risks, these cases are escalated under s42 Care Act for a safeguarding response and, if necessary, onwards to the Creative Solutions Panel.

Recommendation 5

Following publication of this review, ISAB should raise awareness of risk mitigation options regarding fire safety across all partner agencies, registered social landlords and social care providers operating in Islington. Thereafter, partner agencies and registered social care providers and landlords should provide assurance to the ISAB that they have raised awareness of heightened fire safety risks for adults with care and support needs, that staff from relevant agencies know they should share information about known risks and escalate concerns for a multi-disciplinary plan if, following discussions with the adult at risk, the risks are not reduced.

In regard to what guidance is available to staff about what to do for clients who smoke cannabis, the review could not identify whether there is any local guidance. It is a difficult topic as practitioners cannot condone the use of an illegal substance but there are alternatives such as the drug Sativex[9] made from cannabis that is licensed to treat spasticity (muscle spasms and stiffness) in MS.

National institute for Health and Care Excellence (NICE) guidelines[10] state that initial prescription of cannabis-based medicinal products (excluding nabilone, THC:CBD spray [Sativex] and medicines not classed as controlled drugs such as cannabidiol) must be made by a specialist medical practitioner. This could have been an option for Liam as part of reviewing his care, whether he would have agreed to it however is a different matter.

The local Mental Health NHS Trust has an excellent service of having a tobacco dependency action plan which includes dedicated tobacco dependency practitioner. It may also be worth ASC and Public Health discussing this issue with them to review local guidance.

## 11.4 Home Fire Safety Visit referral

In January 2012 a referral was made to the LFB by the Housing Provider, to which Liam consented.

As stated, Islington ASC referred Liam to London Fire Brigade in 2017 who attempted to contact Liam via telephone six times with no response and attempted to visit twice without being able to make contact. The referral was then suspended and subsequently cancelled as, after the number of attempts made to contact him, Liam did not contact the LFB to arrange a HFSV.

Liam's case was complex, he smoked, was immobile and had been prescribed emollient creams so could be classed as high risk. He would also be classed as vulnerable according to the LFB's own reasons why someone would need extra consideration in reducing fire risks:

[9] https://www.mssociety.org.uk/about-ms/treatments-and-therapies/cannabis/about-cannabis-and-ms

[10] https://www.nice.org.uk/guidance/ng144/chapter/recommendations

1. They may not be able to respond to a fire as quickly.
2. They may not be able to escape a fire.
3. They may be more at risk due to lifestyle factors.
4. They may use healthcare equipment such as oxygen or emollient that are flammable.

All these considerations applied to Liam:  he was immobile, so it was more difficult for him to respond and escape a fire and his choice of smoking and using emollient creams increased his risk. For these reasons, more should have been done by the LFB to address Liam's risks. As a minimum they should have contacted Islington ASC to explain that they were unable to complete the HFSV so other ways could be explored to complete one.

From April 2023, the LFB Home Fire Safety Visit strategy changed from a quantitative one to a qualitive one, and the emphasis is on prioritising HFSV's for those that need them most rather than the number completed. The process of referring and producing feedback to partners has also changed. The reviewer understands that a new referral process, including an out of hours system, prioritises low, medium, high and very high cases. Low priority cases will be asked to complete the online home fire safety checker. Other cases will be visited depending on their risk, for instance, medium risk within 30 days, high risk the next working day and very high risk within 4 hours.

There is also be additional guidance on communicating with referrers before and after visits or where visits cannot be completed so that all partners are aware of what has been achieved.

A fire assessment as part of a physiotherapy annual review was completed in December 2019.  Liam was reported to have been smoking cannabis 4 to 5 times a day, however he did not consent to a fire brigade visit so a referral was not made.

It is understandable that some people may not want the LFB to enter their home to complete a HFSV, regardless of the fire risks that have been identified by practitioners who visit their home, especially as this was also a time of the COVID pandemic.

The General Data Protection Regulation, Data Protection Act 2018 (GDPR) and the Crime and Disorder Act 1998 permit the disclosure of information to organisations such as the police, local authorities and social services. A disclosure in the public interest is likely to be justified where it is essential to prevent a serious and imminent risk to public health, national security, to protect other people from risks of serious harm or death, or to prevent or detect serious crime[11]. The Caldicott Principles[12] also help to inform decision making on whether to override consent.

[11] https://www.bma.org.uk/advice-and-support/ethics/safeguarding/adults-at-risk-confidentiality-and-disclosure-of-information

[12] https://www.gov.uk/government/publications/the-caldicott-principles

In terms of the risk of serious harm or death due to a fire, the Fire Brigade are best placed to advise on how to address any fire risks, even if the client refuses a face-to-face visit to their home. In these cases, it is therefore essential that they are still referred to the Fire Brigade or, as recommended above, a multi-agency meeting (which should include the Fire Brigade) should be held to discuss the how the risks can be managed.

In cases where the LFB are not able to access the service user's property, one option is for them provide advice, support or training to any appropriate person or agency that is able to interact with the client and complete a HFSV on the LFB's behalf. However, this is not ideal as this is reliant on others who may not, understandably, have fully knowledge of the range of support available. It is notable that in similar situations where a persons behaviour places their health and public health at risk there are powers (including powers of entry) under the Housing Act 2004, Environmental Health and Public Health Acts. Given this case and the very high number of similar Safeguarding Adults Reviews conducted in recent years as a result of fatal fires, to provide Fire Brigades with similar powers would dramatically improve partners ability to protect adults from future harm.

Since Liam's death Islington ASC and LFB officers now undertake regular review meetings where the outcome of HFSV's for high-risk residents are discussed. This also covers cases where the LFB are unable to visit or cases where practitioners have identified fire risks and the service user refuses a HFSV. This is a good example of agencies self-identifying learning from Liam's case and a process that must continue. It might be appropriate, however, to include a representative from the Local Authority Housing team within these meetings considering their responsibilities under the new Fire Safety legislation introduced since the Grenfell Tower tragedy.

Recommendation 6

That within the ASC/LFB review meetings a process is established whereby, for those people that refuse or decline a HFSV or where the LFB are unable to access the service user's property, the LFB provide relevant feedback, advice, support or training so the HFSV is completed by the appropriate agency on the LFB's behalf.

## 11.5 Human rights

In regard to the Human rights Act, a balance has to be made between the right to a private life, the risks to the individual and duty of care by practitioners. Liam was a very private person and did not like talking about his private life. He said to social workers that he had five children and was in contact with them but would not disclose their details. Practitioners respected this, but this meant the next of kin details were inaccurate and the Local Authority were unable to involve his children in care planning because of Liam's wishes not to do so. There was nothing to indicate that Liam was unable to advocate for himself and therefore an advocate was not necessary in the circumstances. The question is, did not

knowing his next of kin or not having involvement with his family impact on his treatment or the mitigation of fire risks? Evidence suggests that the treatment of his medical conditions were appropriate and annual reviews of his care identified a gradual deterioration of his condition and his care provision adapted to his needs. In regards to mitigation of risks, manual handling risks were identified and addressed with the use of hoists and a wheelchair review instigated following Liam's insistence. It is very possible that if his family had been involved, opportunities to improve his care may have been possible. As practitioners were restricted by Liam's wish not to involve them, this was not possible.

## 11.6 Mental Capacity

The Mental Capacity Act states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. In Liam's case there was no concern identified as to his capacity to make the decision about his smoking behaviour. In addition, he was able to advocate for himself and was, reportedly, very willing to challenge authority. ASC state Liam *"was aware of risks and understood consequences in other areas of his life and was prepared to take risks in order to protect his own dignity and independence",* for example his use of a hoist and ordering his own wheelchair.

The care provider reported they had discussed Liam's smoking and associated risks with him whilst completing their risk assessment. However, he was not receptive to addressing the risks and made it clear that he did not want them to interfere. They did not discuss this further with him, nor did they notify ASC of their concerns so that this could be followed up within annual reviews or via a multi-agency discussion.

Whilst there is nothing to suggest Liam lacked capacity, similar reviews into fire fatalities have recognised that assessing mental capacity, in particular an adult at risk's executive function in relation to fire risks, can be very difficult. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities. The Code of Practice (para 4.21)[13] notes: '*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information, but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given'*. In other words, a person may appear to be able to weigh facts while in an interview or practitioner meeting but if they do not transfer those facts to everyday life (execute the plan) they may not be able to freely take action that would protect them from future harm. Careful consideration is needed as to whether the person understands all the risks (including those posed to the wider public) by unsafe smoking practices. This requires careful recording of what information the person

[13]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

has been given, whether alternative options for safer smoking arrangements have been discussed and consideration of whether they could protect themselves (part of the legal criteria for safeguarding duties under s42 Care Act) if a fire was to break out.

Neither the fire service nor local authorities currently have any general power to regulate or prevent smoking within individual private homes, whether they are owner occupied or rented or whether they are houses or flats (including flats in sheltered units). Cases where there is a high risk of fire due to the person's smoking and the person may lack mental capacity or, even if they have capacity, but lack the ability to protect themselves should be discussed within an MDT meeting involving the LFB, to determine the best way forward to address the risks. It is likely that Liam had capacity and was making unwise decisions regarding his welfare[14]. In practice, under the current legal framework it would have been unlawful for practitioners to use powers under s4 Mental Capacity Act 2005 to impose care 'in his best interests'. Had the risks to Liam been referred for a multi-agency discussion this could have provided an opportunity to offer further assistance or measures that might have mitigated this risk. If, however, he refused additional support the local authority or landlord would likely have had to seek legal authority from the High Court (under it's inherent jurisdiction) to impose restrictions on Liam regarding his smoking. It is unnecessary for the purpose of this review to speculate as to whether the Court would have agreed to impose restrictions on him as a necessary and proportionate infringement on his right to private life. The purpose of this review is to explore systematic change that could prevent future deaths. It is likely that this could be achieved by finding a less confrontational (or costly) way in which landlords and public bodies undertaking safeguarding functions can seek additional legal powers to act, that takes into account the rights of capacitated adults against wider public safety.

Recommendation 7

Given the high number of fatal fires involving adults with care and support needs and the complexity for frontline practitioners mitigating risks when adults have capacity and refuse preventative support, the ISAB should escalate this case via the LGA process to ascertain if there is now sufficient evidence base for a change in the law to enable Fire Brigades to secure legal powers to apply for Fire Safety Prevention Orders, similar to legal powers environmental health officers have to prevent harm or public nuisance.

[14] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*. London: DCA. Para 2.11 "*There may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character. These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices.*"

## 11.7 Telecare

Liam had a basic pendant alarm with Islington Telecare which was installed in August 2011. This was a full service which meant that they could physically respond in an emergency using keys stored with Telecare. The pendant would be kept with Liam and he would press it which would generate a call to the service Control Room and they would be able to have a two- way conversation and establish the issue and respond in the most appropriate way if necessary. It was not connected to the smoke alarm so if the smoke alarm activated a call would not have been made automatically to the Telecare service.

Considering Liam's progressive illness and increased immobility since it was installed, and the risk of smoking in bed, this service should have been regularly reviewed and linking to a smoke alarm considered.

Recommendation 8

That all cases where a service user has Telecare and smokes that the smoke alarm be linked to the telecare system.

## 11.8 Defective Smoke Alarm

It had been suggested that the smoke detector in Liam's flat was defective.

LFB Fire Investigation report states "*A mains supply smoke detector was located on the hallway ceiling above the entrance door. The smoke detector was heat damaged with some of its sections melted. It was later established that this detector was faulty and would not have operated. The defect had been reported to the housing provider and was currently part of an internal investigation by the housing provider Health and Safety Officers."*[15]

This was questioned by the reviewer and the report of the smoke detector being defective came from anecdotal evidence from a witness at the scene.

The housing provider considers that there was confusion about the functioning of Liam's smoke alarm and their account says they received no reports from Liam or anybody else that Liam's smoke alarm was defective. The housing provider note from the Care provider records (which have not been seen by the reviewer) that they were checking the alarm monthly and noted it to be functioning at all times.

The ultimate responsibility for maintaining the smoke detector lies with the occupier of the flat, in this case this was Liam. However, there would also have been a duty of care by other organisations involved in his care considering his immobility and health condition.

For instance, The Defective Premises Act 1972, which applies to all dwellings in England and Wales, the landlord has a duty to prevent personal injury or damage to property caused by

[15] Housing provider was noted in the fire investigation report but not in this report to maintain confidentiality.

defects in the home and is under an obligation to repair or maintain the home, or has a right to enter the property to carry out maintenance or repairs. Also, the Smoke and Carbon Monoxide Alarm Regulations 2015 (which have been amended in 2022), requires all relevant landlords to ensure at least one smoke alarm is equipped on each storey of their homes where there is a room used as living accommodation. The amended regulations in 2022 require a carbon monoxide alarm is equipped in any room used as living accommodation which contains a fixed combustion appliance (excluding gas cookers) and that alarms are repaired or replaced once informed and found that they are faulty.

Also, as part of the Equalities Act 2010, identification of vulnerable people by housing providers is an important part of their role so reasonable measures can be taken to protect their health, safety or care needs. A Person Centred Fire Risk Assessment (PCFRA) is part of this process and considering Liam's health issues, he was a vulnerable person and therefore a PCFRA should have been completed. The housing provider state in their IMR that they *"had not been approached by the Commissioners of his service, care providers or social workers in terms of a potential PCFRA".* ASC liaised with the housing provider in 2018 and 2020 with regard to the installation of specialist equipment to aid with his medical conditions and mobility. The fact that Liam needed specialist equipment classed him as vulnerable (i.e. unable to react or escape in the event of a fire) and should have instigated the completion of a PCFRA, either by care provider, ASC or the housing provider.

Since 2017 the housing provider reported they have been very proactive in introducing PCFRA's in exceptionally vulnerable residents, initially targeted towards those in supported and sheltered accommodation, according to the National Fire Chief Council's (NFCC) guidance[16] which was published in May 2017.

In October 2021 the housing provider added new fields on their customer contact record to record whether a customer is vulnerable or if they are disabled, what their disabilities are and whether any reasonable adjustments have been requested by and agreed with the resident. This new data will help them to better identify vulnerable residents in general needs housing so a PCFRA can be completed and can only be considered as a positive step forward.

Recommendation 9

That housing providers within Islington have effective processes for identifying vulnerable people in their customer contact records so PCFRA's can be completed.

[16] https://www.nationalfirechiefs.org.uk/news/nfcc-launches-specialised-housing-guidance

### 11.9 Multi agency communication

Multi agency communication is key to this report. There is an individual and collective responsibility to identify risks and when identified they should be referred to the appropriate agency. In terms of fire risks this should the LFB.

An organisation involved in this review highlighted "*that there is not a structure within the borough whereby residents receiving support from a number of different agencies have regular automatic MDT discussions"* and "*there seems to have been a communications breakdown in bringing the PCFRAs to fruition and the agencies should work together constructively in an effort to improve the systems designed to reduce the chance of such a tragic death occurring in the future*". Another said there is confusion and definition of "at risk" and being "vulnerable" both in general terms and in terms of fire risk.

Issues raised in this report conclude that multi agency communication was poor in Liam's case. There were a number of opportunities where fire risks were identified but not communicated to other agencies. There also does not seem to be a trigger or criteria to identify cases like Liam's that would instigate an MDT meeting. It seems appropriate that the criteria the LFB use to class someone as vulnerable (see page 16) is starting point criteria to instigate an MDT meeting so extra consideration made and discussions had to mitigate health and/or fire risks. And in these cases the LFB, housing provider and care provider should be included in the MDT meeting so the fire risks and appropriateness of accommodation is part of the discussions.

This topic is also discussed in part two of this report.

## 12 Part two - Results from audits

In the beginning of August 2022 requests to complete the Audit form was sent to organisations who provide housing and healthcare services within Islington, with the expectation for them to be returned by the end of August. Following the request a number of organisations needed clarification on how to complete it so a simpler clearer version was devised with the SAB Business Manager and distributed again. This delayed the return of some of the audits into the beginning of September.

In all, 19 Audits were returned, 9 from housing providers, 4 from care providers, 3 from NHS trusts, in addition to returns from the Metropolitan Police, London Fire Brigade and the Local Authority.

These were reviewed by the Independent Reviewer and comments fed back to each organisation.

### 12.1 Fire Safety training

In regard to whether fire safety training is mandatory for all social care, health, housing and staff responsible for care management or review responsibilities, the majority of returns stated that Fire safety in terms of the workplace, for instance, fire warden, evacuation or

use of extinguishers were well explained and documented. However, accounts were vague and inconsistent about whether risks in the home were included as a specific objective within the training. In response to this review, the care provider confirmed that since Liam's death they have revised their fire safety training for all staff and include within this fire risks in the home.

Large organisations such as national Housing Providers and Local Authority, that are supported by robust and comprehensive IT systems, recorded their training well. Larger housing providers are well placed to respond to the impact of the new fire safety legislation issued following the recommendations from Phase 1 of the Grenfell Tower Enquiry. The introduction of the Building Safety Act 2022 (BSA), Fire Safety Act 2021 (FSA), and Fire Safety (England) Regulations 2022 has highlighted the roles and responsibilities of accountable persons, owners, and managers of residential properties. This now means that housing managers and agents have to extend the coverage of their assessments into the tenants' demised areas and implement new, more stringent fire safety management controls and practices. This adds to the importance of including fire risk awareness in the home within their training.

The audits indicated that smaller organisations (Care providers or local housing providers or associations) that don't have the same resources as larger ones found it difficult to show robust completion or recording of training. Admittedly, smaller housing providers are unlikely to manage large high-rise blocks of flats to which the new legislation applies, but they must consider fire risks in the home in their training.

### 12.2 Commissioning

The review looked at whether commissioners have sufficient standards in place to ensure providers that visit people's homes recognise risk and escalate this appropriately if, despite interventions and preventative advice, risks remain high.

Two organisations that commission services were audited, the Local Authority Contracts Department and the Integrated Care Board (ICB). The ICB had good training for their staff which included fire risks in the home, however the review could not establish whether fire risks in the home training or escalation processes are stipulated as part of their service provider contracts or part of an assurance process that checks contractual agreements are being met.

Recommendation 10

That the SAB seek assurance from multi-agency partners that their staff receive fire risks in the home training and from commissioners that contracts require providers of specified accommodation or home care support services staff receive fire safety training which includes fire risks in the home.

## 12.3 Multi Agency Risk Management processes

The review was asked to assess whether multi-agency risk management processes within the borough are well understood and used effectively to reduce risk to prevent safeguarding concerns and fire risks. The review was also asked to consider whether these reflect local policies (e.g. hoarding protocol) and new powers under the Fire Safety Act 2021 and incorporate wider personal responsibilities owed by the adult at risk to encourage pro-active fire safety practice.

Liam's case has already established that there were issues with multi-disciplinary processes and that there need to be triggers that initiate MDT meetings.

Partners will refer to other agencies if the service user gives consent and don't have any other guidance to reduce the risk if the service user refuses consent to referral. Hoarding is becoming more common as is being highlighted more regularly. The audits identified that one housing provider provided excellent evidence of using the National Fire Chief Councils (NFCC) Specialist housing guidance in their evidence and used the learning from a SAR in Lewisham when creating their policies. They also liaise with a Hoarding charity https://hoarding.support/ and consider Portable Protective Systems. However, lower-level risks such as those associated with fire are not always being highlighted.

New powers under the Fire safety Act 2021 mean that housing providers have to extend the coverage of their assessments into the tenants demised areas. The Fire Safety (England) Regulations 2022 that underpin this new legislation stipulates for high rise buildings, that information about the building must be available within information boxes. This is so Fire services have available information about the building in the event of a fire. Identifying vulnerable people is essential to this as, in any building, a vulnerable person will find it more difficult to escape. This adds more necessity for a PCFRA and a Personal Emergency Evacuation Plan (PEEP) to be completed.

## 12.4 Approach to Risk mitigation

This review has considered whether a public health approach to risk mitigation could improve practice by supporting staff working with those who self-neglect or wish to continue to smoke despite very high risks, by offering smoking cessation support and the enforcement of 'safe smoking' policies.

The audit question in regard to whether Person Centred Fire Risk Assessments (PCFRA) are completed was answered inconsistently. One provider of care provided an excellent example of a "special circumstance risk assessment" tailored to a specific risk, in the case they provided related to smoking. However other care providers said they do not have a PCFRA process but are in the process of appointing someone who will establish one. Other care providers said that generic risk assessments are undertaken but a person centered approach to fire risk was not routinely considered. This is backed up by examples of care plans that were vague in terms of who is at risk as they appear to be more of a risk

assessment for the care worker rather than identifying the risks and mitigation methods for the service user.

Common risk assessments formats identify the hazard (something that has the potential to cause harm), the risk (the likelihood of it occurring), who is at risk, the risk rating before control measures are applied (using a risk rating table 5 point table), control measures that will reduce or eliminate the risk and then the risk rating after control measure have been applied. If this process is applied, then who is at risk (i.e. the service user or practitioners etc.) and the control measures can be more clearly explained.

Another option could be to have two separate risk assessments, one tailored for the carer and the other a specific, person centred care plan, including a risk assessment for the service user.

Liam's case also identified that reviews must be completed regularly, preferably in conjunction with ASC reviews so all risks are identified and communicated and are dependent on changes in the service user's health condition.

Recommendation 11

That care providers review their risk assessment processes and care plans so they are reviewed within appropriate timescales, all fire risks are included and who is at risk is clearly identified.

## 12.5 Summary of questionnaire results

The data from the questionnaire can be seen below. Overall the results were positive, the majority of participants had knowledge of fire risk assessment processes such as the PCFRA. The majority (92%) knew what a PCFRA was however only 39% knew what the first element was. Also only 63% said they used the LFB's PCFRA. This indicates the awareness of the PCFRA but not a working knowledge of using or applying it.

The most significant point identified is the use of Portable Protective Systems (PPS), in that a significant number of practitioners either did not know what a PPS was or confused it with personal alarm system.

PPS is a self-contained water mist system that can be used in one room of a building. These systems are designed for people who spend most of their time confined to a specific area of their home, for instance, high risk cases where someone is chair or bedbound. Water mist systems use a spray of fine water droplets that can suppress a fire by cooling, wetting and displacing oxygen. It can also connect to existing autodialer or telecare systems to alert monitoring or emergency services that the system has activated. They can be quickly installed to protect a vulnerable person and can be moved or re-used as required.

PPS is a method of reducing the effects of a fire and can save lives in cases where there is a significant fire risk. They are expensive to purchase initially and require people to be trained

in their installation and maintenance. However, once purchased and maintained correctly they have the potential to save lives. For more information on PPS see the footnote below as an example.[17] As part of any multi-agency discussion regarding fire risks, it is believed that such a system is necessary to reduce risk to safe levels then consideration will be needed as to how this is made available for instance by multi agency funding as part of a care plan or privately purchased.

Another point of discussion is the risk assessment recording process. PPS is probably the last option to consider when trying to reduce fire risks in very high-risk cases and the process of recording whether one should or can be provided is very important, even if one is not recommended. PPS may not be appropriate in all cases but recording will show that a process has been followed, all the options considered, and the reasons for recommending one or not. It should also include all agencies involved in the case so all views can be expressed and a collective decision made. This means that should the worst happen there is a record that a full and thorough risk assessment process was followed and outcome that can be provided to any subsequent investigations or review.

## 13 Pressure on public services

One issue that was highlighted by a number of partners and from the questionnaire, especially those in the public sector, was the availability of resources to enable them to fully meet their responsibilities. One organisation said that resources were often a barrier for the management of high-risk long term cases. The reviewer also posed a supplementary question during the lunch and learn practitioner event, asking if resources within their service impacted on the level of service they can provide for their clients. Answers that came back were yes, resources are stretched and workloads were high meaning that, it was necessary to carefully consider proportionate responses to reduce (rather than to eradicate) all risk. It is important to note the pressures that safeguarding partners are experiencing and the impact it is having on practitioners across provider and statutory partners.

## 14 Results from questionnaires

As mentioned in the methodology, two practitioner sessions were held to establish whether risk management processes in Islington are understood. These sessions targeted anyone who visited people's homes and involved completing a questionnaire and were an open session where participants had the opportunity to ask the reviewer any fire safety related questions. 38 participants took part, 25 participants attended the first session and 13 the second (which was moved to attract more participants as the first was within school half term holidays). Not all responded to every question, all 38 answered the first 10 questions

[17] https://www.surefire.co.uk/suppression/portable-sprinkler-mist-systems/

but only 32 answered the last 10 questions. The percentages below are based on the actual number of respondents to each question.

Of the 38 who started the session, the majority (15) were from housing providers, 9 from Health care, 6 from Adult Social Services, 2 each from care providers and the voluntary sector, 1 each from the emergency services and mental health services.

It is recognised that 38 people compared with the total number of practitioners from all partners known to support vulnerable adults in their homes is only a representative sample, but it does provide some assurance and identify further areas for workforce learning. The majority (92%) knew what a Person Centred Fire Risk Assessment (PCFRA) was however only 39% correctly identified the first element. Also only 63% said they used the LFB's PCFRA. This indicates the awareness of the PCFRA but not a working knowledge of using or applying it. The majority (87%) knew what PEEP stands for (Personal Emergency Evacuation Plan) and 71% knew when it should be completed.

All participants knew a way to refer an adult safeguarding concern.

37% did not know what a Clutter image rating scale is but 79% new that above 4 of the CIR scale is considered a significant risk and 84% correctly identified the circumstances where action can be taken to address hoarding.

47% said you can restrict someone from smoking in a care home or sheltered housing which is true but indicates that 53% said that you can't. In regard to smoking cessation the majority of respondents (84%) knew the methods that are available on the NHS and all knew how to contact a stop smoking advisor. However, of the 20 respondents who said they had a client who smoked, 5 (25%) said they had not been offered support to stop.

75% knew what an Assistive Technology Catalogue was (which is a catalogue that lists products and services which can help support independence)

18% of participants knew what a Personal Protective System (PPS) was (which is an automatic mist system that activates in the event of a fire), with 56% confusing it with an alarm service for the elderly. This is of concern considering a PPS is a very effective control measure for very high-risk cases. 9 participants said they had recommended a PPS for a client but considering the confusion with an alarm system for the elderly the results could not tell if any of the 6 participants who knew what a PPS was, recommended one or whether respondents to this question meant they had recommended and alarm system.

It is good that the 20 participants who said they had a client who had an increased risk of fire, 75% said they had been offered fire prevention support but worrying that 25% (4 participants) said that they had not been offered support.

74% said where they had a client with long term care needs and/or significant fire risks, they were given sufficient support to manage their care and fire risks. 26% said that they had not been given sufficient support which is worrying. The reviewer asked to clarify why this was and number or participants blamed the pressure and increased workloads that

some organisations, especially public services, are under and that caseloads have to be prioritised so that new cases are dealt with first.

## 15 Conclusion

In regard to Liam it is clear that there were a number of occasions after 2017 where the risk of fire due to his smoking was not identified, or where it was it was not referred either for further MDT discussion or to the LFB. Training is a key issue in the identification of these risks, particularly:

- knowing the criteria for a vulnerable person where extra consideration will be required in terms of fire risks
- The escalation processes including when referring is appropriate without a person's consent.
- When and how to complete a PCFRA
- the use of Portable protective systems (PPS)

Escalation processes are also key, the introduction of the ASC/LFB meetings and the Creative Solutions Panel are significant steps in improving how complex cases are managed but MDT meetings or discussions play an important part within this. With better awareness of fire risks there will be improved identification of these risks and escalated more appropriately through MDT's and further to the creative Solutions Panel if needed. The Creative Solutions panel has been in existence since August 2022, but it is understood that as yet no cases related to fire-risk have been referred to the panel. It will be important for the SAB to monitor this and if necessary raise awareness amongst practitioners that high risk fire safety cases can be escalated, if necessary as a safeguarding concern.

The new legislation introduced since Grenfell also places more importance of multi-agency communication. Building risk assessments should now consider fire risks in demised areas and information about these risks available to residents and the fire service (for use in the event of a fire). Including housing providers in these multi-agency discussions is therefore essential.

Fires will happen, but it is important to show what was done to avoid them. These processes will record what has been done to manage complex cases, so should the worst happen again it can be shown that due diligence was undertaken.

## 16 Acknowledgements

The report acknowledges and gives credit to those organisations which have identified their own learning and that they are asking for advice on how to resolve them.

The Independent Reviewer recognises the support given to him by the SAB Core group and SAB Chair to ensure a balance was made to maintain the open and honest principles of this review. The reviewer would especially like to that the SAB business manager and her team

for their support in liaising with the many agencies involved in this review. Their patience and professionalism was greatly appreciated.

Finally, the reviewer would like to thank Liam's family for their input into this review. The love and affection they had for him was apparent, as was their desire to ensure lessons were learnt to safeguard other adults at risk in the future.

Martin Corbett

MIFireE GInSTR DipHMO

## 17 Glossary

| | |
|---|---|
| ASC | Adult Social Care |
| CIRS | Clutter Image Rating Scale |
| CQC | Care Quality Commission |
| EPA | Environmental Protection Act 1990 |
| EDT | ASC Emergency Duty Team |
| FRS | Fire and Rescue Service |
| HFSV | Home Fire Safety Visit (completed by the London Fire Brigade) |
| HMO | House of Multiple Occupation |
| ICB | Integrated Care Board (formerly the Clinical Commissioning Group) |
| IMR | Individual Management Review |
| ISAB | Islington Safeguarding Adults Board |
| LA | Local Authority |
| LAS | London Ambulance Service |
| LFB | London Fire Brigade |
| LSCP | Local Safeguarding Children Partnership |
| MASH | Multi Agency Safeguarding Hub |
| MDT | Multi-Disciplinary Team |
| MPS | Metropolitan Police Service |
| NHS | National Health Service |
| PCFRA | Person-centred fire risk assessment |
| PEEP | Personal Emergency Evacuation Plan |
| PHA | Public Health Act 1936 |
| PPS | Personal (or portable) protective system (which is an automatic mist system that activates in the event of a fire) |
| RIPFA | Research in Practice for Adults |
| RRO | Regulatory Reform (Fire Safety) Order 2005 |
| SAR | Safeguarding Adults Review |
| SCMA regs | Smoke and Carbon Monoxide Alarm (England) Regulations 2015 |
| START | Short Term Assessment and Reablement Team |