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SAR Commentary: Thematic Safeguarding Adults Review – Fatal Fires

Mr C and Mr D were adults with care and support needs who died in fires at their homes during 2021. The Bi-Borough Safeguarding Adults Executive Board (Kensington and Chelsea and Westminster) commissioned a Safeguarding Adults Review (SAR) which looked at both men's circumstances and was published in August 2023. The SAR included a wider audit and survey about fire safety amongst health and care professionals in the two boroughs.

A four-page Learning Briefing was also published, summarising important learning for all agencies. This commentary adds some additional practical detail which may be helpful for housing and care providers to read alongside the Learning Brief.

The SAR and the Learning Brief can be downloaded from https://www.saeb.org.uk/safeguarding-adults-reviews/published-sars/

Mr C

The Learning Brief explains that "Mr C was an 85-year-old man who lived in an extra care housing scheme who died following a fire in his flat which was likely to have been caused by dropping a match whilst smoking." The SAR reports that Mr C had been sitting in his wheelchair at the time.

The SAR also notes that Mr C had mild learning disabilities and a range of increasingly challenging health issues.

The extra care scheme had previously written a Person Centred Fire Risk Assessment (PCFRA) for Mr C. The risks noted included smoking and the use of emollient creams. Measures to mitigate the risk included metal ashtrays, more frequent washing of bed linen, an agreement that Mr C would not smoke in his bedroom, and advice to use a lighter rather than matches.

A few weeks before his death, Mr C had spent time in hospital due to range of health issues. When he moved back to his flat, his mobility had deteriorated significantly, and he was unable to move independently. His care hours were doubled, to allow 2:1 staff support for his four care visits per day.

When the fire occurred, Mr C was alone in his flat and, presumably, unable to move to safety.

The SAR says that "… there was simply insufficient recognition of the increased risk following his discharge. No agency considered the impact of his loss of mobility on the risks from smoking. No discussion took place prior to discharge. His risk management plan was not updated."

Mr D

The Learning Brief explains that "Mr D died at the age of 61 following a fire in his privately rented flat, in which the most probable cause of the fire was unsafe use or disposal of smoking materials whilst in bed."

The SAR notes that Mr D had experienced several strokes and that his mobility was declining. He required assistance for transfers, and for personal and domestic activities.

After a period in hospital, he moved back home with a care package of four calls a day and practical support from a close friend.

The SAR notes that Mr D's care plan identified a high risk of fire due to smoking. Mr D was to be encouraged not to smoke in bed and water was to be placed in ashtrays. He had a telecare pendant to call for help, although he was reported not to like wearing it.

The SAR notes that Mr D was not wearing his pendant in bed when the fire occurred and that he was unable to call for assistance.

- **Discussion and learning**

The key findings and learning points highted by the Learning Brief include the following:

- The need for greater awareness of fire safety amongst all agencies, recognising that fire safety is everyone's business.
- The need for better information sharing amongst the different agencies involved.
- The need to update fire risk assessments when needs change, for example if a person's mobility reduces.
- The need to ensure that assessing mental capacity is a routine step where people are placing themselves at high risk, for example due to fire; and that executive capacity (ie the ability to carry out a decision) should be considered in relation to fire and smoking risks.
- The need for workers to be supported to develop skill and confidence in having important but at times difficult discussions with individuals about smoking habits and associated risks.

- **Capacity**

The SAR states, "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."

"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."

The SAR concludes, "That neither Mr C nor Mr D underwent a capacity assessment is a glaring and serious omission."

Why is this important? While the SAR does not spell out what practical difference could have made if capacity had been assessed, here are a couple of possibilities:

- A conclusion that someone lacked the ability to act in the moment to keep themselves safe could increase the assessed level of risk and prompt a search for any additional mitigating actions could be implemented.
- A conclusion that someone lacked the capacity to decide whether to smoke in ways that could be dangerous would lead to the need for a best interests

discussion. The best interests discussion could be expected to also lead to a search for additional mitigating actions. It could potentially, in circumstances of very high risk, lead to a decision to restrict a person's access to smoking materials in some way.

- **Practical steps that have since been taken by the extra care scheme**

Mr C lived in an extra care housing scheme provided by a housing association. Mr C's care was provided jointly by the housing association and an external care agency.

The SAR gives extensive detail on the action plan subsequently implemented by the housing association, illustrating how a tragic situation can prompt new thought as to how risks can be mitigated.

The actions reported to have been taken by the housing association include the following:

- PCFRAs and PEEPs were reviewed for all customers, resulting in some additional mitigating actions, including:
  - The provision of fire blankets.
  - Provision of misting towers for three customers. (These are portable devices that release mist if a fire is detected.)
  - Encouragement to smokers to use lighters/appropriate technology.
  - Fire brigade visits for all high-risk tenants.
  - Fire-retardant bedding and smoking aprons.
- A register of customers for whom there is a high assessed risk of fire was created and is reviewed bi-monthly.
- A monthly audit was started of all actions related to high fire risk customers.
- After hospital discharge, any changes to risk or care needs are now updated within support plans and risk assessment.
- Regular requests are made to GPs to prescribe lower risk emollient creams.
- The medication changes book is now updated on the day of the change by the Care Coordinator, identifying any changes to prescribed creams.
- Laundry has been increased to twice per week to prevent cream build up and enhanced laundry records now monitor laundry tasks.
- The PCFRA form was updated to include risk of incontinence aids and storage.
- No smoking signs were put on bedroom doors and increased fire safety information discussed with customers in a range of formats.
- The handover form was enhanced to record completion of fire safety actions e.g., when laundry is completed, ash trays emptied, bins emptied.
- Floorplans were updated to include specific details of tasks staff are expected to undertake during individual care calls.
- The extra care housing scheme has followed up with the local authority adult social care team (ASC) to get the most up to date care plans and to ensure that smoking and other high risks are highlighted in those plans.

- The scheme also follows 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 are 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.
- 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 don't follow fire safety actions.

The roles of housing and care providers will vary between types of service, and the actions relevant for each organisation will vary depending on that. However, one of the biggest learning points from this SAR was that fire safety is everyone's business. There is a real need to work together on this, rather than in organisational siloes.

Mr D lived in private rented accommodation. The SAR doesn't tell us whether any actions have been taken following the fire by Mr D's landlord, or by his care agency.

- **Telecare and fire**

Mr D had smoke and heat detectors, but they were not connected to his telecare system. Consequently, when fire broke out, the alarm was not raised automatically.

The London Fire Brigade has published a seven-minute briefing highlighting the need for this to be considered where there is a high risk of fire. The briefing can be downloaded from https://www.saeb.org.uk/wp-content/uploads/2022/10/7-minute-briefing-telecare-and-fire.pdf

- **Concluding comments**

It is hoped that, read alongside the Learning Brief and ideally the main SAR report, this commentary will be helpful for housing and care providers as they consider how they can reduce fire risks experienced by people who have care and support needs.

Any feedback or queries would be welcomed via peter.cheer@care-inc.co.uk.

Safeguarding Adults Executive Board

LEARNING BRIEFING

Thematic Safeguarding Adults Review (SAR)
Learning from Fatal Fire Deaths

Background: Over the course of 2020 the Safeguarding Adults Executive Board (SAEB) were informed of several fatal fire deaths across Kensington and Chelsea and Westminster, which led to several improvement actions being completed.

In response to two further fire death notifications in 2021, the SAEB commissioned Independent Reviewers Professors Michael Preston-Shoot and Suzy Braye to undertake a thematic review. As well as exploring the individual circumstances of the two cases the review adopted a broader approach to consider how well fire safety improvement actions already completed had become embedded into practice.

Sharing learning is a key priority of the SAEB and ensures that lessons in relation to safeguarding adults support direct practice and encourages a culture of continuous improvement.

All staff and mangers are encouraged to read this briefing and reflect together with your team(s) on how the issues presented resonate within your own practice. Please also look out for the forthcoming SAEB Lunch and Learn webinar sessions planned for later in the year which will share the key learning from this review.

You can also read the full SAR report on the SAEB website.

The review focused on the cases of two men, referred to as Mr C and Mr D in the anonymised report. Mr C was an 85-year-old man who lived in an extra care housing scheme who died following a fire in his flat which was likely to have been caused by dropping a match whilst smoking. Mr D died at the age of 61 following a fire in his privately rented flat, in which the most probable cause of the fire was unsafe use or disposal of smoking materials whilst in bed. Both men had experienced a decline in their physical functioning in the recent months prior to their deaths.

The review examined the following areas of practice:

- What do the cases tell us about the barriers and enablers in managing the care and support needs of people with reduced mobility who continue to smoke despite ongoing risks?
- What can we learn about the challenge of identifying how reduced functional ability affects smoking risks?
- How well is mental capacity, including executive functioning, considered in working with an individual who continues to smoke regardless of the fire risks involved?
- What can we learn about the role of Registered Social Landlords in supporting people with complex needs around managing fire risks? Are there sufficient standards in place to ensure the fire safety of residents within supported accommodation who choose to smoke in their own homes?

Key findings and learning points

Amid all the efforts made to meet the men's care and support needs, attention to fire safety was lacking. Although the risks were noted, appropriate actions to manage the fire risks were not taken. The reasons for these omissions were a collective responsibility across agencies, and included:

- A lack of information sharing between agencies.
- An absence of adequate training in fire risk management.
- Challenges in the process for assessing and reviewing a person's needs following discharge from hospital.
- An absence of prompts within assessment documentation to support practitioners to consider and manage challenges of managing fire risks.

Fire safety is everyone's business! The review reflected that more work is needed to enable practitioners to put fire safety at the heart of their practice, regardless of their role or agency they work for. Improvements to training are an important part of this, but other changes are required such as:

- Ensuring that fire risk assessment and management plans are updated routinely following a change in circumstances.
- Improving referral pathways and partnership working around arranging Home Fire Safety Visits from London Fire Brigade.
- Supporting practitioners to develop skill and confidence in having important but at times difficult discussions with individuals about smoking habits and associated risks.
- Improve recording on fire safety advice provided and to ensure this is shared across all relevant agencies involved.
- Ensuring there are clear pathways for escalation of concerns about managing complex cases involving fire risks to support effective supervision and management oversight.

Assessing mental capacity should be a much more routine step in practice where individuals are placing themselves at high risk of serious injury or even death, including in relation to fire risks. In line with the Mental Capacity Act 2005, a person's mental capacity should be established if there are concerns over their understanding of risks in relation to their smoking habits and/or ability to give informed consent to planned interventions and decisions about fire safety measures.

It is also important to consider a person's executive capacity in relation to fire and smoking risks – i.e., their ability to carry out the decision they have outlined. For example, an adult may tell you that they are able to extinguish a cigarette safely when smoking in bed, but their ability to respond safety in the actual moment of putting out a cigarette may be impaired. In the context of undertaking mental capacity assessments good practice is for practitioners to ask adults to demonstrate how they can undertake actions, such as putting out a cigarette when smoking in bed.

The review and other national SARs have reflected the challenges in striking the balance to respect a person's wish and lifestyle choice to smoke alongside considering the risk to others. The review noted three key areas where this was relevant:

- The legal powers of housing providers (and others) to restrict activities that lead to fire risk and present risk to other residents living in the same building are not fully clear.
- Mandatory training on fire risk for care workers in registered services is not set out in law.
- Home Fire Safety Visits require the person's consent, which creates a risk that that person's refusal of consent may present a risk to others living in the same building.

What we are doing to respond to the learning

An action plan has been developed to take forward learning and make improvements to services. Areas of development include:

- Reviewing and developing multi-agency fire safety training, and ensure training is offered across the partnership including provider services, registered social landlords, and the voluntary and community sector.
- Building a suite of additional learning resources relating to fire safety and awareness of risks which will be available to professionals as well as members of the community.
- Developing a multi-agency fire safety framework to provide frontline staff with practical guidance to support the effective management of fire risks. This will bring together risk assessment tools, referral pathways and provide guidance around best practice including mental capacity considerations and balancing individual rights with rights of others.
- Seeking assurance from partner agencies that effective fire safety measures are included within relevant care and support and risk assessment documentation, that information about fire risks is shared effectively across agencies and that the recommendations from the review lead to changes being embedded in practice.
- Raising the issues of national significance around potential gaps in fire safety law with the regional and national Safeguarding Adults Board (SAB) Chairs Network.
- Facilitating a learning event in 2024 to track progress around practice and service improvements in fire safety practice.

Family and carer perspectives

SARs have an important part to play not only in relation to leading to change and improvements in safeguarding systems and practices, but in highlighting individual human stories and the impact upon adults and their families and carers. Mr D's informal carer was willing to participate in the review and share her perspectives.

Mr D's carer described him as "*gentle, very quiet, soft, talented, generous, kind and loving*" and that 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. For Mr D smoking was one of his only pleasures left in life which Mr D said was "all he had". This offered a valuable insight into Mr D as a person, and why he may have struggled to engage with formal support and the services working with him and continued to smoke heavily despite the significant risks created by his disability and change in physical functioning.

Key Points for Learning and Reflection

- Do you fully consider fire and smoking risks when working with adults with care and support needs? Do you use risk assessment documentation to record risk factors and management actions?
- Do you ensure information about risks and risk management is shared with all relevant agencies involved? How do you ensure all relevant agencies are involved in discharge / care and support planning? How do you ensure that agreed actions are monitored and followed up?
- Are you aware of London Fire Brigade's Home Fire Safety Checker and the process to make referrals for Home Fire Safety Visits?
- Do you feel you have the skills and confidence to have what can be difficult conversations with adults about smoking habits and associated risks?
- Are you confident in applying the Mental Capacity Act in practice to ensure you consider the person's mental capacity to understand the risks associated with their smoking? Do you feel confident to check the person's ability to physically carry out actions they say they can do – i.e., consider executive capacity?

Further resources and reading

To make a referral for a home fire safety visit use the online form below:
London Fire Brigade Home Fire Safety Checklist
London Fire Brigade Person-Centred Fire Risk Assessment

General enquiries with London Fire Brigade: 020 8555 1200 available Monday to Friday 8.30am – 5.30pm

SAEB Learning Briefings:

- Fire Safety and Safeguarding
- Emollients and Smoking
- Telecare and Fire

SAEB Escalation Policy
London Multi-Agency Adult Safeguarding Policy and Procedures
Mental Capacity Act Code of Practice

Concerned about abuse or neglect?

To raise a safeguarding adult concern, contact the Information and Access Teams:

Westminster: 020 7641 2176 adultsocialcare@westminster.gov.uk

Kensington and Chelsea: 020 7361 3013 socialservices@rbkc.gov.uk

For more information about this briefing contact:

Makingsafeguardingpersonal@rbkc.gov.uk

www.saeb.org.uk

7 Minute Briefing: Telecare & Fire

Background:

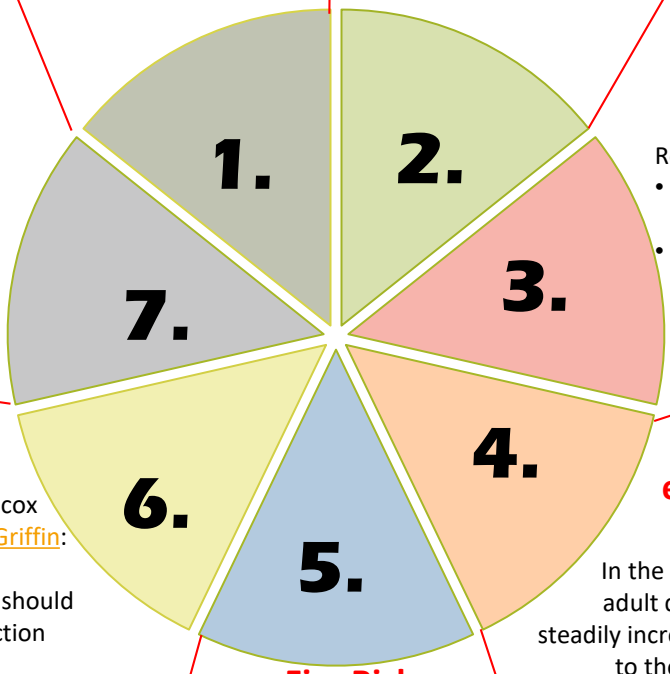
Telecare is way of providing support and assistance when required by using equipment which is monitored at a distance by an organisation. Devices such as smoke alarms, fall detectors and pull cords alert the responsible organisation that a vulnerable person needs urgent assistance. When installed and operated in accordance to the relevant British Standards telecare can improve a resident's likelihood to survive a fire.

The role of telecare during fires:

- Early detection of fire in the room of origin
- Alerting the resident to escape or raise the alarm (if possible)
- Alerting the onsite staff to take appropriate actions
- Reduction of delays in summoning the fire brigade due to the automatic fire alarms
- Provision of an emergency line of communication, which can facilitate vital fire survival Guidance during a fire.

Questions to consider:

1. Would the resident benefit from receiving telecare? For example do they have reduced mobility or mental health issues that could impair their ability to react to a fire appropriately or effectively?
2. If the have existing smoke alarms, are they linked to the telecare system?
3. Are telecare systems installed, monitored and maintained in accordance with the British Standards?



Why it Matters:

A significant proportion of people who die in accidental dwelling fires in London had telecare in place, but it was not linked to smoke detection, or operated in accordance with the relevant British Standards,

Recurring issues include:

- Fire detection not linked to a monitored telecare system.
- Over-reliance on pendants, where fire detection would be more appropriate.

What to do:

The following recommendations were issued by coroner Fiona Wilcox following the death of Elizabeth Griffin:

1. All users of telecare systems should have some form of fire detection linked to FAMOs.
2. Contractual requirement, for new and existing clients to have linked fire detection. In the same way such providers insist on the provision of keys to access client's home.
3. Telecare system operators should apply the call handling protocol in British Standards.
4. Telecare Providers should base staff training for appropriate response on British Standards.
5. Training on what smoke alarms sound like in the background of a call to a client
6. It should be recorded which clients do not have linked detection. The response in life critical situations should be based on this knowledge.

More people are expected to receive care at home

In the years to come the demand for adult domiciliary care is projected to steadily increase to high levels, largely due to the England's ageing population.

The Dept of Health & Social Care (DHSC) predicts that 57% more adults aged 65 and over in England will require care in 2038 compared to 2018. According to the National Audit Office there were 814,000 adults in England receiving domiciliary care in March 2020.

The NHS Long Term Plan states that people will be increasingly cared for in their own homes with the option for their physiology to be effortlessly monitored by a wearable device. This means that the 1.7million people who receive telecare in the UK is likely to rise.

Fire Risk assessment:

The use of telecare must be considered in your fire risk assessment to ensure that all reasonably practicable steps are taken to reduce the risk of a fire and its likelihood of occurring.

British Standards:

The following British Standards must be complied with to ensure that residents have a reduced probability of dying in a fire:

- **BS 9518:2021** Processing of alarm signals by an alarm receiving centre.
- **BS 5839 Part 6 2019** Fire Detection and Fire Alarm Systems for Buildings
- **BS 8604-1:2019** Social alarm systems Design, installation and maintenance of social alarm systems in specialized grouped living environments

Adapted from the Lancashire Safeguarding Adults Board and Lancashire Fire and Rescue Service information

Safe at Home – Fire Safety - YouTube