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