Safeguarding Adults Executive Board

Multi-Agency Fire Safety Framework

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1. Purpose of this framework

1.1 The multi-agency fire safety framework has been developed to provide guidance for the effective management of fire risks within people's own home and residential settings, including within care homes, supported accommodation and extra care housing schemes.

1.2 This framework is for front-line practitioners and operational managers of the partner agencies of the Safeguarding Adults Executive Board (SAEB) who are responsible for delivering care and support services to the residents of Kensington and Chelsea, and Westminster. It is essential that all staff who are providing care and support in any capacity are able to identify fire risks and take appropriate and timely action to address and manage those risks.

1.3 The framework aims to:

- Provide awareness of the key risk factors of individuals who have increased vulnerability towards fires.
- Provide an understanding of the impact this vulnerability can also have on neighbouring occupants.
- Outline the importance of early intervention and prevention in considering what control measures can be used to mitigate and manage risks in the most effective way.

1.4 This document is intended as an overarching framework, and it is the responsibility of respective organisations to develop more detailed workplace guidance around its implementation.

2. Background and learning from Safeguarding Adults Reviews

2.1 Over the course of 2020 the 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 a thematic Safeguarding Adults Review (SAR) to explore the individual circumstances of the two cases, but to also consider how well the fire safety improvement actions already undertaken had become embedded in practice. The Fatal Fires SAR report and learning briefing can be accessed from the SAEB website.

2.2 The Second National SAR Analysis, published in July 2024, identified that a number of SARs have been completed across London and nationally in relation to fatal fire deaths (see Appendix 5), which reflect the following common themes:

- Absence of referrals made for Home Fire Safety Visits (HFSVs).
- Insufficient concerned curiosity and lack of recognition of fire risks.
- Reasons for fire risks not being explored.
- Absence of occupational therapy home-based assessment.

- Tenancy management assessment relating to the building but not to individual properties.
- Silo working – missed opportunities to share information and recognise scale of the risk.
- Lack of knowledge about available legal powers.
- Failure to escalate unmitigated risk.

2.2 This fire safety framework has been developed in partnership with London Fire Brigade (LFB) and other SAEB partner agencies as a direct result of the Fatal Fires SAR and learning from the National SAR Analysis and recognises that 'fire safety is everyone's business' and that we all have a key role to play in identifying, preventing and reducing fire risks, and ultimately in protecting adults at risk.

3. Fire risk and vulnerability factors

3.1 One of the best ways to keep the adults we work with safe from fire is to understand common risks and consider ways to reduce them – *early intervention and prevention is key*. For all practitioners working with adults who have increased vulnerability to fire risks, it is essential that we are able to identify fire risks and take immediate action to address and manage those risks.

3.2 When considering vulnerability and risk factors the following areas should be explored:

- The person (an individual's physical abilities / cognitive impairments)
- Their behaviours
- Their living environment.

Fire Risk – Vulnerability Factors *Note: This list is not exhaustive*		
Person	**Behaviour**	**Environment**
Older Person Frailty Being bed bound Poor physical health Reduced mobility / falls Poor mental health Cognitive impairment, including dementia resulting in a lack of capacity to understand fire risks Sensory impairment Reduced physical ability to be able to respond to a fire and/or escape unaided Use of emollient creams	Risky smoking practices Alcohol and/or drug misuse Self-neglect and/or hoarding Has difficulty engaging with care and support services Unsafe cooking practices Lack of awareness of consequences of risk taking Mobility issues particularly where the base line has changed due to recent hospital admission e.g. health episode such as stroke	Multiple ignition sources Living alone Smoke alarms not present / not working Cluttered / hoarded home environment Portable heaters / open fires Candles / naked flames Unsafe electrics / wiring / overloaded electrical sockets Use of electric blankets Use of oxygen cylinders and air mattresses Use of incontinence products Evidence of previous fires / scorch marks

3.3 The factors listed above should be considered when carrying out an assessment of an adult's vulnerability to fire risks. Simply put, the more factors that are present, the greater the level of risk, and steps should be taken to undertake a comprehensive assessment of risk and then how this can be mitigated.

4. Assessing risks

4.1 Risk assessment and risk management are an essential part of responding effectively to concerns about fire safety. It is recommended that LFBs Person-Centred Fire Risk Assessment is used in the first instance. Templates for more detailed risk assessments in relation to fire and smoking risks are contained at Appendices 1 and 2.

4.2 Comprehensive risk assessments should include:

- Risks identified, including the likelihood and severity.
- The adult's views and wishes, and where appropriate views of others, such as family members.
- How risks will be mitigated and managed, including the adult's protective factors. Who is responsible for each action and timescales should be clearly recorded.
- Ongoing monitoring arrangements and who is responsible for this.
- Contingency plan if risk increases, including when to seek legal advice and the escalation process.

4.3 Good practice is to complete joint risk assessments where possible – for example between ASC and a care provider. Risk assessments should be clearly recorded and shared with the adult and all relevant professionals so that everyone has a clear understanding of what the risks are and what measures can be put into place to address these.

4.4 It is important to ensure that risk assessments are regularly reviewed and updated. An important example is following a change in the person's needs, such as after discharge from hospital, when the base line of the person may have changed.

4.5 Where significant and ongoing risks remain, it may be necessary to convene further multi-agency meetings until there is agreement that the situation has become stable, and the risk of harm reduced to an agreed acceptable level. Cases in which the shared multi-agency approach has not been successful in mitigating the risk of significant harm should be escalated to the relevant level of senior management.

5. Mental capacity considerations

5.1 In line with the Mental Capacity Act (MCA) 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.

5.2 Robust mental capacity assessments are critical in determining the approach to be taken by professionals, either to support the decision making of an adult with capacity or to intervene to protect the best interests of a person who lacks capacity. In complex cases legal advice may need to be sought.

5.3 It important to ensure that mental capacity assessments are recorded comprehensively. Good practice is to record the questions as they were asked, and the responses provided by the adult.

5.4 When completing mental capacity assessments in relation to the person's ability to understand their smoking risks, it may be beneficial to conduct joint assessments. For example, involving an Occupational Therapist can provide additional insights into the individual's functional ability and support the assessment of capacity.

5.5 If a person lacks the mental capacity to make decisions about their fire safety, actions taken on their behalf must be in their best interests (MCA s.4), and the less restrictive option, respecting their Article 8 rights. If someone holds a legal status, such as a Lasting Power of

Attorney or Deputy, professionals must understand the scope of their authority, share relevant information and consult them appropriately.

5.6 If an individual has capacity and refuses a HFSV from LFB, but it is considered that the person is at significant risk of fire (life risk to self and others), agencies should consider the level of risk being presented and ensure appropriate safeguarding arrangements are implemented. This may include, initiating multi-agency meetings to consider risk management and to develop a collaborative action plan with partner agencies involved. LFB representation should be requested at any multi-agency risk management meetings in relation to fire safety matters. Good practice is to ensure that effective communication is maintained with the adult throughout, that risks and potential consequences are set out clearly, and that risk assessments and outcomes of multi-agency discussions are shared.

Decisional and executive capacity

5.7 Another common area of difficulty relates to the distinction between the capacity to make a decision (decisional capacity) and the ability to actually carry out the decision (executive capacity). These are important contextual terms to use when we need to explain the challenges of assessing a person's decision-making capacity when they can seemingly 'talk the talk' (decisional capacity) but cannot 'walk the walk' (executive capacity); especially when we believe that this inability to 'walk the walk' may be "because of an impairment of, or a disturbance in the functioning of the mind or brain" (MCA section 2(1)).

5.8 People's ability to respond to risks in relation to smoking can change as a result of increasing care and support needs, or a significant change in their physical functioning, for example after having a stroke. In either situation, the person may not be able to acknowledge how their change in functioning will impact on their ability to smoke safely.

5.8 When working with an adult who is at risk from fire because of their smoking, it is essential to assess their capacity to act on decisions they have made. For instance, an adult may say that they are able to extinguish a cigarette safely when smoking in bed, but their ability to consistently act on this decision and respond safely in the actual moment of putting out a cigarette may be impaired. In the context of undertaking mental capacity assessments, practitioners should evaluate the person's ability to demonstrate actions, such as safely extinguishing a cigarette in practice.

5.9 When completing mental capacity assessment, it is important to look beyond words to actions. It is important to distinguish between the fact that decisions can be purely decisional (taken just in the moment) or decisional and performative (the application of information taking place outside of the initial discussion). This means that the person has to understand, retain, and use or weigh the relevant information, not only during the mental capacity assessment and within the context of an abstract discussion, but also outside of this; applying information in practice at the time that they themselves need to enact their decision.

Applying the pyramid model in mental capacity assessments

5.10 Case law and practice guidelines from the Court of Protection often reference how different levels of awareness and understanding influence mental capacity assessments. Whilst

they do not explicitly refer to a 'pyramid model', a layered approach to understanding, reasoning and awareness is inferred. Integrating a pyramid model into mental capacity assessments in relation to fire and smoking risks helps to assess not just the person's factual understanding, but deeper levels of awareness and executive function.

5.11 The pyramid model of awareness includes the following levels:

(1) **Basic Awareness**: The person recognises basic facts or risks – for example understanding that smoking can cause fires.

(2) **Situational Awareness:** The person is aware of how their behaviour could contribute to those risks in specific situations – for example understanding that when tired their actions may not be completed safely, e.g., in extinguishing a cigarette and this can increase fire risk.

(3) **Executive Awareness:** The person can plan or modify their behaviour based on this knowledge – for example they take steps to reduce fire risks such as using safety measures or choosing not to smoke indoors.

5.12 Appendix 3 includes a mental capacity assessment and best interests' decision template, along with practical guidance on addressing fire risks associated with smoking.

6. Referrals to London Fire Brigade for a Home Fire Safety Visit

6.1 LFB will carry out free HFSVs to give advice on fire prevention and safety measures. Visits can include the fitting of smoke alarms, and other fire safety specialist items and equipment.

6.2 During a HFSV LFB will:

- Assess fire safety in every room in the property.
- Identify and make occupants aware of the potential fire risks in their home.
- Make sure occupants know what to do in order to reduce or prevent these risks.
- Help put together an escape plan to be used in the event of fire.
- Ensure occupants have working smoke alarms, install where necessary, and advise on maintenance and testing.
- Issue fire retardant bedding where the risk assessment identifies a clear and demonstrable need.

6.3 To request a Home Fire Safety Visit, practitioners should complete LFBs online Home Fire Safety Checker.

6.4 LFB triage referrals into risk categories from low to very high. People who meet the criteria for very high risk are prioritised for a HFSV within four hours, high risk within a week and medium risk within a month. Low risk people will not receive a visit and will be provided with tailored advice from the Home Fire Safety Checker.

6.5 LFB categorise an individual as being **very high risk** if they have all of these six characteristics:

- smoker
- living alone
- over 60 years old
- in receipt of care (informal, formal or both)
- no working smoke alarms in their home
- user of mobility aids, or chair/bed bound.

A very high-risk individual can also be identified if they are at risk or are a victim of **arson.**

6.6 Where practitioners' own risk assessment processes identify that an individual has all of the six characteristics and may fall into the very high-risk category, they may also call LFB on **0208 536 5955** 24/7 to book a HFSV. This HFSV will be carried out within four hours.

6.7 Where required, consider if a joint visit would be of benefit, for example, if an adult requires encouragement and support to engage with a visit from LFB. This has the added benefit of the practitioner hearing the advice the adult received from the HFSV.

6.8 If not present for this, good practice is for practitioners to follow up on the progress and outcomes of referrals by contacting LFB via email at SWCFSHFSV@london-fire.gov.uk

7. Telecare and equipment options

7.1 Telecare is a way of providing support and assistance through the provision of equipment which is monitored at a distance by an organisation. In the content of managing fire risks, a range of equipment can be considered, including the provision of smoke alarms which are linked to community alarm systems.

7.2 Telecare can play a vital role in supporting the early detection of fire, alerting the person to escape and/or raise the alarm, and ensuring that LFB are summoned at the earliest opportunity.

7.3 The table below lists a range of equipment and telecare options and which agency to contact to complete an assessment.

Equipment	**What is it?**	**Who provides?**
Flame retardant bedding	Bedding materials that are treated with chemicals or substances to slow down the spread of fire.	In the first instance bedding should be sources by the individual themselves, or within a care home or accommodation-based service, by the responsible person. LFB can provide the bedding free of charge if there is an immediate /

		high risk. Make a referral for a HFSV.
Fire retardant smoking aprons	The smoking apron is designed to offer smokers better protection from cigarette burns. Designed mainly for wheelchair users, the aprons are wide enough to cover the arms of the chair.	Fire retardant smoking aprons should be sourced by the individual themselves, or within a care home or accommodation-based service, by the responsible person.
Telecare linked smoke and heat detectors	Wireless optical smoke and heat detection systems with two alerting systems – one audible in the home, the other in a 24-hour monitoring service.	Contact Adult Social Care (ASC) as outlined below.
Misting towers / portable protective systems	A self-contained water mist is essentially a sprinkler system, designed for people who spend most of their time confined to a specific area of their home. Misting towers use a spray of fine water droplets that can suppress a fire by cooling, wetting and displacing oxygen.	Contact Adult Social Care (ASC) as outlined below.

7.4 Any equipment fitted which is linked to a community alarm and, installed by ASC will be reviewed and maintained by ASC. If misting towers are provided, these require regular six-monthly checks, which again will be managed via ASC.

7.5 LFB will not undertake equipment reviews. If any issues arise regarding any equipment provided by LFB, such as it being faulty or needing replacement, contact can be made with the HFSV line on 0800 028 4428 or a new referral for a HFSV should be made.

7.6 To make a referral for fire safety telecare and equipment to ASC use the contact details below:

For Kensington and Chelsea:

- For ASC staff, use the TELECARE 65 referral form on Mosaic and email to hm-cas@rbkc.gov.uk
- For other agencies, contact the ASC Information and Advice Team who can make the referral on your behalf – 020 7361 3013 or socialservices@rbkc.gov.uk

For Westminster:

- For ASC staff, use the ASSISTIVE TECHNOLOGY referral form on Mosaic and email to telecare@westminster.gov.uk

- For other agencies, contact the ASC Information and Advice Team on 020 7641 1175 or adultsocialcare@westminster.gov.uk

8. Fire safety within residential care homes, supported accommodation and extra care housing schemes

8.1 Fire safety regulations for care homes and accommodation-based provider services are governed by the Regulatory Reform (Fire Safety Order) 2005, more commonly known as the Fire Safety Order. The responsible person (registered manager) has a legal duty to carry out a fire risk assessment of their premises and take appropriate measures to minimise the risk of fire and ensure the safety of residents, staff and visitors.

8.2 These regulations state that a registered person must:

- Consult with their local fire authority for advice.
- Take adequate precautions against fire risk, including having a clear evacuation plan in place.
- Plan for the detection, containment and extinguishment of fires through the provision of recommended fire safety equipment.
- Ensure the regular maintenance of fire safety equipment.
- Be responsible for the training of staff, and the appointment of competent fire wardens for the premises.
- Organise regular fire drills to practice evacuation procedures; all drills must be recorded, as should any equipment testing.

8.3 When working with providers such as residential care homes, supported accommodation and extra care housing schemes make sure they have access to the guidance below in addition to having a robust fire safety policy.

Fire safety risk assessment: residential care premises - GOV.UK (www.gov.uk) – relevant for residential care home settings specifically

NFCC Specialised Housing Guidance

8.4 Care homes differ from other accommodation-based services, such as sheltered or extra care housing schemes, in that they can stipulate having a designated area for smoking, which must be well-ventilated and not allow for smoke to get into other rooms. The Thematic Fatal Fires SAR noted the limitations in relation to fire safety in other accommodation settings, such as supported or extra care housing, in that as residents have individual tenancy arrangements, they are permitted in law to smoke within their properties and the provider cannot insist on the use of a designated smoking area.

8.5 Regardless of whether the person lives in a care home or a supported accommodation, best practice is to ensure that each resident has a Person-Centred Fire Risk Assessment, and a Personal Emergency Evacuation Plan (PEEP) and that LFB carry out a HFSV for all high-risk residents.

8.6 These types of accommodation have to ensure there is good management of fire safety, including good, clear, and accessible procedures as well as housekeeping procedures that will help to minimise fire risks. All staff should know the procedures and receive mandatory training as well as clearly understand their role and responsibilities in ensuring and maintaining good fire safety. The Multi-Agency Fire Safety Competency Framework set out by LFB (Appendix 4) supports a consistent approach to fire safety training across the SAEB partnership.

9. Fire safety and self-neglect and hoarding

9.1 Hoarding is where someone acquires an excessive number of items, which can result in unmanageable amounts of clutter. Hoarded materials present an increased fire risk, as they can easily catch alight if they come into contact with heat sources, such as overloaded extension leads, the kitchen hob or naked flames, like candles or cigarettes. Because of the amount of potentially combustible possessions, fires will also spread more quickly and grow bigger than in a non-hoarded property.

9.2 A robust and comprehensive risk assessment, which is likely to require a specialist multi-agency response across ASC, LFB, housing, environmental health and mental health services is important and should help to shape the support that is provided to people who hoard.

9.3 Hoarding is a form of self-neglect, which may require a safeguarding response. The Care and Support Statutory Guidance which accompanies the Care Act 2014 sets out that ordinarily concerns about self-neglect "may not prompt a Section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this without external support" (14.17). Practitioners should contact ASC for advice on concerns relating to an individual who is self-neglecting and/or hoarding, and for a decision as to whether the concerns should be responded to via local self-neglect policies, or whether a Section 42 enquiry is warranted in situations where risks remain significant and unresolved, such as in complex hoarding cases.

9.4 The Clutter Image Rating Tool offers a useful resource to professionals when assessing concerns relating to hoarding and LFB expect referrals to their service to use this tool.

10. Case studies

10.1 **A case study in which a fire risk assessment led to positive outcomes**

Frank was a man in his late 60s who lived alone in a one-bedroom flat. He had a history of alcohol misuse, depression and anxiety, and was receiving support from his local community mental health services. Frank was also a heavy smoker and often fell asleep with a cigarette in his hand, putting himself and others at risk of fire. The mental health team referred Frank to the local fire service for a HFSV, where they conducted a person-centred fire risk assessment and identified several hazards, such as clutter, faulty electrical

appliances, and lack of smoke alarms. The fire service provided Frank with some fire prevention advice, installed smoke alarms and a fire-retardant bedding pack, and arranged for a follow-up visit to monitor his progress. They also liaised with Frank's social worker and other agencies involved in his care, to ensure a coordinated approach to his fire safety and wellbeing. As a result of the intervention, Frank reported feeling more confident and secure in his home and reduced his smoking and alcohol intake. He also engaged more with his support network and attended activities at a local day centre. The fire service noted a significant improvement in Frank's living conditions and fire safety awareness, and no further incidents of fire or near misses were reported.

10.2 **A case study in which a multi-agency approach to fire safety was beneficial**

Linda was a woman in her early 50s who lived with her adult son, who had a learning disability and autism. Linda was his main carer and received support from a learning disability team. Linda also had some physical health problems and mobility issues, which made it difficult for her to access and maintain her home. Linda and her son were both smokers and used matches and lighters to light their cigarettes. The learning disability team noticed that there were signs of fire damage and scorch marks on the carpets, curtains, and furniture in Linda's home, and raised concerns about their fire safety. They contacted the local fire service, who agreed to carry out a HFSV and a person-centred fire risk assessment. The fire service found that Linda and her son had no working smoke alarms, no fire escape plan, and several fire hazards in their home, such as flammable materials, overloaded sockets, and faulty wiring. The fire service provided Linda and her son with some fire prevention advice, installed smoke alarms and a fire-retardant bedding pack, and gave them some safer alternatives to matches and lighters, such as electric lighters and ashtrays. They also referred Linda to a local charity that offered home improvement and maintenance services, such as clearing clutter, fixing electrical faults, and fitting fire doors. The fire service worked closely with the learning disability team and other agencies involved in Linda and her son's care, to ensure a holistic and person-centred approach to their fire safety and wellbeing. As a result of the intervention, Linda and her son reported feeling safer and happier in their home and improved their smoking habits and fire safety behaviour. The fire service noted a significant reduction in fire risks and potential harm in their home, and no further incidents of fire or near misses were reported.

10.3 **The benefits of a multi-agency approach to fire safety**

A serious fire incident occurred in West Cromwell Road in Earls Court on 12th February 2021, in a four-storey house converted into flats. The fire started in a flat on the first floor, where the occupant was a hoarder and a smoker, and had previously been involved in several fire-related incidents. The fire spread quickly and affected three other flats, where four people had to be rescued by the fire service, two of them using fire escape hoods. One of the residents had a history of violence towards emergency services and was arrested by the police. The fire caused extensive damage to the property and posed a high risk to the lives and wellbeing of the residents and neighbours.

This incident illustrates the benefits of a multi-agency approach to fire safety, as it involved collaboration and communication between different organisations and professionals, such as the fire service, the police, the housing association, ASC, and a local charity. The fire

service had conducted several fire safety audits and inspections of the property in the past and had issued informal notifications of deficiencies and safeguarding referrals to the relevant agencies. The fire service also provided fire prevention advice, equipment, and support to the residents, especially those who were vulnerable due to their smoking habits, health conditions, or living environment. The fire service worked closely with the other agencies to ensure a holistic and person-centred approach to the fire safety and wellbeing of the residents, and to share information and good practice. The multi-agency approach helped to reduce the fire risks and potential harm in the property, and to improve the outcomes and satisfaction of the residents. It also helped to identify and address any gaps or challenges in the service delivery, and to create learning opportunities for staff development and training. This multi-agency approach to fire safety was beneficial for both the residents and the professionals involved, as it enhanced the quality and effectiveness of the service provision and the fire safety culture.

11. Staff support and training

11.1 In this section, we will share some examples of good practice and learning opportunities for staff who work with people who may have increased fire risks due to their smoking habits, physical or mental health conditions, or living environment.

11.2 Good practice tips are listed below:

TOP 10 FIRE SAFETY PRACTICE TIPS	
1	**Be professionally curious** When working with adults who have increased vulnerability to fire risks, it is important to act on your instincts and ask questions and explore with the adult any concerns about fire risks. Confirm what you see and hear – for example: • In every room, could a fire start here? If it did, could the person get out and is there anything that would affect their ability to leave, such as impaired mobility, a cognitive impairment or blocked escape routes? • If the person smokes, look for appropriate disposal of cigarettes. Also, how do they light their cigarettes? Use of matches can increase fire risks. • If you see a smoke alarm, check that it works – or refer to LFB to check this as part of a HFSV. • Ask the person about their bedtime routine and specifically what they do to ensure fire risks are managed before they go to bed. For example, are they checking that any portable heating devices, gas fires or cooking appliances are switched off.
2	**Conduct comprehensive fire risk assessments …**

	… for any individual who smokes using tools such as the LFB Person-Centred Fire Risk Assessment, the on-line Home Fire Safety Checker, or use the risk assessment templates in this framework.
3	**Regularly review risk assessments and always when there is a change in the person's circumstances…** …such as following a hospital discharge, a change in care provider, or a deterioration in the person's health, physical functioning and mobility.
4	**Effective information sharing is key** Work collaboratively with all other agencies involved, such as the LFB, housing providers, care agencies, and health professionals, to share information, agree on actions, and monitor the outcomes of the fire safety plan. Don't assume that someone else is doing something. Ensure that a coordinated and agreed action plan is in place detailing who leading on specific actions and who will monitor or review and when.
5	**Apply the principles of the Mental Capacity Act …** …and assess the person's ability to understand, retain, use or weigh and communicate information about fire safety risks. As part of the assessment consider the person's executive functioning and their ability to act on their decision about fire safety. If the person lacks capacity consider the less restrictive options to protect them from harm, such as providing alternative smoking devices, installing sprinklers, or arranging supervision.
6	**Adopt an early intervention and prevention approach** Always consider the least restrictive and early preventative options to protect a person from harm, such as providing alternative smoking devices, installing telecare equipment, ensuring fire evacuation plans are in place, or arranging supervision.
7	**Ensure practice is person-centred and strengths-based** Adopt an approach that respects the person's wishes and preferences, while also balancing the risks to themselves and others. Exploring the reasons why the person smokes, what benefits or challenges it brings to them, and what support or alternatives they would consider, such as being referred to a smoking cessation programme where nicotine replacement may be offered to support them. Ceasing smoking an impact significantly on some psychiatric medication so, if relevant, this needs to be a planned cessation programme.
8	**Provide clear and accessible information and education…** … to the person and their family or carers about the fire risks and how to reduce them. Using different methods, such as leaflets, videos, or demonstrations, to suit the person's needs and abilities.

9	**Recognise and respond to any signs of abuse or neglect that may increase the fire risks** …such as hoarding, self-neglect, financial exploitation, or domestic violence. Raise a safeguarding concern if necessary and following the local procedures and guidance. Use the following contact details to raise a concern: **For Kensington and Chelsea:** • Telephone: 020 7361 3013 • Email: socialservices@rbkc.gov.uk **For Westminster:** • Telephone: 020 7641 2176 • Email: adultsocialcare@westminster.gov.uk
10	**If you are concerned, refer to LFB!** Always share any fire risk concerns with your line manager and take urgent action to manage and reduce those risks by referring to LFB and seeking advice, even for adults with capacity who decline the offer of a HFSV.

11.3 **Everyone needs fire safety awareness training**. The Fire Safety Competency Framework at Appendix 4 provides a framework to outline individual organisation's responsibilities around training to ensure appropriate standards of fire safety competence is in place.

11.4 LFB have produced a video training guide for anyone providing a caring role or for those in support services around recognising and responding to fire risks. In addition, LFB in conjunction with the SAEB has produced a training webinar to support practitioners who support adults at risk in the community around fire safety.

11.5 It is also important that all partner agencies have robust supervision and management oversight processes in place to ensure that staff are fully supported and have opportunities for de-briefing, reflection and to share learning and good practice within teams.

12. Useful resources

12.1 The following LFB resources provide useful information in relation to fire safety:

- LFB Home Fire Safety Checker
- LFB Person-Centred Fire Safety Risk Assessment
- A Carers Guide to Home Fire Safety

- Fire Safety and Hoarding
- Flame Retardant Bedding and Portable Protective Systems
- Cooking – Fire Safety at Home
- Candles – Fire Safety at Home

12.2 The Safeguarding Adults Executive Board (SAEB) has produced the following fire safety learning briefings:

- Fire Safety and Safeguarding
- Emollients and Smoking
- Telecare and Fire
- Fatal Fires Thematic Review
- Fire Safety Awareness – Questions and Answers
- Electrical Fire Safety Webinar – December 2024
- Fire Risk Awareness in the Home Training Webinar – LFB – March 2025

12.3 Other useful resources:

- Care Quality Commission – Fire risk from use of emollient creams
- NFCC Fire Safety in Specialised Housing

Appendix 1: Multi-Agency Fire Risk Assessment

Responsible agency:	
Risk assessment completed by:	
Date completed:	
Adult's name:	
Address:	

Date of review:		**Note:** The risk assessment should be completed and reviewed in accordance with an individual's care plan arrangements
Assessors signature:		

Area	Risk Assessment	Yes	No	Comments
Smoke Alarms give the earliest warning of fire – please check	Are there smoke alarms on each floor of the property? **See guidance note 1**			
	Test these – do they work?			
	Is there a Telecare/community alarm?			
	If there is a Telecare/community alarm – is it linked to a Telecare smoke alarm?			
Smoking – a major contributor to fire deaths	Are there signs of burns on carpets, furniture, bedding or clothing?			
	Are there carelessly discarded cigarettes on floor?			
	Are there lighters/matches in reach of young children?			
Alcohol/ substance misuse and prescribed medication	Are there indications of alcohol misuse?			
	Are there indications of substance misuse?			
	Is the person medicated to help them sleep? **See guidance note 2**			
Sensory impairment	Does the person have a sensory impairment?			
	Can the service user hear the alarm if they aren't wearing hearing aids (if required).			

	Does the person with a sensory impairment have additional fire protection equipment e.g. vibrating pads etc			
Disability – physical or mental health including dementia.	Does the person have a disability – physical or mental health including dementia?			
	Would the disabilities affect the person's ability to understand the sound of the smoke alarm?			
	Would the disabilities affect the person's ability to raise the alarm?			
	Would the disabilities affect the person's ability to escape from the property? **See guidance note 3**			
Hoarding greatly increases the fire loading	Are there flammable materials stored near to ignition sources?			
	Are there dangerous or highly flammable materials being stored?			
	Are exit routes blocked?			
General Home Safety	Is there previous history of fires? **See guidance note 4**			
	Is there any threat of arson?			
	Are there overloaded electrical sockets? **See guidance note 5**			
	Are there electrical/gas appliances in a poor or dangerous condition? A build-up of fat and grease can cause a fire. **See guidance note 6**			

Multi-Agency 'Person at Risk' Fire Risk Assessment – Guidance Notes

Guidance Note 1

Smoke Alarms – Are the smoke alarms fitted to the ceiling?
As a minimum there should be one alarm per floor, but consideration should be given to rooms presenting high fire risks i.e. bedbound occupier, evidence of burn marks, hoarding.

Guidance Note 2

Consider any condition that may mean the service user forgets / leaves cooking unattended for extended periods or could allow them to fall asleep whilst smoking.

Guidance Note 3

Think about at night when it is dark – is it locked with a key, and would the user be able to insert the key if they were panicking? Do they have the dexterity to unlock the door?

Guidance Note 4

What caused the previous fire? Does this highlight potential risks?

Guidance Note 5

Are there enough plug sockets in the property? Does the service user plug an extension lead into another extension lead? Are wires exposed within the cables?

Guidance Note 6
Domestic deep fat fryers are usually manufactured with a thermostatic control to prevent a fire starting in the machine. If the service user uses a normal frying pan or saucepan, this would present a higher risk.

Additional Guidance

- **Emollient Creams:** Residue from emollient creams can build up on fabrics, such as clothing or bedding, and cause them to catch fire more easily in addition to any cream on an adults skin.

- **Air Flow Mattress:** Smoking in bed is a high-risk activity which increases further when using an air flow mattress.

Appendix 2: Smoking Risk Assessment

This template has been developed primarily for use within residential care settings, such as care homes, supported accommodation and extra-care housing schemes, but can also be used by other agencies, including Registered Housing Providers.

Accommodation-based provider services have a responsibility to look after the health and safety of all the adults in their care; this Smoking Risk Assessment is intended to support these responsibilities.

The assessment should be completed by the provider manager, ideally prior to the resident taking up residency, and reviewed on a six-monthly basis, or before as required, for example in relation to a change in circumstances.

Adult's name:		**Date of birth:**	
Flat / Room number:		**Date of assessment:**	
Assessment completed by:		**Job title:**	

Adult's care and support needs **Does the adult have any of the care and support needs listed below, which may increase their fire risk in relation to smoking?**		
Area of need	**Tick if applies**	**Details**
Physical health need e.g. condition which has resulted in reduced mobility and functional ability		
Mental health need e.g. anxiety, depression, schizophrenia		
Cognitive impairment e.g. dementia or learning disability*		
Substance use e.g. drugs or alcohol		
Sensory impairment e.g visual or hearing loss		
Communication needs e.g. use of Makaton, speech		

impairment, interpreter needed		
Other – please specify		

** Please note – a person's mental capacity must be assessed if there are concerns about their ability to understand and manage the fire risks associated with smoking habits – see mental capacity assessment and best interests' decision template at Appendix 3.*

Clinical risks		
Area of need	**Tick if applies**	**Details**
Does the adult use oxygen cylinders?		
Does the adult use any emollient creams?		
Does the adult use any medications which sedate?		
Other – please specify		

Details of smoking behaviour		
What does the adult smoke? **E.g. manufactured cigarettes, roll-up cigarettes, cigars, vapes etc.**		
What does the adult use to light their smoking materials? **E.g. matches, lighter, stove top, combination, other.**		
Where does the adult smoke? **E.g. living area, in bed, outside smoking area, combination.**		
How often does the adult smoke during the day / night? How many cigarettes does the adult smoke per day?		
Is the adult able to light / extinguish their smoking materials safely?	**Yes**	**No**

Is the adult able to hold their smoking materials safely and securely?	**Yes**	**No**
Would the adult be able to raise the alarm if there was a problem whilst they were smoking?	**Yes**	**No**
Are their historical burn marks on the adult's clothing, furniture, blankets etc?	**Yes**	**No**
Doe the adult consent to wearing a smoking apron?	**Yes**	**No**

Smoking advice and preventative measures		
Area of need	**Yes / No**	**Details**
Has the adult been given information and advice about safer smoking and safety equipment available?		
Has the adult been given advice about smoking cessation and services available to assist them to reduce or stop smoking?		

Current risk mitigation measures in place
1.
2.
3.
4.
5.

Summary of overall risk **Based on the information gathered above, the provider manager is required to make an evaluation of risk using the following definitions and placing a cross in the low, medium or high box**

Low: The adult is considered competent to smoke with little or no assistance from staff Medium: The adult is at risk of igniting either their clothing or other material whilst smoking and requires staff assistance / supervision High: The adult requires a high level of staff assistance and needs to have additional safety arrangements in place prior to smoking		
Low	**Medium**	**High**

Summary of issues identified and actions to be taken Note - All high-risk smokers must be referred for a Home Fire Safety Visit from London Fire Brigade
(1)
(2)
(3)
(4)
(5)

Information sharing Tick to confirm that a copy of this risk assessment has been shared and discussed with relevant parties (with the adult's consent, or in their best interests should they be assessed to lack capacity)	
The adult	
Their family / carer / nominated next of kin	
ASC	
Other agency – please specify	

Smoking risk assessment review			
Review Date	**Was a change identified?**	**Details**	**Sign and Print Name**
	Yes / No		

	Yes / No		
	Yes / No		
	Yes / No		

Appendix 3: Mental Capacity Assessment and Best Interests Decision Template – Individuals at Risk of Fire Hazards due to Smoking

Purpose of this tool:

This tool is intended for use after completing a comprehensive risk assessment when there is concern about a person's mental capacity regarding individuals at risk of fire hazards due to smoking habits or associated behaviours.

Informing the individual of the assessment:

It is essential to inform the individual of the purpose of the assessment and its focus on promoting their safety and well-being. Any member of staff can carry out an assessment, provided they follow the Mental Capacity Act's legal guidelines. If there is evidence that the individual lacks capacity, a *Bests Interests Decision* must be made, in consultation with relevant partner agencies such as Adult Social Care, NHS and the LFB to develop an action plan.

Recording assessments:

It is important to ensure that mental capacity assessments are recorded comprehensively. Good practice is to record the questions as they were asked, and the responses provided by the adult. Professionals should tailor communication to meet the individual's needs, such as simplifying language, rephrasing, or using visual aids. For complex cases, assessments may require multiple visits to establish clarify and rapport.

Guidance for Mental Capacity Act (MCA) Assessments

The five statutory principles of the MCA 2005:

(1) "A person must be assumed to have capacity unless it is established that they lack capacity" (**presumption of capacity**).
(2) "A person is not to be treated as unable to make a decision unless **all practicable steps** to help them to do so have been taken without success" (help the person make the decision).
(3) "A person is not to be treated as unable to make the decision merely because they make an **unwise decision**".
(4) "An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**".
(5) "Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved that is **less restrictive** of the person's rights and freedom of action".

To apply the test, it can best be broken down into three questions:

(1) Is the person about the make a decision?

This is known as the Functional Test: a person is considered unable to make a decision if he/she is unable to do any **one** of the following:

- Understand information relevant to the decision about smoking-related fire risks.
- Retain relevant information long enough to make a decision.
- Use or weight relevant information in the decision-making process.
- Communicate his/her decision.

If so:

(2) Is there an impairment or disturbance in the functioning of the person's mind or brain?

This is known as the Diagnostic Test: only if he/she does can you potentially conclude that he/she lacks capacity under the MCA. This can involve a formal medical diagnosis, or there is sound basis for believing the person has an impairment or disturbance in the mind or brain. Examples of this may include:

- Apparent cognitive issues in the absence of a formal diagnosis.
- The effects of alcohol or drugs.

If so:

(3) Is the person's inability to make the decision because of the identified impairment or disturbance?

This is known as the Causative Nexus.

Mental capacity considerations

Key considerations for smoking-related fire risks:

A person's mental capacity must be assessed if there are concerns about their ability to understand and manage the fire risks associated with smoking habits. The relevant information that a person needs to understand, retain and use or weigh, will vary from case to case. However, it is likely to include:

The reasonably foreseeable consequence of their smoking habits, deciding one way or another, or failing to make the decision.

Please refer to the risk assessment template at Appendix 2 for valuable context and evidence, supporting decisions regarding mental capacity assessment. As well as using good observation skills, see below for examples of some questions you may wish to ask where you are concerned about someone's safety.

Examples of questions to assess a person's capacity to smoke safety and manage associated fire risks:

1. Can you explain the fire risks associated with smoking in your home?
2. What could happen if a lit cigarette is left unattended and not disposed of properly?
3. Are you aware of specific risks in your home, such as smoking near oxygen cylinders, flammable items, or while in bed?
4. Do you remember any previous advice or warnings provided about fire safety and smoking habits?
5. Can you recall any past incidents where smoking caused a fire in your home?
6. What steps do you take to reduce the risk of fire when smoking?
7. Do you use fire-safe measures, such as using a metal ashtray, fire-retardant bedding or ensure that cigarettes are completely extinguished?
8. How do you balance your choice to smoke with the potential fire risks to yourself and others?
9. If you were told your smoking habits, put you or others in danger, what would you do to address those concerns?
10. Are you able to make and follow through on decisions to reduce fire risks, such as limiting where you smoke or using fire safety devices?
11. Can you accept support, such as a Home Fire Safety Visit from the fire service to help

manage fire risks at home?
12. Can you clearly explain your understanding of fire risks and how you manage them?
13. Are you comfortable discussing your smoking habits and fire safety measures with professionals or family members?

Additional contextual questions:

1. Have you ever fallen asleep while smoking or struggled to remember to extinguish a cigarette?
2. Do you have any physical or cognitive conditions, such as mobility issues or memory impairments that might affect your ability to safely manage smoking?
3. Are there any barriers preventing you from implementing fire safety measures, such as a lack of resources or support?

How to test executive capacity (the ability to actually carry out the decision):

- Use the articulate / demonstrate approach, for example:
  - Could you describe to me how you would put out your cigarette?
  - Can you show me how you do that?
  - I'm not sure what you mean… could you just show me?

- Check the extent to which the person is aware of their deficits:
  - That is are they able to understand, and/or retain, and/or use or weigh, the fact that there is a mismatch between what they think they can do and what they can actually do

These questions aim to establish whether the individual:

- Understands the risks and consequences of their smoking habits.
- Can implement and maintain fire safety precautions.
- Needs additional support or intervention to manage risks.

Mental Capacity Assessment Template			
Name:		**Date of birth:**	
Address / current location:		**First language:**	
		Is an interpreter required? If yes give details:	
What has led to this assessment taking place at this time? *(you must have grounds to consider that one is necessary to do at this time)*			
What is the decision to be made? *(focus on evaluating the person's capacity to make the specific decision(s) regarding fire safety and managing risks to self and others. For example; "To ascertain if P has the capacity to make decisions about fire safety and managing their own risks ir relation to smoking".*			

The following practicable steps have been taken to enable and support the person to participate in the decision-making process *(consider the location and timing; relevance of information communicated; the communication method used; and the involvement of others)*
The recording of the conclusion reached as to whether the person has capacity
Is the person able to understand the information about the decision to be made? *(do they have a general idea of their current situation, the reason why the decision is needed and the likely effects of deciding one way or another, or making no decision at all?)*
Is the person able to retain the information relevant to the decision? *(a person only has to remember information long enough to weigh it up during the assessment and use it to make a decision)*
Is the person about to use or weigh up the relevant information as part of the decision-making process? *("to think through decisions non-impulsively", "to give coherent reasons" use information to weigh up the risks faced if he/she doesn't have this help and consequences of decisions, but also the ability to implement the actions)*
Is the person able to communicate their decision by any means?
Is the person's inability to make the decision because of the identified impairment or disturbance in the function of the mind or brain? Explain the rationale *(the inability to make the decision is because of an impairment of, or a disturbance in, the functioning of the mind or brain – causative nexus)*
OR - In my opinion the person HAS capacity to make this specific decision *("I have a reasonable belief that this person has capacity at the moment to make this particular decision …" Remember that if there is evidence that the person cannot do any one of these things then they must be found to lack capacity about that decision, for example, often a person may be able to understand but cannot retain or use the information)*
Please note if the answer is yes, do not proceed to make a best interests decision.

Assessor's name and role:	
Signed:	
Date:	

Best Interests Decision Process and Checklist

The best interests principle:

Best interests is a statutory principle set out in section 4 of the MCA. It states that 'any act done, or a decision made, under this Act on or behalf of a person who lacks capacity must be done or made in his/her best interests'.

Because the best interests principle is statutory, there is a legal requirement for all decision-makers to apply it when making decisions on behalf of a person who lacks capacity.

Checklist for applying the best interests principle:

The MCA Code of Practice sets out the steps that you must take (or at least consider taking) in all cases to ensure that the best interests principle is applied when making decisions.

Only decisions that have been made using this checklist can be defined as best interests decisions under the MCA.

The steps that are taken, and the manner in which they are taken will vary depending on:

a. The specific circumstances and needs of the person.
b. The decision that is to be made, and;
c. The urgency of the decision to be made.

Mental capacity involves not only weighing up information and being able to understand consequences of decisions and actions, but also the ability to implement those actions. For those who lack capacity for the decision, the intervention focus will be to reduce the risk through a best interests decision. **You should discuss with your Manager or refer the situation to the responsible body.**

Best Interests Decision Template

To use this form for decisions in relation to fire risks related to smoking, the person must be aged 16+ and a formal mental capacity assessment has been completed which shows that the person lacks capacity to make the decision in question

List all available options:

(1)

(2)

(3)

(4)

What is the proposed option / intervention / action(s) to take to reduce the risk of harm?

What are the benefits / justification for the intervention / actions(s)?		
What are the individual's past and present wishes, feelings, statements regarding this decision?		
Is there a less restrictive option or any alternatives to consider? *Consider if there are less restrictive options in terms of the person's rights and freedom of action. This should be based on available options only.*		
Views of others: *As practicable and appropriate people who have an interest in the welfare of the person*		
Names and roles of people consulted (family, friends, professionals) and summary of their views: **(1)** **(2)** **(3)** **(4)**		
Can the decision wait? Consider if the person will have mental capacity sometime in the near future in relation to this matter. If so, when?		
Decision on agreed course of action in the person's best interests:		
Do all parties agree with the decision?	Yes	No
If no, details of objection:		
Is a formal best interests meeting required?	Yes	No
Action	**Assigned to and timescales**	

Lead Decision-Maker's name and role:	
Signed:	
Date:	

Appendix 4: Multi Agency Fire Safety Competency Framework

It is recognised that many partner agencies who are responsible for providing front line emergency services, health or social care support services may be presented with opportunities to identify significant risk factors with regards to fire safety within the home environment. This objective of this document is to provide a clear framework for partner agencies to achieve, maintain and demonstrate appropriate standards of fire safety competence within their workforce to manage risk factors. Knowledge and understanding elements are presented as a tiered approach to reflect suggested workforce responsibilities, however, partner agencies should review these elements against organisation specific roles and training needs analysis. This document is intended as an overarching framework and so it is the responsibility of respective organisations to develop more detailed workplace guidance around its implementation.

Development Methods:

Training delivery should be balanced between e-learning methods and face to face training; development should be supported through additional methods such as mentoring/shadowing, professional group discussions, reflective supervision etc.

Recording:

Partner agencies should ensure that workforce training is recorded appropriately to enable assurance and competence review.

Recommended resources:

- **Fire Safety and Safeguarding**
- **Emollients and Smoking**
- **Telecare and Fire**
- **Fatal Fires Thematic Review**
- **London Fire Brigade Carers Guide to Home Fire Safety**
- **Telecare Services Association e learning**
- **London Fire Brigade Carers Guide to Home Fire Safety**
- **Telecare Services Association e learning**
- **NFCC Specialised Housing Guidance**

Level 1 (Operational) Training Requirements
This is the minimum level required for all staff (including agency staff, voluntary staff, and specified contracted providers) working in any front-line emergency service, health or social care settings who may have contact with patients, clients, their families, or carers.
Knowledge & Understanding **Fire safety training at this level should include the following elements:**

Element	Learning Outcome
Fire risk factors	**Understand how the following factors increase fire risk:**
	• **Smoking – with signs of unsafe use of smoking or vaping materials (e.g. smoking in bed, unsafe charging).** • **Use of emollient creams that are petroleum or paraffin based.** • **Air pressure mattress or oxygen cylinders are used.** • **Unsafe use of portable heaters (e.g. placed too close to materials that could catch fire).** • **Unsafe cooking practices (e.g. cooking left unattended).** • **Overloaded electrical sockets/adaptors or extension leads.** • **Faulty or damaged wiring.** • **Electric blankets used.** • **Evidence of previous fires or near misses, burns or scorch marks on carpets and furniture.** • **Unsafe candle/tea light use (e.g. left too close to curtains or other items that could catch fire or within easy reach of children or pets).**
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • **Identify all common fire risk factors within a practical setting/case study scenario**

Level 1 (Operational) Training Requirements	
Element	**Learning Outcome**
Ability to react to a fire/alarm	**Understand how the following factors impact ability to react to fire/alarm:**

	• Mental health issues (e.g. anxiety or depression). • Cognitive or decision-making difficulties. • Alcohol dependency or misuse of drugs. • Sensory impairments (e.g. hard of hearing or sight loss).
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • **Identify all factors that impact an individual's ability to react to a fire/alarm within a practical setting/case study scenario**

Level 1 (Operational) Training Requirements	
Element	**Learning Outcome**
Ability to escape from a fire	**Understand how the following factors impact ability to escape from a fire:**
	• **Restricted mobility, frailty, or history of falls.** • **Blindness or impaired vision.** • **Lacking capacity to understand what to do in the event of a fire.** • **Hoarding, or cluttered/blocked escape routes (including by mobility devices)** • **Bed or chairbound.** • **Internal doors left open at night.** • **Inability to unlock front door to escape.**
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • **Identify all factors that impact an individual's ability to escape from a fire within a practical setting/case study scenario**

Level 1 (Operational) Training Requirements

Element	Learning Outcome
Practical Fire Safety	**Identify, understand, and apply simple fire safety measures to control risk e.g.:**
	• Smoke and heat detection (incl. testing) • Safer candle/match use • Safer cooking • Safer use of heating • Smoking (incl. e-cigarettes/vapes) safety measures. • Escape plans • Safe use of electrics • Bed time routines
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • Identify fire safety risks and apply simple fire safety measures within a practical setting/case study scenario.

Level 1 (Operational) Training Requirements	
Element	**Learning Outcome**
LFB Home Fire Safety Checker, Referral Pathways & Home Fire Safety Visits (HFSV)	**Understand:**
	• The use of the LFB on-line Home Fire Safety Checker • The method of identification of Very High-Risk individuals and referral pathways to LFB for priority HFSVs • Local Authority Safeguarding arrangements in relation to fire risk • What happens during a HFSV. • Supporting HFSVs through joint visits • How to request feedback following a HFSV
Practical Application:	**Learning Outcome** **Demonstrate the ability to:**

	• **Complete appropriate referrals for a practical setting/case study scenario.**

Level 2 (Supervisory) Training Requirements

This is the minimum level required for all staff (including agency staff, voluntary staff, and specified contracted providers) providing supervision, management and/or leadership to operational staff in a front-line emergency service, health, or social care settings (NHS or non-NHS) who have contact with patients, clients, their families or carers, or the public. This level is also applicable to those who engage in either completing or reviewing any risk assessments.

Knowledge & Understanding
Fire safety training at this level should include all elements at Level 1 the following elements:

Element	**Learning Outcome**
Cognition & Capacity (Fire risks)	**Understand:**
	• **Why an individual's mental capacity should be established when there are concerns over their understanding of risks, (especially in relation to their smoking habits) and/or ability to give informed consent to planned interventions and decisions about fire safety measures.** • **How to determine the approach to be taken by professionals, either to support the decision making of an adult with capacity or to intervene to protect the best interests of a person who lacks capacity** • **How to record a mental capacity assessment and what to include** • **The importance of considering executive capacity and exploring individual's ability to act on decisions they have made.**
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • **Identify when a mental capacity assessment may be required within a practical setting/case study scenario.**

	• **Complete a mental capacity assessment within a practical setting/case study scenario (agency dependant).**

Level 2 (Supervisory) Training Requirements	
Element	**Learning Outcome**
Person centred fire risk assessments	**Understand:**
	• **The 9-step person centred fire risk assessment process, including:** 1. **The characteristics, behaviours and capabilities of a resident that may lead to fire risk.** 2. **Determining the potential causes of fire and the existing measures to prevent fire.** 3. **Identifying any circumstances that could lead to the rapid development of fire.** 4. **Identifying existing measures to protect the resident if fire occurs.** 5. **Considering the capacity of a resident to respond appropriately to fire alarm signals or signs of fire.** 6. **Considering the ability of a resident to make their way to safety.** 7. **Determining the level of risk to the resident from fire.** 8. **Preparing an action plan.** 9. **Determining the period for review of the assessment.** • **When to complete a risk assessment** • **How to record and store risk assessments** • **When and with whom to share risk assessment outcomes** • **The importance of routinely updating risk assessments, especially following a change in circumstances (such as hospital discharge or significant change in health or functional ability).**
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • **Undertake a person-centred fire risk assessment within a practical setting/case study scenario.**

Level 2 (Supervisory) Training Requirements	
Element	**Learning Outcome**
Personal Emergency Evacuation Plans (PEEPS)	**Understand:**
	Who may require a PEEP **Who may complete a PEEP** **When and with whom to share PEEPs** **The importance of routinely updating PEEPs, especially following a change in circumstances (such as hospital discharge or significant change in health or functional ability)**
Practical Application:	**Learning Outcome** **Demonstrate the ability to:** • **Identify when a PEEP may be required within a practical setting/case study scenario (agency dependant)**

Level 2 (Supervisory) Training Requirements	
Element	**Learning Outcome**
Multi Agency Approach to Fire Risk management	**Understand:**
	• **When a multi-agency approach may be required to mitigate fire risks** • **Actions to take should multi-agency approach be unable to resolve outstanding fire risks**

Practical Application:	Learning Outcome
	Demonstrate the ability to: • **Mitigate fire risks within a practice multi-agency panel using a case study.**

Level 3 (Strategic) Training Requirements

This is the minimum level required for all staff (including agency and voluntary staff and specified contracted providers) providing strategic/board level management/leadership within frontline emergency service, health, or social care settings (NHS or non-NHS) organisations, including Safeguarding Adults Executive Board Members. This Level is also applicable to those developing organisational policy/guidance related to fire risk.

Knowledge and Understanding
Fire Safety Training at this level should include awareness elements at level 1 & 2 and the following elements.

Element	Learning Outcome
Strategic Multi Agency Fire Risk Management	**Understand and recognise:**
	• **The legislative requirements surrounding fire risk within front line emergency service, health or social care settings (NHS or non-NHS) organisations.** • **The strategic need to embed fire safety within all agencies irrespective of primary agency responsibilities.** • **The statutory role of safeguarding boards including partnership arrangements, policies, risks and performance indicators, staff roles and responsibilities in safeguarding (fire risk); and the expectations of regulatory bodies in safeguarding.** • **The need for organisational-level support to promote, embed and monitor practice, alongside ongoing support for practitioners from managers and workplace supervisors.**

Practical Application:	Learning Outcome
	Demonstrate the ability to:

- **Employ strategic fire management within a case study scenario.**

Appendix 5: National Safeguarding Adults Reviews (SARs) Relating to Fire Risks / Deaths

The following list is not exhaustive but includes a number of SARs undertaken across the country in relation to fire risks.

- Bexley – Victoria (July 2020)
- Bi-Borough of Kensington and Chelsea and Westminster – Thematic Review (August 2023)
- Buckinghamshire – CC (August 2020)
- Cheshire East – Mervyn (May 2021)
- Cheshire East – Mr C
- City and Hackney – EF (March 2021)
- Devon and Torbay – Thematic Review (February 2023)
- Hammersmith and Fulham – Alison (March 2023)
- Milton Keynes – Thematic Review
- Lancashire – Adult M (August 2022)
- Leeds – Thematic Review
- Lincolnshire – Peter and Judith - Joint SAR/Domestic Homicide Review (October 2021)
- Oldham – Thematic Review (January 2020)
- Sandwell – Adeena (June 2019)
- Slough – David (June 2023)
- Sutton – EE (June 2019)
- Sutton – Thematic Review (February 2022)
- Walsall – Clara (August 2019)
- Wigan – Diane (2021)