1

1 CASE SUMMARY Mr A

Mr A had a number of health conditions, including partial paralysis, significant difficulty communicating verbally and skin conditions which required the application of emollient cream (petroleum based). He lacked capacity to make complex decisions.
In 2013 he moved into 24 hr supported accommodation and received significant input to meet personal care needs. His care staff requested a review, concerned his smoking posed a risk following 2 small fires from discarded cigarettes (Feb and May '16). His GP also noted, following a burn that he had a 'habit of putting cigarettes, lighters and remote controls down his trousers' (May '16). In July 2016 the London Fire Brigade ['LFB'], during an inspection of the property conducted under the Regulatory Reform (Fire Safety Order) 2005, highlighted informally that he posed a fire risk if he was permitted to smoke despite the premises' 'No smoking' policy. In August 2017 Mr A tragically died. The inquest recorded that burns and exposure to fire fumes were the cause of Mr A's death. The coroner also noted that 'the use of emollient creams which were applied regularly are likely to have had a bearing on the intensity of the fire'.

2 MAKING SAFEGUARDING PERSONAL

In July 2013 social care staff recognised their duty to make reasonable adjustments to support Mr A to communicate and participate in key decisions regarding his care, but these were not subsequently employed to discuss fire safety and the risk of harm his continued smoking posed. A key principle of safeguarding is empowerment- this means giving information to people so they can protect themselves. Mr A wasn't offered support for smoking cessation or access to safe nicotine replacement options. Nor was he referred to the London Fire Brigade for a Home Fire Safety Visit. This was a missed opportunity and should've been explored, especially following previous fire incidents.
Learning point: Systems should support professionals to record, retain and share where appropriate, information on an adult's communication needs and access requirements necessary to ensure a person-centred approach is followed.
Recommendation: All those providing care (social care staff, providers, district nurses) should consider any fire risk to an individual during any contact and to take steps to mitigate foreseeable risk. Also, important to ensure entitlement to advocacy support (s67 Care Act) is explicitly considered.

3 FIRE RISK ASSESSMENT

Learning point: There had been significant activity, multi-agency involvement and partner challenge to mitigate the fire risk, but this was not person-centred so, in practice, was ineffective. Partners across all agencies should be aware of significant fire risk factors (e.g. history of fire setting, immobile adults, self-neglect, heightened risk with certain health equipment (i.e. oxygen, petroleum based creams/lotions, history of fire setting, immobile adults, self-neglect, heightened risk with certain health equipment and indoor smoking). When identifying a fire risk, all staff must consider what action is needed to reduce the risk. Anyone with a duty of care- as a landlord, employer of care staff or professional involved in an adults health or social care provision (GP, nurse, OT, care manager or commissioner) should actively consider what proportionate action is necessary to reduce or remove the risk.
Recommendation: BSAB to establish a formal process between the LFB and adult social care for the referral of adults identified as high risk of fire who live within sheltered or supported living accommodation. This should have regard to the LFB Home Fire Safety Risk Referral Matrix.

4 A RIGHT TO SMOKE?

Learning point: Staff reported a real dilemma to balance Mr A's perceived 'right' or desire to smoke against the potential fire risks to him and others. The 'No Smoking' policy of the landlord wasn't well understood or enforced by care provider staff, because the policy was ambiguous as to whether this applied in both communal areas and private flats and a lack of clarity as to which agency (landlord or care provider) should take remedial action to prevent a fire. Staff also mistakenly believed Mr A had a 'right to make unwise decisions'. S.1 Mental Capacity Act 2005 simply states that a '*person should not be treated as unable to make a decision merely because he makes an unwise decision*'. This principle requires consideration of the person's capacity in a time and issue specific manner. His ability to realise and weigh up the risks his smoking posed was never explored, nor was his ability to make an informed decision against safer options to manage his smoking habit. Staff didn't update their capacity or risk assessments when his needs changed increasing risk that any incident could be fatal.

Recommendation: Barnet SAB explore how to support partners understand legal implications which apply to supported accommodation and how to balance any conflicting desires with their duty to promote wellbeing.

5 FIRE PREVENTION OPPORTUNITIES

Learning point: The review found that requests for individual home fire safety visits within supported living schemes currently operates on an ad hoc basis. LFB will respond to a request to visit residents identified at significant risk of fire, but BSAB will develop agreed working practices between agencies to identify and refer those most at risk.

Recommendation: Where the LFB provide verbal advice on fire prevention following an inspection or home safety visit, this should be followed up in writing and shared with relevant agencies to ensure any cases where there is a high fire risks is acted on or, if the adult is reported resistant to preventative steps, reviewed at the Multi-agency High Risk Panel meeting.

6 DUTY OF CARE

Learning point: LFB inspections under the Regulatory Reform (Fire Safety Order) 2005 relate to fire risk to a building and not to single dwelling such as supported living flats: they shouldn't be relied on as individual fire risk assessments. Care providers, landlords and commissioners must, when fulfilling their functions, ensure they have met their duties to adults at risk.

Recommendation: All care plans should specify what equipment or arrangements are necessary to safeguard adults at risk and prevent harm. Where these may increase risk or intensity of a fire, additional arrangements/equipment to reduce foreseeable harm (including those associated with flammable hoist materials) should be considered, with clarity provided on who is responsible in line with LFB guidance on personal protection systems.

7 ESCALATION OF CONCERNS

Learning point: The GP, district nurses and OT had identified the risks of harm by fire to Mr A. The GP reflected, as part of this review, on the importance (and challenges) of following up on concerns raised to ensure they resulted in any required action by other agencies.

Recommendation: BSAB to ensure that escalation processes are in place and that staff performing a supervisorial role can demonstrate that their staff understand how to use them within their organisations and how to constructively challenge partners when required. Already an internal audit of safeguarding repeat referrals tested effectiveness of escalation processes across the partnerships can be tested to ensure effectiveness.