Safeguarding Adults Review

“Alison”

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1 Executive Summary

Since 2019 Hammersmith and Fulham has experienced three fatal fires. A fire involving "Brian" (a pseudonym for confidentiality) on the 31st December 2019, one involving "Claire" (a pseudonym) on the 31st January 2021 and the most recent, involving "Alison" (again a pseudonym), on the 10th December 2021.

When looking at Brian and Claire, the Hammersmith and Fulham Safeguarding Adults Board (HFSAB) identified common factors in the circumstances of their deaths, one being smoking, therefore undertook a review to establish if any multi agency learning can be established from these cases. This review found a number of findings and established an action plan to address these findings.

However, on the 10th December 2021, H&F experienced another fatal fire involving Alison, the circumstances again being similar to Brian and Claire. Following this incident HFSAB had a number of concerns about whether the learning from the Claire action plan had been implemented and whether partner agencies could have worked better in Alison's case and agreed that it met the criteria for a formal Safeguarding Adults Review (SAR), undertaken by an independent reviewer, according to the Care Act 2014 (Section 44).

The review identified that much has been done since Alison's death:

- The care agency has introduced better risk assessments
- Adult Social Care (ASC) have updated the MOSIAC system to include additional triggers for a Person-Centred Fire Risk Assessment (PCFRA) and a clearer escalation process
- A better MDT network approach involving more partners
- An improved escalation of complex cases to the High Risk Panel
- There are better relationships between the Fire Brigade, ASC and housing as part of a fire safety assurance Multi-Disciplinary Team (MDT) approach.
- Changes to the way the London Fire Brigade (LFB) prioritise Home Fire Safety Visits (HFSV) and,
- The use of Personal Protective Systems to better mitigate fires in the most complex cases.

All these things will reduce the chance of a similar incident occurring again.

However, multi-agency communication is the most important element in reducing the risks for any case, but in particular, high-risk, complex cases and especially in cases involving drug dependency which was a significant issue in Alison's case. Having an awareness of what other partners can provide to mitigate risks places more significance on joint working (for instance in assessing mental capacity) and

MDT meetings. Having formalised ones as is proposed with the new network will aid this communication.

Alison's disengagement with the Drug and Alcohol Wellbeing Service (DAWS) after 2018 meant she did not receive specialist help and support to address her drug habit and better MDT coordination could have instigated a different, more effective, client centred approach used by the DAWS.

Housing providers can play a huge part in identifying vulnerable people who may be at a greater risk of fire in their home considering their responsibility to a large proportion of tenants within H&F. The checks as part of tenant home visits should identify these people to allow for earlier intervention. Similarly, a hospital discharge process that identifies vulnerable people who are more at risk of fire in their home, will aid intervention when they most need it.

The Fire Safety Act 2021[1] and Building safety Act 2022[2] introduced since Grenfell Tower also places more importance of multi-agency communication. Building risk assessments should now consider fire risks in demised areas[3] and information about these risks should be available to residents and the fire service (for use in the event of a fire). Including housing providers in these multi-agency discussions is therefore essential.

Training is a key issue in the identification of fire risks, especially knowing the criteria for a vulnerable person where extra consideration will be required in terms of fire risks and what to do to reduce them.

Better awareness of fire risk mitigation solutions will allow issues to be addressed at a more local level so only the most complex, high-risk cases that require more creative ways to resolve and additional resources that MDTs cannot provide, are escalated to the High-Risk Panel.

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

[1] https://www.gov.uk/government/publications/fire-safety-act-2021

[2] https://www.gov.uk/guidance/the-building-safety-act

[3] The phrase "demised area" describes the space that is occupied by a tenant under a lease or rental agreement

2 Purpose of the review

Within the Care Act 2014 section 44 there is a statutory requirement to undertake Safeguarding Adult Review (SAR) if:

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

or if:

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

It is not about apportioning blame, but to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

This SAR is about learning lessons for the future, making sure that Safeguarding Adults Boards get the full picture of what went wrong and improving the practice of all organisations involved.

3 Wider context

Tragically there have been numerous SARs into fire deaths nationally[4]. London Fire Brigade data report that in 2021 there were 50 fatal fires in London. The factors that influence the chances of a fire casualty becoming a fire fatality are complex. Some of the main contributors include:

- how able the person was to respond to the fire (i.e., were they mobile; were they awake; were they impaired by drugs or alcohol).
- how early the fire is discovered.
- how quickly the brigade is called.
- the materials involved in the fire.

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

- the size and construction of the room/building.
- the proximity of the victim to the fire.
- the arrival time and response of the brigade.

Over the last five years, 10 percent of those who died in fires were aged between 0 to 15 years, 49 percent of fire fatalities were people within the 16 to 64 age range, 39 percent of fatalities were of those aged 65 and over and two percent were unknown. Men are slightly more likely to die in fires than women. Around 74% of fires (based on the average over the ten years to 2021) were of accidental motive. Whilst most fires start in a kitchen, these fires are less likely to be fatal. Most dwelling fires with fatalities happen in a living room, followed by the bedroom. However, in some of these incidents, the living room was also being used as a bedroom. Over the last five years to 2021, bedrooms and living rooms resulted in 32 and 39 percent respectively for all fatal fires in dwellings.

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

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

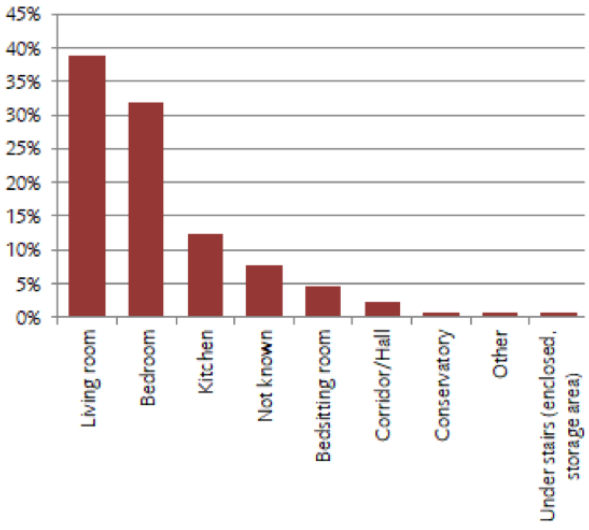
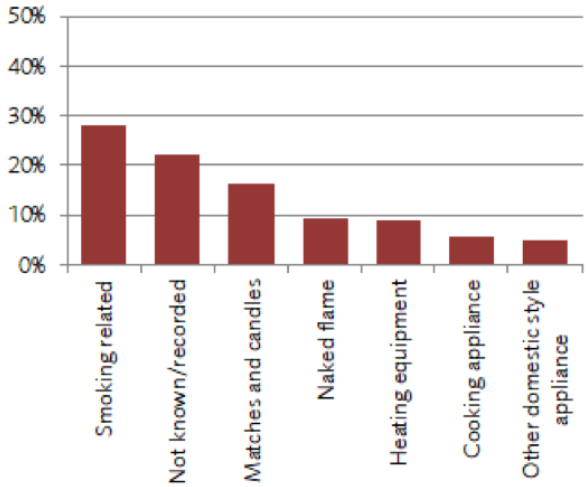


Chart 13: Top seven source of ignition for fires in dwellings with fire related fatalities, five years to 2021



The proportion of older people who die in fires is higher than the proportion of that age group within the population for London. Around only 12 percent of Londoner's are aged 65 and over.[5]

FIRE STATISTICS TABLE 0503a: Fatalities[1] by age, gender and type of location, England

Select a year and gender from the drop-down lists in the orange boxes below:

2021/22

All genders

	Fire-related fatalities[1]									
Age of victim	**Total**	Dwellings - Total	Dwellings - Single occupancy[2]	Dwellings - Multiple occupancy[3]	Dwellings - Other / unspecified[4]	Other Buildings	Road Vehicles	Other Outdoors	Age of victim	Fatality rate[5] per million population
Total	**272**	**208**	**199**	**1**	**8**	**11**	**35**	**18**	**Total**	**4.8**
Under 1	**2**	0	0	0	0	1	1	0	Under 1	3.2
1 - 5	**7**	6	6	0	0	1	0	0	1 - 5	2.2
6 - 10	**0**	0	0	0	0	0	0	0	6 - 10	NA
11 - 16	**1**	0	0	0	0	0	1	0	11 - 16	0.2
17 - 24	**6**	1	1	0	0	0	4	1	17 - 24	1.1
25 - 39	**26**	18	17	0	1	1	5	2	25 - 39	2.3
40 - 54	**39**	31	29	1	1	1	7	0	40 - 54	3.5
55 - 64	**31**	24	22	0	2	1	2	4	55 - 64	4.4
65 - 79	**79**	70	67	0	3	2	4	3	65 - 79	10.4
80 and over	**55**	48	47	0	1	3	0	4	80 and over	19.7
Unspecified	**26**	10	10	0	0	1	11	4	Unspecified	..

1 Includes fatalities marked as "fire-related" but excludes fatalities marked as "not fire-related".
Those where the role of fire in the fatality was "not known" are included in "fire-related". Fire-related fatalities are those that would not have otherwise occurred had there not been a fire.

2 Single occupancy includes: Bungalow, Flat/Maisonette (Purpose Built and Converted), House and Self-contained Sheltered Housing.

3 Multiple occupancy includes: HMOs (licensed, unlicensed and unknown if licensed) and Tenement buildings.

4 Other / unspecified includes: Caravan/Mobile home, Houseboat and Other dwelling.

5 Based on the Mid-year population estimates from the Office for National Statistics, although figures from 2021 were incomplete at the time of publication, and so estimation was involved for five age bands (between 0 and 24):
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

4 Demographic of Hammersmith and Fulham[6]

In Hammersmith and Fulham, the population size has increased slightly (0.4%), from around 182,500 in 2011 to 183,200 in 2021. At 0.4%, Hammersmith and Fulham's population increase is lower than the increase for London (7.7%).

As of 2021, Hammersmith and Fulham is the sixth most densely populated of London's 33 local authority areas, with around 80 people living on each football pitch-sized area of land.

Hammersmith and Fulham has seen an increase of 15.2% in people aged 65 years and over, a decrease of 0.5% in people aged 15 to 64 years, and a decrease of 4.2% in children aged under 15 years. This is significant considering the statistics above of someone aged 65 or over dying in fire.

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

[6] https://www.ons.gov.uk/visualisations/censuspopulationchange/E09000013/

Approximately 500 adults are receiving care in a care home and approx. 2000 receiving care at home (care provision in H&F is free)[7].

5 Terms of reference

5.1 Lessons learnt from previous fatal fires and the implementation of the action plan

- What lessons learnt from previous fatal fires, and the subsequent action plan, were/are embedded within the borough?
- Who was involved in the dissemination and implementation of the plan and what monitoring processes were put in place?

5.2 Safeguarding risks and Making Safeguarding Personal

- How did Alison's heroin addiction and approach to risk influence the attitude of service providers and in their interactions with her?
- How is independence, choice and risk managed in high-risk cases like Alison?
- What is the level of understanding of the multi-agency risk management processes in H&F and how effective are they in reducing safeguarding risks from fire?
- How do these processes identify opportunities for intervention and include the learning from cases like Alison prior to escalation to the SAB?
- How are/ were practitioners supported to ensure decisions regarding Alison's 'ability to understand' risk was actioned (specifically Alison's mental capacity in to understand fire risk)?
- What other options are considered if the adult at risk refuses help or support and the risk of serious harm or fire remains?
- How well are all these decisions or assessments documented?

5.3 COVID

- What impact did the COVID pandemic have on implementing lessons from previous fires or on the management of care for Alison prior to the fire?

6 Methodology

- Review the action plan and recommendations developed in response to previous fatal fires, and if required interview leading players in its creation

[7] Approximate data from H&F Adult Social Care team

- Review Alison's Individual Management Review (IMR) and accounts by leading representatives from organisations involved in Alison's care
- Review the chronology of events leading to the fire involving Alison
- Interviewing leading representatives from organisations involved in Alison's case and organisation that commission care services (or any other agency or partner deemed appropriate at the time)
- Review their processes or documentation such as risk assessments and service provider contracts
- Review practitioner training systems, specifically in the context of adult safeguarding and fire risks in the home
- A question set will be provided prior to the interviews and used as a basis for discussion.
- Carry out two "practitioner learning workshops" where multi agency practitioners complete a questionnaire and have the opportunity to take part in a fire risk Q&A session.

7 Agencies involved in IMR and interview process

Alison's interaction with the following partner agencies was reviewed by the independent reviewer to identify learning.

- Local Authority Housing team
- Care provider
- Two Acute NHS Trusts
- Local Community NHS Trust
- Adult Social Care (ASC)
- GP Practice
- Drug and alcohol Welfare service
- Fire Service

8 Membership of the Review Panel

The role of this group is to provide project oversight, by contributing to and scrutinising information submitted. Wider engagement with this project will be required across partnership agencies.

9 Involvement of the family

Unfortunately, Alison's long-term partner "Debbie" (again a pseudonym) passed away before the commencement of the review and records indicate that Alison did

not have any other close family. However, there was a neighbour who helped Alison and visited her on a regular basis. The neighbour was contacted by the reviewer to seek their views and to feedback the recommendations from this report. They felt very strongly about what happened and as such they use Alison's story to promote change in their role working for an organisation that provides housing for their staff.

10 Legal Considerations

There are ongoing parallel coronial processes. Therefore, this report has used pseudonyms to anonymise personal information so as not to impact on the integrity of ongoing coronial process.

11 Alison's Background

Alison was in her late fifties and was living with her civil partner (Debbie) in a leasehold flat within a block of Local Authority owned flats.

Alison had a history of substance (heroin) misuse dating back to 1986 and would use wound sites to inject heroin and continued to do so until her tragic death. Her drug use is considered as a significant contributory factor in her multiple health issues. She was known historically to commissioned Drug and Alcohol Welfare Service (DAWS) but at the time of her death was not receiving support from them. She was also a smoker and smoked around twenty cigarettes a day.

Alison also had multiple health issues including brittle bone disease, history of infection in right arm resulting in no functional use, braces and metal work in right hand, history of broken right leg, infection on right thigh scars on both legs, low body weight, Grade 2 pressure sore, paraplegic post brain tumour, and Chronic Obstructive Pulmonary Disease (COPD).

Her partner Debbie, whom she had known for over thirty-five years, has been described as caring greatly for Alison. Debbie had her own health issues including a leg amputation (she used a wheelchair) resulting in her also being in receipt of a package of care. Alison was in receipt of homecare from the care provider from 14 March 2019 until 10 December 2021, when she died.

The couple are described as being very private people who have family in the UK but do not maintain contact with them. They had a supportive neighbour who visited twice a week.

District nurses visited twice a week to provide care for a pressure sore and wounds on her thigh which repeatedly became infected due to Alison using the wound sites as drug injection points.

The Care Agency provided care to Alison from 14 March 2019 until the time of her death on 10 December 2021. They report that at the time of the fire there were two flame retardant blankets in use as well as a fire-resistant ash tray. They also report that the fire alarm was in good working order.

Alison was reliant on carers to support her with all aspects of her daily living tasks. Debbie supported with prompting of medication and meals. Equipment was in place to support with this. Alison was in receipt of a package of care consisting of three calls a day seven days a week:

- Morning - 9am: 45 minutes, 2 x Carers, 7 x days a week. Carers to provide full bed care. Change pads, prompt medication, encourage nutrition, change bed linen if required, dress in the mornings and undress at night; reposition in bed
- Lunchtime - 1pm: 45 minutes, 2 x Carers to support with changing pads, prompt meds, encourage nutrition and hydration, change bed linen if required and lunch preparation.
- Evening - 6.30pm: 45 mins, 2 x Carers to change pads and get undressed for the night, change pads, prompt meds, encourage nutrition and hydration, change bed linen if required.
- Wednesday: Domestic Call, once a week for one hour. Carer to assist and support to complete weekly housework; to sweep and mop the kitchen and bathroom floors

12 Circumstances of Alison's death

At approximately 00:25 hours on 10th December 2021, Alison's partner was in her wheelchair in the kitchen when she heard a smoke alarm. Thinking it was a false alarm she made her way out to the hallway and attempted to reset the alarm using a broomstick. At this point she noticed an orange light coming from the bedroom.

Alison's partner got to the bedroom door, where she could see her sat up in bed with flames on the bedding. Alison's partner attempted to remove the bed covers before going to the kitchen to get a fire blanket. Returning, she threw the fire blanket over Alison in an attempt to extinguish the fire, which momentarily died down but quickly flared up again. Alison's partner opened the front door and shouted for help before going back inside.

Neighbours heard a smoke alarm. The alarm wasn't very loud and after approximately five minutes it was still sounding. One neighbour went to investigate and found that the sound was coming from the neighbours flat and saw smoke

coming from around the top of the front door. They also heard someone call for help from inside.

They then made the first of two 999 calls to the London Fire Brigade (LFB). Whilst on the line they informed the Fire Brigade Control Operator that two people were in the property, one was in a wheelchair and the other was bedbound within the bedroom where the fire was located. They then kicked at the door which opened straight away and once opened, black smoke came billowing out. He could see Alison's partner in the hallway in her wheelchair, her sleeve appeared to be on fire and was asking for help. She told him that Alison was trapped in her bedroom. The neighbour then brought Alison's partner out of the flat.

On arrival the Fire Brigade, breathing apparatus crews quickly entered the property and made their way to the bedroom. They extinguished a fire involving the bed and whilst searching located Alison on the bed. Due to the restricted visibility, they could not assess her injuries and so they started to rescue her from the property. However, it became apparent that her injuries were incompatible with life and was declared deceased by London Ambulance Service (LAS) Paramedics.

Alison's partner, Debbie, was taken to hospital suffering from smoke inhalation and burns. She spent three to four days in hospital. She was allocated to a Social Worker from the hospital who was supporting her before being discharged into temporary accommodation provided by the Local Authority (LA).

There were two possible causes for this fire. Firstly, the halogen heater, which was reported to be in use at the time of the fire and was close enough to come in contact with the bed and ignite the bedding. Secondly, it is also possible that Alison had dropped a cigarette onto the bedding which burnt through to the air mattress.

Both of these scenarios could be consistent with the observations that were made by Alison's partner. She described the smoke alarm sounding, located just outside the bedroom and when she went to reset, she saw an orange glow. On investigation she described seeing Alison sat up in bed with flames on the bed. She has then tried to remove the bedding and it is likely that some of the bedding fell to the left side of the bed which accounts for the fire developing in that area.

For these reasons, the LFB were not able to state if the fire was the result of combustible items coming into contact with the halogen heater, or the unsafe disposal of smoking materials[8].

[8] London Fire Brigade Fire Investigation Report

12.1 Multi-agency interaction

12.1.1 Hospital care

Alison was admitted or seen at hospital five times since 2017.

1. On 12th June 2017 she was brought in by ambulance to the Emergency Department after falling from the commode when transferring back to bed. Debbie could not help her back so called an ambulance. Alison was admitted due to possible end stage COPD and sepsis. It was suspected that the sepsis was from a wound on her right hip where she had been injecting Diamorphine (Heroin).

Alison was admitted for two days where she received pain relief and IV antibiotics. A safeguarding concern was raised as the pharmacist contacted her GP who denied prescribing or administering Diamorphine. Alison had stated her partner collects her prescription and administers. This was resolved and it was found that her partner collects the Diamorphine from DAWS.

2. On 23rd February 2019 she was taken by ambulance to an Emergency Department after a fall at home. She was found to have two grade 2 pressure ulcers, one to sacrum and one to her bottom. She also had multiple lesions on her right thigh. A Safeguarding concern was raised. A Computed Tomography (CT) scan was undertaken for a suspected head injury where no acute haemorrhage or infarct (dead tissue) was detected and endoscopy for gastritis. A review was also undertaken by a psychiatric nurse which included her anti-depression medication. A discharge plan was made with Adult Social Care with a package of care for Alison and Debbie, and deep clean of their home.

3. On 10th July 2019, Alison was admitted to hospital after attending the Emergency department, having been referred by the District Nurse (DN) due to an infected ulcer on her right thigh. She was kept in overnight and discharged the next day with the DN arranging follow up on discharge.

4. On the 7th September 2019 Alison was taken to an Emergency Department via ambulance with chest pain, and discharged following investigations. Record of her transport home in liaison with Debbie shows Debbie was noted as her friend rather than her partner.

5. On the 3rd November 2021, Alison was visited by a podiatrist who noticed swelling of her right leg. A GP phone consultation resulted in a 999 call and admission to an Emergency Department. It was noted that there was a new swelling to her right foot radiating to her shin. There were no associated symptoms, no pain and no swelling

to thigh, no chest pain, no signs of infection or deep vein thrombosis (DVT) so she was discharged and referred back to her GP in regard pitting oedema[9].

Alison's care whilst in hospital, in terms of her medical treatment, appears very thorough. However, considering Alison died in a fire, this review looked into whether anything further could have been done to reduce the fire risk as it is noted that fire risks were not considered as part of discharge plans.

The reviewer spoke to the safeguarding leads from the two hospitals involved in Alison's care, specifically in regard to the identification of vulnerable patients who may need extra consideration to reduce the risk of fire in their homes and how this can be part of devising discharge plans.

Both have very robust and comprehensive safeguarding processes but no trigger to raise lower-level concerns such as patients who may be at a risk of fire at home.

Identification of such patients is the start and should part of the either the admission and discharge process. The reviewer had long discussions with the safeguarding leads about how this can be done, as combining this with other hospital processes and systems is complex. A variety of options were discussed including involvement discharge teams in referral processes (who are normally only involved in complex cases where someone may not necessarily be discharged to their home), discussing with patients within discharge lounges[10], or using Occupational Therapists who may be better placed to identify patients at high risk of fire in their home. Ultimately the hospitals are best placed to devise how to identify those who may be at a higher risk of fire in their home.

The LFB's guidance on people who need extra consideration can be used to identify those who may need referral to the LFB[11]. This guidance recommends referral is made for:

- Anyone that may not be able respond to a fire as quickly.
- Anyone that may not be able to escape a fire.
- Anyone who may be at more at risk due to lifestyle factors (such as smoking or drug use, whether prescribed or not)

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[9] Excess fluid build-up in the body, causing swelling, when pressure is applied to the swollen area, a "pit", or indentation, will remain.

[10] Discharge lounge is an area where patients move to before discharge to free up beds. They deal with practicality or going home, transport, keys, relatives, care etc.

[11] https://www.london-fire.gov.uk/safety/carers-and-support-workers/

- Anyone that uses healthcare equipment such as oxygen or emollient creams that are flammable.

This mainly covers older people, people with disabilities, those who may be immobile, people with visual and hearing impairments, and people who are vulnerable for other reasons as they all need careful consideration when it comes to fire safety in their home.

How the LFB is informed is key as one hospital will cover a number of local authorities, each having their own referral systems. What is needed is a consistent process so any hospital can refer in the same way.

ASC have legal powers and duties to assess care and support needs under section 9 of the Care Act 2014. When discharging from hospital, this should involve contacting any relevant agency that can help in addressing aspects of the patient's needs and wellbeing. In regards to the risk of fire this will be the LFB. In cases where a significant fire risk has been identified or a patient is considered needing extra consideration as per the criteria above, a direct referral to the LFB and the Local Authority ASC would be better as it will quicken the process of getting a HFSV either before the patient returns home or as soon after. To help facilitate this as hospitals serve many Local Authorities, a standard referral method of contacting the LFB is needed.

Training is also key. If staff know which patients are more at risk to a fire in their home, they will be better placed to identify them. Therefore, learning outcomes such as what behavioural issues, medical conditions or factors that constitute someone as needing extra consideration or a referral to the LFB, should be included in their training.

It was noted by the safeguarding leads that staff workloads are high, but the positive sell to this is if there is a simple referral process.

Recommendation 1

That hospitals establish a process to identify those more vulnerable to the risks of fire in their home and refer to LFB as part of discharge plans.

Recommendation 2

The London Fire Brigade establish a standard process whereby any hospital can refer vulnerable patients directly for a Home Fire Safety visit.

12.1.2 Alison's domiciliary care

As already described, Alison had a comprehensive daily care package delivered by the domiciliary care provider which was seen to be appropriate and addressed Alison's care needs.

In terms of identifying risk, the care provider's risk assessment at the time of Alison's death (dated 18/5/2021) was person-centred and highlighted her risks associated with choking, health, pressure sores, mental health, immobility, smoking and manual handling. There was also a section on *"internal risk assessment of home"* which included other areas within the home but not any other fire risks. So other than smoking no other fire risks were included in the risk assessment.

There is also a contradiction in terms in regard to emollient creams. The care provider's care plan states moisturisers are used three times a day but the risk assessment says "flammable creams" are not used. Any emollient cream is flammable whether paraffin based or not. During the interview with the care provider the ways to reduce the risk of emollient creams was not fully understood (i.e., regular washing of clothes and bed linen). It was not known that the fire risk from moisturisers is much the same as emollient creams[12], something that all practitioners should also be made more aware of.

In general terms it is the reviewers experience that care providers undertake generic risk assessments, but a person-centred approach to fire risk was not routinely considered. Care plans are vague in terms of who is at risk as they appear to be more of a risk assessment for the care worker rather than identifying the risks and mitigation methods for the service user.

Standard health and safety risk assessment formats identify the hazard (something that has the potential to cause harm), the risk (the likelihood of it occurring), who is at risk, the risk rating before control measures are applied (using a risk rating five point scale), control measures that will reduce or eliminate the risk, and then the risk rating after control measure have been applied. If this process is applied by care

[12] https://www.nationalfirechiefs.org.uk/News/nfcc-warns-of-fire-risk-when-using-emollients

providers, then who is at risk (i.e., the service user or practitioners etc.) and the control measures can be more clearly explained.

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

Since Alison's incident the care provider have been very proactive in identifying lessons and have created a new and very comprehensive risk assessment which could be used as best practice for other care providers. The care provider has also taken on board the risk of emollient creams and are devising leaflets for their clients.

Recommendation 3

That commissioning services, in conjunction with other agencies, lead a review of care provider risk assessments to ensure they are person-centred and include all potential fire risks in the home.

In terms of training, the care providers training does not cover fire risks in the home in detail. The new risk assessment will partly address identification of risks, but training is an essential part. When asked the question if fire risk awareness in the home is part of mandatory training the care provider said it was part of a fire module within the Health and Safety day training. When discussed further in the interview it was established that there were no specific objectives within the training for identification of fire risks in the home but rather the responsibilities as an employer under the Regulatory Reform (Fire Safety) Order 2005 (known as the RRO). The care provider was also not aware of the Personal Protective Systems (PPS)[13] that can be used to mitigate very high-risk service users.

Again, the care provider was very responsive to feedback by the reviewer and will be changing their training objectives to include fire risks in the home.

In terms of communication with other partners the care agency highlighted risks to the Local Authority and had a process of requesting HFSV by the LFB via the Local Authority. However, their view was that these were not always actioned, or feedback provided to say that it has been forwarded to the Fire Brigade. As a consequence, the care agency now refers directly to the LFB with the Local Authority

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

ASC copied. This now allows the LFB to provide feedback to the care agency which they say is done on a regular basis.

12.1.3 Drug and Alcohol Welfare Service (DAWS)

As part of a new contract for Drug and Alcohol Wellbeing Service (DAWS), Alison was transferred to a new drug rehabilitation service in April 2016, from a previous provider. They work with people who need support with their drug or alcohol use, mental health, offending behaviour, unemployment issues and people with a learning disability.

Keyworker sessions started in January 2017 and regular sessions continued until September 2018, during which time Alison's medication was reviewed and she was prescribed Diamorphine (200mg) and changed to oral Methadone (90mg daily) in August 2017 due to possible sourcing difficulties and issue with injecting. The keyworker also discussed safeguarding risks with Alison as well as her financial situation and determined that no additional support was needed at that time.

A further review was held by the keyworker and clinical lead in June 2018, where Alison was reported as being stable on her prescription, abstinent on illicit substances, and stable in her psychological wellbeing and physical health despite mobility issues. Her medication reduction, detox and rehabilitation were discussed but declined.

In July 2018 support from ASC was discussed and Alison said she will self-refer and make contact to have a reassessment. However, in September 2018 Debbie delivered a letter to the service informing them of Alison's disengagement. A home visit was carried out to discuss the issue; Debbie answered the door but declined entry to workers and access to Alison for discussion. A letter was sent by the DAWS hub manager informing them of their concerns and that self-discharge is against clinical advice, but no response was received. After two months, in November 2018, Alison was discharged from the service.

Two further independent referrals were made to DAWS, one from the care agency in August 2019 (which ASC followed up in November 2019) and another by the GP in February 2021 but despite these referrals Alison remained disengaged with the service. The DAWS state that they where not invited to any multi agency discussion during this time even though there were concerns about Alison's drug use. If they had been then their DAWS Plus service (see appendix 2), an approach use for clients who are not open to treatment or who are resistant to change, could have been used.

As part of the review the reviewer investigated the role of the DAWS in identifying risks in the home as keyworkers visit clients in their home so are ideally placed to identify any risks. It is clear from their account and risk assessment template that safeguarding, mental health, drug and health risks are part of their review process. Housing is also included in terms of poor accommodation or living conditions but fire risks are not specifically referenced. It is noted that in Alison's case, the DAWS were unable to access Alison's home making it impossible for them to assess these risks.

In regard to future cases, including fire risks on the risk assessment template should improve identification of client's fire risks and trigger a referral to the Fire Service.

In regard to whether keyworkers are able to identify risks associated with fire in the home, fire risks in the home in not covered within DAWS training and it is expected that the risks from their fire safety in the workplace training are transferred and applied in the home.

Fire risks in the workplace are very different from those in the home. Fire safety in workplaces is very well regulated and because of this workplaces are generally well managed and safety maintained. The same cannot be said for people's homes, so expecting that the risks from the training in the workplace are transferred and applied in the home by keyworkers, is not sufficient. Dedicated objectives for fire risks in the home should be included in the training.

The DAWS have a datix incident management system[14] that records fire safety incidents and is used to identify lessons learnt. They have an excellent escalation process; any concern is raised with line managers who would instigate an internal complex case meeting within the DAWS service then a Multi-Disciplinary Team (MDT) meeting, and if required a further escalation to the Community MARAC. It was noted that the DAWS were not aware of the role of the High-Risk Panel as part of the escalation process.

Incidents or near misses relating to fire are referred to ASC and it is expected that ASC forward to LFB for a home fire safety visit. However, it is not always known that this has been done (which is a similar concern raised by the care provider and hospitals). As part of this review ASC questioned why it is considered their role to forward referrals to the LFB. Referring should be the responsibility of all agencies and consideration should be made to referring to ASC and LFB at the same time to provide a quicker Fire Brigade response, particularly in high-risk cases.

[14] The same as used by NHS providers (the acute trusts, the community trust and General Practice) for all incident reporting which enables management review or escalation processes and policies.

Recommendation 4

That all agencies and partners have a process of referring cases involving fire risks directly to the LFB and inform ASC at the same time so they can maintain an overview of the case.

12.1.4 Community nursing

Alison was referred to the district nurse (DN) service in March 2019 following discharge from hospital, for wound care relating to delayed healing of abscesses (formed when drugs injected under the skin). She was visited twice a week to dress Alison's leg wounds, with regular visits for continued treatment of these wounds and pressure ulcers until she was last seen on the 7th December 2021.

It is positive that DN's communicated with other partners regarding the risk of fire, for example they referred to the LFB in January 2020 as they noted cigarette burns on her bedclothes and bedding and referred to the care agency in February 2020 to ensure use of the flame-retardant bedding issued by the LFB. They also had a conversation with the LFB about the use of non-paraffin based emollient creams.

In December 2020 they noted that Alison was using scissors to cut off parts of the duvet that had cigarette burns as Alison said they were sharp on her skin. Both these instances show the risk of fire remained.

The DN service have a clear process of escalation hoarding cases but DN's may be less certain of how to escalate other high-risk cases which involve, immobility, smoking, air mattresses, emollients etc. Alison's DN did inform others involved in her care but it was not coordinated in a formal way so that all the risks were considered, and all people and agencies involved in Alison's care were aware of the risk factors in order to allow a consistent approach to treatment and risk mitigation. Issue of fire was considered but maybe not fully appreciated in terms of risk to Alison who was bedbound, smoked, used emollient creams and what can be done to mitigate such risks. This is also where greater awareness of the High-Risk Panel's remit and how to refer is needed (as per section 13.4)

12.1.5 GP service

Alison was registered with her GP service in January 2020 after previously being with another local Surgery.

Between March 2020 and February 2021, the Surgery tried to contact her on seventeen occasions where there was no answer on her landline phone.

There were communications from ASC regarding a HFSV referral to the Fire Brigade which was completed on 16th February 2020.

The GP advised there are fortnightly patient MDT meetings which is an opportunity to discuss risks for registered patients. He explained these meetings are coordinated by the Community Nursing Service (Matron) who identifies which patients need to be brought for discussion based on presenting risks. Normally the GP, district nurse, OT or ASC (sometimes) attend these Integrated Domiciliary Hub meetings together with the GP care navigator. There is a record in her patient notes that Alison was discussed at this meeting in February 2021 following ASC contacting the GP in relation to the risk of needles in her home to care workers and the wounds on arms.

The GP patient record evidences that a referral was made to the drug abuse counsellor, however no minutes of this meeting has been shared with the reviewer from any of the agencies in attendance. It is unknown whether ASC (the referrer) was in attendance at this specific meeting, or how, or if, they received feedback. The DAWS confirmed they received this referral from the GP, but Alison declined assessment and treatment. Neither the GP or ASC received any feedback from the DAWS on this referral outcome and were not notified that risk therefore remained unmitigated.

In terms of being able to identify fire risks, fire safety at work training is used which, according to the GP, does not include specific fire risks in the home as an objective. Considering that in the reviewer meeting it was admitted that some GPs don't know what the Clutter Image Rating (CIR)[15] scale is, suggests a lack of sufficient fire risk awareness. The GP also stated that immobility was the main reason for Alison dying in the fire and it was a higher risk factor than her drug use, which is true as she was unable to escape due to this immobility (it must be noted that it is not known whether she was under the influence of drugs at the time). However, this shows a lack of understanding of the risks associated with fire in the home in that if the fire had not started Alison would not have died.

[15] https://hoardingdisordersuk.org/research-and-resources/clutter-image-ratings/

12.1.6 Adult Social Care

In February 2019 a formal protection plan was created following a safeguarding concern raised by the LAS. This resulted in a review of Alison's care and support needs with a several things done to aid her including an increase to care, a key safe number put on front of a file, a pendant alarm in place, access to a telephone, and updating information / action plan for front door staff. At that time Alison was assessed as having capacity to make decisions in relation to her care and support needs.

In August 2019 a concern was raised by the care agency. Their care workers reported that Alison's house contained multiple used needles and posed a risk to care workers. Also, Debbie had been admitted to hospital due to an ischaemic foot (inadequate blood flow to the foot) and there were concerns that Alison's care would be affected considering Debbie was in hospital. Their review established that she was coping with three visits a day by the care agency, but sharps remained which they picked up and disposed of in the sharps box provided. Alison was also referred to the DAWS, but she declined their support.

In September 2019 a safeguarding concern was raised by the DN and carer who reported that Alison had reported that on the 19th August 2019 a man came into her room early in the morning raped her. This was reported to the Police who investigated (and submitted a Merlin report[16]) but no evidence was found to corroborate the allegation. Alison made no allegation to the Police and there is no way of anyone gaining access unless they have a key or key safe number.

In February 2021 a review of Alison's care was undertaken and it was decided to increase in care provision to four daily calls, seven days weekly to meet identified health and social care needs. In March 2021 another safeguarding concern was raised in relation to a man and dog having moved into her property alleged to be providing both Debbie and Alison with drugs. The safeguarding concern was closed as the decision was taken that neither Alison nor Debbie were at risk of abuse as both had capacity to make unwise decisions in relation to their wellbeing. They consented to this man residing in the property so that they could continue their drug use, but it was unclear as to the arrangement that the two parties had. However, there were concerns that drug taking in her property could pose safety risks to

[16] The Merlin system allows police officers to record and share concerns about vulnerable members of the public with partners to effectively safeguard them. A Metropolitan Police Service employee records their findings in a Merlin which is then processed according to the type of report written.

carers. The care agency responded that they have their own Risk Assessment in place.

In April 2021 a home visit was undertaken to review Alison's package of care and check the concerns raised regarding cuckooing. As part of the review of care fire risk and staying safe were discussed. Alison stated that she smoked about 20 cigarettes per day, with the holes in the bed because of this, and that the LFB had done a fire safety check. The social worker advised on the benefits from wearing a fire-retardant apron, which she should wear whilst smoking. Alison described the ash falling down her back and it was determined that the LFB would be able to advise, so referral needed for another fire safety check. Debbie stated that fire alarms and sensors were already put in the flat.

In summary, ASC records show it is clear that Alison was a complex case and there were multiple risks to her health and wellbeing which were reviewed with the care providers. These involved her general health, drug use, smoking and cuckooing. Each issue was reviewed and investigated when practitioners raised concerns. There is no evidence to show if an MDT meeting was held to coordinate all the concerns in a multi-agency way or when the LFB referral recommended in April 2021 was made. It is assumed that this instigated the calls made by the LFB (see section 12.1.8) and the attempted visit on the 8th November 2021.

12.1.7 Occupational Therapy

In August 2020, after numerous contacts were attempted by the Occupational Therapy team, they managed to complete a home visit (it is unclear whether one or several visits were made during August) and a number of recommendations were made with various items of equipment ordered for Alison.

At these visits, a discussion was had regarding fire risks. The Occupational Therapist (OT) mentioned the need for smoke detectors in the rooms, heat detector and carbon monoxide detector - Debbie said that the LFB visited the property around February, and they provided flame-retardant bedding which would help to limit the extent of damage caused by a fire in the bed. The OT was not aware of the LFB visit and was unsure whether she noticed the flame-retardant bedding on the bed. Regarding a smoke detector, the LFB decided that all that was required was for a smoke detector to be placed in the hallway because smoking could repeatedly set them off if placed in the bedroom, and they appear to have not felt that more were required.

The OT also raised the use of Careline with Debbie again. Debbie was very concerned that Alison will not use it appropriately and there was also concern about the cost

(despite there being no costs for those in receipt of benefits). Alison had in the past called out the ambulance three times to take her to hospital. OT also referred to LFB for a carbon monoxide detector even though they are not something that the LFB will supply, and should normally be provided by the housing provider, or if the property is owned, the resident themselves.

During another visit the OT noticed Alison was in bed with her fire-retardant duvet which had lots of holes in it through her smoking in bed and dropping the cigarette. Alison admitted that she would fall asleep with the cigarette alight. Alison said that some of the other fire-retardant bedding was in the wash. Alison was advised again that smoking in bed was unsafe.

12.1.8 London Fire Brigade

From records provided by the LFB a number of HFSV's were completed for Alison.

On the 16th September 2019 and 1st November 2020, visits were completed as part of a Group Risk Visit (GRV). These are visits where crews target a specific area or postcode that are deemed higher priority based on the location (P1 postcode). The P1 postcode is a targeted approach and uses a combination of MOSAIC[17] lifestyle data, fire data, demographic profiling and a range of risk factors such as smoking, drinking and mobility impairment. The intention of GRVs according to P1 postcodes, is to focus on those homes where the risk of fire is thought to be higher; given the size of London, the LFB will only ever reach a very small percentage of households, so targeting based on risk is critical.

Another HFSV was completed on 20th February 2020 (the review could not identify who referred Alison for the visit). During the visit it was recommended that Alison receive flame retardant bedding and this was provided at that time. Discussions were also had with the district nurse about using non-paraffin based emollient creams.

In May 2021 a request for a second set of flame-retardant bedding was made by the care provider via the local authority.

Six attempts to contact Alison by landline phone were made to book an appointment and as contact could not be made a visit to Alison's address by local fire crews was allocated for 8th November 2021. Unfortunately, as the LFB record, Alison was not available. Whether this was because she was immobile and not able to answer the door or that she was out when the LFB visited, is not known. The crew waited at the

[17] Mosaic is a system for geodemographic classification of households. It applies the principles of geodemography to consumer household and individual data collated from censuses and other sources.

address for a time as they believed this was arranged as a joint visit with care workers, but no care worker arrived.

No cancellation of the case took place and LFB records do not reflect a rescheduled visit having been arranged after the attempted visit on the 8th November. The HFSV team leader reports that the process does include notification to the referral agency when scheduled visits are not completed and they believe this took place, but it cannot be proven.

Effective communication and liaison with other partners to ensure the outcome of HFSV's is known and documented in case notes or risk assessments is an essential part of multi-agency communication. The fact that a number of HFSV's were completed and flame-retardant bedding provided is positive and shows that partners were thinking of the risks associated with Alison's lifestyle and referred them to the LFB.

It is understood that the LFB Home Fire Safety Visit strategy is changing from a quantitative one to a qualitive one, and that the emphasis will be on prioritising HFSV's for those that need them most rather than the number completed. The process of referring and producing feedback to partners is also changing. The precise process has not yet been confirmed but the reviewer understands that a new referral process, including an out of hours system, is planned from April 2023 which will prioritise low, medium, high and very high cases. Low priority cases will be asked to complete the online home fire safety checker. Other cases will be visited depending on their risk, for instance, medium risk within 30 days, high risk the next working day and very high risk within 4 hours. An individual as being classed as 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

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

The change to the HFSV process is a very positive step forward, however what is essential is communication between local partners rather than central teams. Local Fire Brigade management (preferably the watch-based staff, who undertake the

visits) are best placed to liaise with other partners about actions or recommendations from a HFSV.

12.1.9 Housing provider

The challenge for housing providers or managing agents is that they are somewhat restricted in what they can enforce within peoples homes. The Regulatory Reform Order requires that they manage the fire safety of communal areas, but they don't have jurisdiction past the front door. What made it even more challenging with Alison was her leaseholder status, which meant that the Housing team had little opportunity to maintain regular contact with her.

The housing team were contacted by the care agency in February 2021 as they were concerned about Alison's smoking and the lack of flame-retardant bedding. Considering it was the third COVID lockdown the Housing Fire Safety Team contacted Alison by phone in March 2021, offered flame retardant bedding and a Person-Centred Fire Risk Assessment (PCFRA), however Alison refused saying she had already been seen by the LFB.

The introduction of the Building Safety Act 2022 (BSA), Fire Safety Act 2021 (FSA), and Fire Safety (England) Regulations 2022 has highlighted the roles and responsibilities of accountable persons, owners, and managers of residential properties. This now means that housing managers and agents must extend the coverage of their assessments into the demised areas and implement new, more stringent fire safety management controls and practices. Regarding demised areas, housing managers will need to consider both tenants and leaseholders in this assessment so any vulnerable person known to them can be included in plans given to the Fire Brigade in the event of a fire so they can prioritise their rescue.

Since Alison's incident, the housing team have established better communication with the LFB and have introduced a check as part of tenant home visits. The question asked is "are you or anyone in your family unable to self-evacuate in the event of a fire in your home?". If the answer is yes, they are referred to the Fire Safety Team so they can undertake a PCFRA and Personal Emergency Evacuation Plan (PEEP). This is more difficult for leaseholders and housing teams are reliant on vulnerable people being referred to them by ASC, one more reason for housing teams to be involved in MDT meetings.

This question could also be used by other practitioners to assess whether further consideration is needed to prevent fires in service users' homes and could be used as a trigger to refer to the LFB for a HFSV.

12.2 Personal Protective Systems

Another significant change since Alison, discussed with the housing team, is the introduction of supplying Personal Protective System (PPS)[18] for complex cases.

This was also highlighted as part of the practitioner questionnaire, in that a significant number of practitioners either did not know what PPS was or confused it with personal alarm systems.

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

PPS is a method of reducing the effects of a fire and can save lives in cases where there is a significant fire risk. They are expensive to purchase initially and require people to be trained in their installation and maintenance. However, once purchased and maintained correctly they have the potential to save lives.

It is understood that PPS was not considered an option in Alison's case. However as part of the research for this review, members of the High-Risk Panel were made aware of PPS and have implemented a referral process to the panel. As a result, a number of cases have since been referred to it and PPS has been recommended and used as a solution to mitigate fire risk.

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

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

Recommendation 5

That the High-Risk Panel and Local Authority housing teams continue to consider Personal Protective Systems to be available, and appropriate people within the borough be trained to install and maintain them, for use by all partners.

13 Questions posed within terms of reference

13.1 Impact of Alison's heroin addiction and risk appetite

Alison's drug use was at the heart of or root cause of her health and wellbeing. One theory is that addiction may not really be classed as a 'lifestyle choice' but a maladaptive coping mechanism to escape problems.

Both the care provider and Community Health district nurses felt that Alison's drug use did impact on her care. Skin wounds were used as a site to inject drugs which meant they did not heal and extended the treatment of these wounds. However, whilst practitioners were frustrated with this, there is no evidence that it affected the level of care that was provided to Alison.

It was felt that the regular visitors that both Alison and Debbie had overnight supplied them with drugs and that there was potential cuckooing, but there was not much the practitioners could do to stop this other than refer to the appropriate agency, which they did. The care provider suggested that Alison and her partner's risk appetite increased due to her drug taking and as already mentioned Alison's drug use may have changed her mental capacity. An example of this being the constant use of wounds to inject and furniture moved around by Alison's partner and visitors which included the heaters.

This is backed up by other practitioners who took part in the questionnaire. 43% said they had a client with drug dependency and that it hindered or affected how their case was managed. The reasons being:

- The client would not listen or take heed of advice to address risks in their home or how to improve their health (35%)
- The service users drug dependency took priority over other more important parts of their care (31%)
- Supporting the client was pointless until their drug dependency was addressed (4%)
- The practitioner felt they had done all they could to help the service user (17%)

As mentioned, Alison's drug use was at the heart of or root cause of her health wellbeing. NICE clinical guidelines [CG52][19] provide guidance on opioid detoxification; however her disengagement created a barrier to her receiving this help and support.

Engagement is a big issue with someone with drug or alcohol dependency and something that was available at the time of Alison's death is "The Blue Light Project"[20] which seeks to address by developing alternative approaches and care pathways for people who drink and who are not in contact with treatment services. Whilst this project is aimed at those who drink, the principles it promotes could equally be applied to substance misuse. For instance, treating people in a different, client or person-centred way rather than just drug users and identifying potential barriers to change.

Similarly, the 2021 publication "How to use legal powers to safeguard highly vulnerable dependent drinkers"[21] by Professor Michael Preston-Shoot and Mike Ward, challenges common myths or misconceptions that have grown up around the care of and support for this group of people. It also discusses many of the issues raised in this report, the knowledge of which would be of use to all practitioners who have clients with complex needs and those with a history or substance misuse.

The DAWS Plus service as described in appendix 2, applies the principles of the Blue Light Project and work as a dedicated outreach team, working alongside partner agencies, with the overall aims to support more reach of clients, raise insight into a client's own use, provide harm reduction support to ensure clients are able to make informed decisions about whether or not to engage in treatment and support. It uses the assets of the client and local community to reinforce permanent change and support sustained recovery.

Recommendation 6

That the DAWS Plus service is considered for clients with known substance misuse and who have disengaged, or are at risk of disengaging, with support services.

[19] https://www.nice.org.uk/guidance/cg52/chapter/1-Guidance#opioid-detoxification-in-communityresidential-inpatient-and-prison-settings

[20] https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-lightproject

[21] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-finalAugust-2021.pdf

13.2 Independence, choice and risk management

Independence and choice is a primary element of social care. However, a balance has to be made between the right to a private life[22], the risks to the individual, and duty of care by practitioners.

When does the risk of death or injury outweigh the choice of the individual? What can be done if practitioners have done all they can, and the risk remains? For example, in cases where someone smokes, is chair or bedbound and is known to take drugs or drinks alcohol, as was the case with Alison, the combination of these risks means the likelihood of a fire occurring is very high.

Alison could be considered as having fluctuating mental capacity when she was under the influence of drugs and she may not have had capacity to understand the risks associated with fire (this is discussed in more detail in section 14.2). If she had been formally assessed as not having capacity, a best interests meeting could have been held to address the risks.

It appears that each practitioner dealt with the risk in their own way according to their own processes, for instance referring to the appropriate agency. Outcome focussed and person-centred care with mitigation of risks as much as possible can be challenging if a service user is considered to be making unwise decisions or chooses to refuse support. The OT, DN, care provider and housing team all spoke to Alison and her partner about fire risks, but Alison and her partner chose to refuse further intervention saying the LFB had already visited. Careline services were also recommended but refused by Alison which meant the risk was not fully addressed.

There was a lack of a coordinated, multi-agency approach, so that all agencies involved in Alison's case were aware of the risks and a common plan established to address them. Joint mental capacity assessments, formal MDT meetings, best interest meetings and the High-Risk Panel will help to support the assertive approach and not allow the service user to "play one practitioner off with another". They will also help to ensure the trauma informed[23] principles of safety, trust, choice, collaboration, empowerment, and culture are considered.

The General Data Protection Regulation, Data Protection Act 2018 (GDPR) and the Crime and Disorder Act 1998 permit the disclosure of information to organisations

[22] Human Rights Act 1998, article 8. The right to respect for your family and private life

[23] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/workingdefinition-of-trauma-informed-practice

such as the police, local authorities and social services. A disclosure in the public interest is likely to be justified where it is essential to prevent a serious and imminent risk to public health, national security, to protect other people from risks of serious harm or death, or to prevent or detect serious crime[24]. The Caldicott Principles[25] also to help inform decision making on whether to override consent.

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

In cases where the LFB are not able to access the service user's property, one option is for them to provide advice, support or training to any appropriate person or agency that is able to interact with the client and complete a HFSV on the LFB's behalf. This may require some further discussion to agree how this will be done, for instance, a form or disclaimer, indemnity, or in the longer-term a Memorandum of Understanding.

Recommendation 7

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

Annual reviews, escalation, recording and risk assessment processes are really important in all cases where the service user is uncooperative, fiercely independent or continually refuses help and support, but particularly important where addiction or dependency issues affect the persons ability to change.

One thing that could outweigh the choice of the service user is if there is a risk to others. If a fire should start in the service users' premises and it could endanger other occupants within the building or restrict their escape, then this could be used as

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

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

evidence to justify more assertive action. This could involve using tenancy agreements, or in the case of Alison, terms of a leasehold agreement, to comply with recommended support. In extreme cases this could involve legal processes to secure a move to more appropriate accommodation.

Article 8 of the Human Rights Act (HRA) may also apply in this situation. Article 8, the right to respect your private and family life, is a qualified right. This means a public authority can sometimes interfere with your right to respect for private and family life if it is in the interest of the wider community or to protect other people's rights, for instance Article 2, the absolute right to life. It must also show that it has a specific reason set out in the Human Rights Act for interfering with your rights. The HRA calls these reasons a legitimate aim.

Examples of legitimate aims include:

- the protection of other people's rights
- national security
- public safety
- the prevention of crime
- the protection of health

In cases where there is a significant increased risk of fire, especially in blocks of flats, should a fire occur the health risk to neighbours in the building due to smoke inhalation is likely. In Alison's case there was a potential risk to others in the building and the fire did have a significant impact on them during and afterwards.

It is not known if there is any case law that has tested this element of the HRA. Therefore, in regard to future cases, any decisions would need to be made on a case-by-case basis and legal advice about how the HRA applies, gained at the time.

13.3 Understanding and effectiveness of multi-agency risk management processes

Practitioners did not fully understand how risk assessments are applied and in terms of fire risks they do not fully understand risks within the home. Practitioners are aware of the PCFRA but not necessarily how to apply it and what can be done to mitigate fire risks, especially in complex, high risk cases and how to escalate. In terms of escalation, the change to the MDT network approach (see section 14.1) and changes to the ASC Mosaic system[26] will help practitioners to understand the risk

[26] The Mosaic System is a social care case management system, not to be confused with the MOSAIC geodemographic classification of households.

management processes but including fire risks in the home and fluctuating and executive mental capacity in regular mandatory training will also help.

Commissioning team audits that include fire risk processes, as per the Claire action plan (below), will also help ensure service providers include fire risks in their management of their clients.

13.4 Escalation process

H&F has two Multi Agency Risk Assessment Conferences (MARAC), one for domestic abuse (DAMARAC) and one for anti-social behaviour (community or CMARAC). The DAWS mentioned that they refer cases to the CMARAC but as fire risks are not part of either group terms of reference, it is not the most appropriate escalation pathway. This highlights a gap in how to escalate cases that involve fire risks. Rather than create another forum for dealing with cases involving fire risks, the current escalation process of joint mental capacity assessments/ MDT/ best interests meetings seem to be the most appropriate means to discuss cases before escalation to the High-Risk Panel if the case is complex or they cannot address the issues. At the time of writing, it is understood that MDT's do not have formal terms of reference but there is best practice. As mentioned before, it is essential that full and accurate records kept.

The High-Risk Panel, which has become more established since Alison, has clear terms of reference, that includes significant fire risks, and will greatly contribute towards addressing future complex cases:

The panel will consider case presentations for situations which have already been considered within partner agencies risk assessment processes and there remains a significant risk arising from

1. *Hoarding that has reach level 5 or above in the Clutter Index[27] shown in appendix 2, <u>for at least one room</u>*
2. *A significant fire risks. This might include*
    a. *evidence of cigarette burns to clothes or bedding*
    b. *residence displays evidence of small burns or fires*
    c. *unsafe storage of inappropriate flammable liquids or gases*
    d. *where the person's ability to identify and manage a fire risk is impaired by a lack of decision-making capacity or substance misuse*

[27] International OCD Foundation, Hoarding Centre, Clutter Image Rating 7 Naik, Lai, Kunick & Dyer 2006

3. *Self-neglect which is having a significant effect on the individual's ability to manage their:*
    a. *personal care and hygiene*
    b. *home environment*
    c. *activities of daily living such as shopping*
    d. *health conditions*
    e. *finances*
4. *Complex homelessness.*

These terms of reference are very clear and if practitioners are more aware of them, more appropriate referrals will be made.

Recommendation 8

That, in relation to fire risks, the SAB seeks assurance that MDT meetings, decision making and escalation processes to the High-Risk Panel, are formally documented.
Also, that the SAB promote best practice MDT working and expectations, and increase awareness of the High-Risk panel and its purpose as part of the Fire Safety Assurance MDT approach briefings.

13.5 Opportunities for intervention and learning from other cases

Prior to Alison, there were two similar cases in the previous two years where an adult died in a fire in H&F:

Brian - 31st December 2019

A male, HIV positive, who smoked and drank. His wife also smoked and had a brain injury and found multi-tasking difficult and her memory recall was poor. A care package was in place, possible domestic abuse accusation that his wife hit him. Cause of the fire was a discarded cigarette whilst sitting in his chair.

Claire - 31st January 2021

An Black-Caribbean female, aged 69, who lived with her daughters in a Victorian terrace house which was adapted to her needs. She smoked cannabis and cigarettes, was immobile, had a four times daily care package and Careline. She had cognitive impairment due to a stroke and took anti-depressants. In regard to fire prevention, she had five smoke alarms, all of which worked, and did not like the flame-retardant blanket given to her by the LFB.

She died in a fire after her carers had left her in the morning in her recliner. The probable cause of the fire was a dropped cigarette which ignited the duvet she was using and burnt through Careline cable wire.

There was not much previous interaction with her (three calls previously: once when she was locked in, the other to assist within the property and one to fit in smoke alarm). At that time house was found in good condition and no safeguarding concerns or fire risks noted or raised.

13.5.1 Claire Action plan

As a result of Claire, the H&F SAB SAR case review group met on 7th April 2021, mainly to discuss Claire, but Brian was mentioned. The minutes of the meeting mainly focus on the events of the incidents, interaction and intervention agencies had with Claire, and there are not specific outcome or action from the meeting. The group concluded that it did not meet the criteria for a SAR and that, according to the minutes *"'Claire' seemed to have been thoroughly assessed by Cognitive Impairment and Dementia Service (CIDS), GP, ASC and that she was receiving appropriate level of support and care; was capable of communicating if she was in a distress situation by being able to press the alarm on the pendant, demonstrated that she understood the risk of fire but chose to continue smoking, had fire retardant bedding in place."*

It was mentioned by the LFB Borough Commander at the meeting that the *"critical point is that everybody should be aware of the risks… and that one point to consider is that professionals who visit the same person for a long time can become 'property blind'".* He also said he would be meeting with the H&F Chief Executive Officer soon to brief her about the recommendations for future as there is some learning, such as providers flagging up when somebody is a heavy smoker and what risk assessment were being done. This was not however, recorded as an action of the meeting.

On the 5th July 2021 the SAR Review group held a meeting to discuss Brian who was referred to the group by the LFB.

The meeting concluded that there were issues regarding a mental capacity assessment or possible lack of professional curiosity, such as perhaps not asking enough questions. The Chair considered it could be a discretionary SAR but was satisfied that the learnings from this case can be carried forward as part of the ongoing work on fire risk prevention. This is presumed as a result of the Claire case.

Following the Claire case, an Individual Management Review (IMR) took place which highlighted several findings and made thirteen recommendations. To

implement the findings an action plan was devised, owned by the LA Chief executive. Monthly meetings to review the action plan were planned for twelve months after the incident. The last action plan (v12) was dated 2nd July 2021 (although some actions have been updated in August 2021), eight months after the Claire incident.

There are a number of queries which imply that the action plan was not fully completed:

- The action plan timeline was for twelve months but updates stop after August 2021, eight months after Claire incident.
- RAG ratings for six of the recommendations are green, implying they have been completed, the remainder are amber implying they are still in progress.
- There are various comments suggesting work was still in progress. Examples being repeated (and the same) commissioning comments throughout the action plan about identifying gaps, internal processes and awaiting final drafts of their internal risk assessment; the audit quality visiting form template contained within the action plan does not include the fire risk assessment and action taken by provider included Q 5.12.
- It is not known whether the multi-agency learning meetings were held to agree governance so that all agencies are held to account from delivering on the action plan.

This review into Alison has highlighted several issues similar to those found in the Claire review, which indicate that the lessons learnt from Claire have not been implemented.

- Fire Safety training for practitioners who visit people's homes is still an issue. The previous action plan does not specifically include risks in the home and solutions to mitigate risks for high-risk patients. The questionnaire also highlighted several things that a proper training package can address, for instance, the PCFRA process, clutter image rating scale, emollient creams, use of PPS etc.
- Risk assessments considered smoking but did not include other fire risks such as emollient creams, air mattresses and other risks in the home such as heaters or unsafe electrics. This was evident from the care providers risk assessment (which, since Alison, has been updated and is now much more thorough).

Identifying people who are more vulnerable to the risk of fire is the key and establishing opportunities for intervention and the learning from Alison will help to do this.

The trigger mechanisms within the ASC Mosaic system will better identify opportunities for intervention and referring to other agencies. It will also ensure better MDT engagement and widening the invites to the Fire LFB, Housing teams, or any other agency involved in a case such as the DAWS, will ensure better management.

13.5.2 Change of leadership

It is understood that a couple of significant stakeholders left their relevant organisations during the time of implementing the Claire action plan. This included the owner of the action plan, the LA Chief Executive and the LFB Borough Commander. A handover of leadership will no doubt have an initial effect on the delivery of any action plan. New leadership will have differing views and opinions which shape strategic priorities. It does appear that this change did impact on completing the Claire action plan but the review cannot establish the exact reasons.

Considering that the overarching purpose of the SAB is to gather assurance that effective adult safeguarding arrangements are in place, governance of such an action plan would more appropriately sit with them. It would also mean the collective responsibility of the SAB would not be affected by any strategic leadership change.

Recommendation 9

That the SAB govern and manage any action plan devised as a result of this review.

13.6 Recording of decisions and assessments

Practitioner notes are the first step in the recording of decisions from practitioner appointments or visits and are an essential part of professional standards and best practice. The recording of notes that the reviewer had sight on were generally good, however some statements and decisions made were ambiguous and needed clarification. Workloads do impact on note taking, which is discussed later in the report, but clear and concise notes are important to protect the practitioner and ensure a more accurate account is available in the event of subsequent reviews or investigations.

As already mentioned, in Alison's case it is unclear if MDT meetings are formally recorded. Risk assessments covered health risks but did not include all the risks associated with fire, the care plan only included smoking and there is no evidence of MDT or ASC risk assessments.

Annual reviews by care providers and ASC must accurately record the risks, including previous risks to identify whether they remain or have changed. MDT meetings

convened should include ALL relevant partners, with discussions and decisions properly minuted. This is particularly important in cases where service users refuse help and support. The change to the MDT network approach established since Alison will better address this.

Similarly, recording escalation processes right through to the High-Risk Panel must be done. Appropriate and proper recording of risk management plans is essential, as if done properly any plan or decision is defensible in court should a serious incident occur.

13.7 Support for practitioners

ASC have a process where social workers should discuss all high-risk cases within supervision with line managers and use a very comprehensive one-to-one supervision record. It would also be expected that immediate risks are flagged as part of daily interactions with their line manager and guidance is that they should not wait for formal supervision to have these conversations.

From the questionnaire, 78% of practitioners from across the partnership that took part said that where they had a client with long term care needs and/or significant fire risks, they were given sufficient support to manage them. However, 22% said that they had not been given sufficient support which is worrying. The reviewer clarified why this was and number of participants blamed the pressure that some organisations and consequently practitioners are under, and increased workloads meant they could not be as thorough or conscientious as they would like. It was also mentioned that workloads had an impact on the accurate recording of notes as less time is available to write them.

Human, financial and physical resources also have an impact on the management and support of high-risk long term complex cases. H&F has seen a 40% rise in the number of people eligible for care in their own homes due to its commitment to free home case (in place since 2015). H&F is a small London Borough with a population of 180,000+ and leads the way in London and nationally regarding the amount of care in the community it provides. It also provides free day services and short-stay care and a subsidised daily hot meal of £2.00.

During the COVID pandemic, a system called Discharge to Assess[28] was introduced to help reduce the time they spend in hospital and avoid unnecessary delays in discharging patients. Where a patient does not require an acute hospital bed, but

[28] https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-toaccess.pdf

may still require care services in the short term, they are discharged to their own home with funded help and support, or to another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the patient.

The impact of this is that more higher risk people are living at home. Whilst this is positive, as independence for those people is maintained, increased resources are needed to reduce practitioner workloads and enable effective management of these cases.

The social care workforce is not a regulated profession (not to be confused with Social Work which is a regulated profession) and much needs to be done to raise carer standards especially in regard to the identification and management of fire risks. Including how to identify and mitigate fire risks in the home in mandatory training should address this.

In terms of mental capacity, as has been highlighted earlier, Alison was considered as having capacity but there is no evidence that capacity in a "issue specific" area of fire risks was considered. The review could not highlight whether this was due to a lack of training, managerial support or peer supervision. However, clarifying this area of mental capacity with all practitioners will help with the management of future complex, high risk cases.

13.8 Other options if adult at risk refuses help or support

This is a theme throughout the review and has been discussed in a number of previous sections; mental capacity section 14.2; choice and risk section 13.1 in regard to completing HFSV on behalf of the Fire Brigade; Claire action plan section 13.5.1 regarding the ASC Mosaic system "red flag" triggers for MDT meetings.

The theme is that practitioners should be more assertive in their approach and use their professional curiosity to explore and understand the reason for refusing, rather than accepting the refusal at face value. There are times, especially when the risk to the service user is high, when challenging or trying to persuade them further by explaining the consequences, even in more graphic terms, would be appropriate. In terms of fire risk, understanding fire risks in the home is key to this which then places the importance of training, joint mental capacity assessments, multi-agency working and recording of these discussions. If then the service user continues to refuse, it can be escalated as described in section 13.4.

As discussed under the mental capacity section, if the service user has capacity and the risk remains, care provision continues and all mitigating options for support or

help have been refused, then a signed document that they accept the risks may be an option to explore as a last resort and with the consent of the adult.

13.9 Impact of the COVID pandemic

There were three national COVID lockdowns, the first from 23rd March 2020, with various indoor and outdoor restrictions continuing until October when the second national lockdown came into force from 31st October for four weeks and the third from 5th January 2021. Various restrictions remained until the 19th July 2021 when legal limits on social contact were removed.

During this time, public organisations had to react to reduction in staff and prioritise their response to the pandemic over their normal functions with some staff redeployed to other duties and then later on, the delivery of the vaccine programme.

During this time Alison continued to receive face-to-face visits from the care provider to provide domiciliary care and the DN to redress her leg wounds. However, records show that from April to July 2020 numerous unsuccessful attempts were made to contact Alison by the OT. It cannot be determined whether this was due to the lockdown, but the dates do coincide. They managed to speak with Debbie in July 2020 as she was in hospital and then complete a home visit in August 2020.

The housing fire safety team contacted Alison by phone rather than making a visit in March 2021. LFB home fire safety visits were reduced during the pandemic however one was completed for Alison a month before the first national lockdown began and attempts were made to make a further after restrictions were eased in July 2021.

This shows that not all agencies were visiting the home during the pandemic, but essential care service from the care provider and DN were still being maintained. This may, to some extent, have left Alison and her partner more isolated to undertake risk taking behaviours.

One question the review has not answered is why it took eighteen months for the Safeguarding Adults Case Review Group (SACRG) to formally review the Brian case. Brian was formally referred to the group by the LFB in July 2021 and should have been done much earlier. The Brian incident occurred just before the first COVID lockdown, however the SACRG met three times in 2020, but no record of Brian being discussed apart from a recent fatal fire being mentioned but not identified as Brian. 2020 was a difficult time for everyone, reacting to the uncertainty of the pandemic, regular changes in government guidance and significantly reduced staff numbers, whilst trying to maintain essential services put enormous strain on all public services. It can therefore only be assumed that the response and impact of the pandemic delayed the LFB referring the Brian case.

14 Issues raised from Alison's case

14.1 Multi agency communication

MDT meetings are key to ensuring all risks to a client or patient are known by everyone involved. The review highlights that some agencies did communicate with each other, for instance the DN, GP and ASC and care agency but there was not a coordinated approach. The GP did hold one for Alison but this was to address the specific risk of Alison's drug use and needles in her property being a risk to care workers. The reviewer has not seen a record of the meeting so the review cannot determine whether other risks were discussed.

From accounts it was found that practitioners tended to be task focused rather than looking at the wider risks. It is clear that the DN, OT and the care agency were aware of the fire risk posed by Alison's smoking and made the appropriate referrals, however when the risk remained and further evidence was found of burn marks on her duvet and blanket (August 2020 and December 2020), these look to be independent reports and it appears no further action was taken until the care agency requested a second set of flame-retardant bedding in February 2021.

Alison's situation and presentation was a complex one, she was immobile, and bed bound, smoked, used drugs, used emollient creams and an air mattress. These characteristics were all the triggers for treating as someone who needs extra consideration of their risk due to fire and should have instigated a better MDT response.

The issues with Alison, in addition to her general care and wellbeing, that required a further discussion were:

- Use of Careline (which the LA will provide at no cost)
- Her continued smoking, drug use and the risk of needles and sharps
- Additional carbon monoxide and smoke alarms (for instance the use of a heat detector in the bedroom instead of a smoke detector)
- Maintenance and use of flame-retardant bedding
- Increased fire risk due to having an air mattress
- Use of emollient creams
- Risks to others within the building

In Alison's case, in addition to the GP, ASC, OT, care agency and DN, the LFB, Housing teams and DAWS should have been involved in a formal MDT meeting, led by one agency, to address these risks and record the outcome:

- The LFB to provide more specific fire prevention advice,

- Housing to complete a PCFRA, PEEP and determine the potential risk to others in the building, and
- DAWS to provide alternative approaches to reduce her drug use.

Following Alison's case, ASC have reviewed their attendance at the Integrated Domiciliary Hub meetings as social work attendance was a bit 'hit and miss'. Workloads meant that representatives from non-health partners didn't always attend as their organisational structures did not mirror the primary care networks. Each GP practice in the Borough is part of a primary care network (PCN), of which there are five in H&F.

Virtual MDT meetings in each of the PCN areas consist of the community matron, DN, GP and practice link worker, a senior social worker, a dementia link worker and a representation from the geriatric service. Other services such as community neurorehabilitation or respiratory team, are invited as required. These meetings discuss several cases and are therefore short and focus on complex clinical assessment needs and management (because of the case list, this is is not the place for a longer case specific MDT review). Any issues raised would result in actions for discussions outside of that meeting. For instance fire may be raised but the action may be outside of that meeting to review assessment and need for referral. The meeting is recorded and the community matrons will normally make a note of the outcomes.

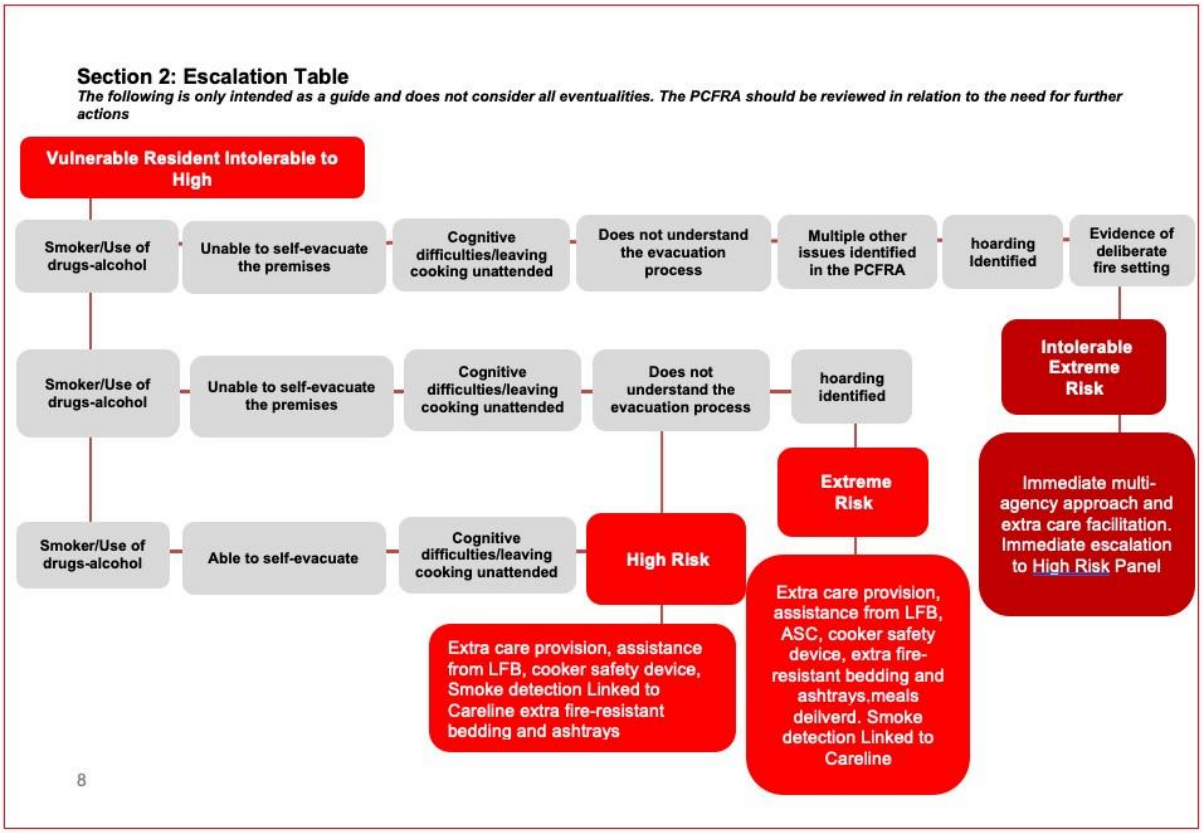
A six month pilot is currently underway of funding two additional social worker posts from health winter monies. These 2 additional posts are aligned to the five PCNs to provide additional capacity to support these MDTs. This pilot was in response to ASC being unable to configure to PCN geographies and being unable to regularly commit to attend MDTs. The Hammersmith and Fulham Health and Social Care Partnership will need to evaluate the pilot in May and identify recurrent funding as required.

This approach ensures that if a practitioner raises an issue, initial discussions are held with relevant agencies. However, it is important that if this process doesn't or can't resolve the issue then a more formal case specific MDT meeting is held with all involved partners. **In short, getting the right people round the table at the right time.** If need be further multi agency discussions are had and if there is still no resolution to the risk, the case is referred to the High-Risk panel. The most importance thing is that at each stage minutes are taken and care notes record outcomes and decisions.

In addition to this, strategic managers from Community nursing, ASC, Housing and the Fire Service now meet regularly to discuss cases and support the network to ensure appropriate escalation.

As part of the Claire action plan in 2021, which unfortunately was not completed prior to Alison's incident but has been since, the electronic Mosaic system used by ASC now triggers a "red flag" for completion of PCFRA for cases where a service user smokes, refuses consent or access and it is known that the risk remains. As part of this there is a very clear escalation flowchart (see below). This also triggers an annual review within care reviews or when health of service user changes.

It is essential that in these cases that there is a clear recording of these cases on a PCFRA or case notes trigger MDT discussions or escalation to High-Risk Panel. For instance, where smoke detectors are refused in bedrooms as was the case in Alison and her partner refused access to Alison. Practitioners should be more assertive in these cases and clients persuaded to comply with fire precautions. For instance, if they do not and carers are put at risk, withdrawal of care could be used to persuade them to comply. If there is a risk to others within the building should a fire occur, housing officers can use conditions within tenancy agreements.



14.2 Mental Capacity

The Mental Capacity Act states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. In Alison's case, in August 2019 ASC state that the GP said she had capacity and again in March 2021 as part of a safeguarding review. The decision was taken that neither Alison or Debbie were at risk of abuse as both had capacity to make unwise decisions in relation to their wellbeing.

Some social workers believe wrongly that the Mental Capacity Act provides a right to make unwise decisions, creating risks for service users[29]. Practitioners often mistakenly believe adults have a 'right to make unwise decisions' re smoking in their home and believe they cannot take any further action if a person is making unwise decisions, or that they do not consider repeated unwise decisions as possible sign that person lacks capacity and requires assessment.

Section 1 of the Mental Capacity Act 2005 states that a 'person should not be treated as unable to make a decision merely because they make an unwise decision'[30]. This principle requires consideration of the person's capacity in a time and issue specific manner, so their ability to realise and weigh up the risks smoking posed must be explored.

Assessing mental capacity, in particular executive mental capacity in relation to fire risks, is often very difficult. Executive Capacity is about the ability to use or weigh information. The Code of Practice (para 4.21)[31] notes: '*For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information, but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given*'. In other words, a person may appear to be able to weigh facts while in

[29] How misinterpretation of 'unwise decisions' principle illustrates value of legal literacy for social workers. By Angela Jenkinson and John Chamberlain.
https://www.communitycare.co.uk/2019/06/28/misinterpretationunwise-decisions-principle-illustrates-value-legal-literacy-social-workers/

[30] The concept of 'unwise decisions' is contained within the principles set out in the Mental Capacity Act 2005, which states (section 1) that "a person is not to be treated as unable to make a decision merely because he makes an unwise decision".

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

an interview or practitioner meeting but if they do not transfer those facts to everyday life (execute the plan) they may lack mental capacity.

The care provider, DN and OT all discussed Alison's smoking with her on several occasions. However, it is likely that her drug use changed her mental capacity and that her drug use changed her ability to make informed decision about smoking. One time she could be coherent and understand the risks but once she had taken drugs, she could be unaware of them. It is also likely that her drug use increased her risk appetite and became the priority over her care. Considering repeated discussions were made about the risks of her smoking and she made, what the Mental Capacity Act 2005 calls 'unwise decisions'[32], this should have triggered further investigation via MDT meeting or a robust joint mental capacity assessment to determine her capacity to understand the risks and consequences associated with her drug taking and smoking.

The LFB, as part of a HFSV can provide an opinion in this "issue specific" area, in other words, whether a person understands the fire risks associated with smoking or other fire risks and the consequences should a fire start. If they don't then they could be considered as not having capacity in that issue specific area and this should be communicated to ASC either via local communications or a formal safeguarding concern. The next most appropriate step prior to an MDT meeting would be to complete a joint assessment with the LFB and Clinician (social worker or District Nurse). The LFB being the subject matter expert in fire prevention and the clinician in mental capacity and jointly they would be able to assess the mental capacity of the service user in this issue specific area. The LFB or the Clinician should instigate and lead the MDT with the specific aim of finding ways to mitigating the risks considering the outcome of the mental capacity assessment.

Neither the fire service nor local authorities have any general power to regulate or prevent smoking or drug use within individual private homes, whether they are owner occupied or rented, or whether they are houses or flats (including flats in sheltered units). Cases where there is a high risk of fire due to the person's smoking (or other risks) and where the person may lack mental capacity should then next be

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

discussed within an MDT or Best Interests meeting, with the LFB being a key contributor, to determine the best way forward to address the risks.

Recommendation 10

That cases where there is doubt as to the capacity of a service user to understand fire risks in their home:

a) a joint LFB mental capacity assessment is completed with other relevant professionals and,
b) that the LFB are invited to future MDT or best interests meetings.

Recommendation 11

In cases that involve significant fire risks, the LFB lead MDT meetings

The most problematic issue is if, in these high-risk cases involving someone who smokes or takes drugs, it is determined that they have mental capacity and therefore the right to make unwise decisions. If all mitigating options for support or help have been fully discussed and refused or ignored, then this must be fully recorded. In addition, a signed document that the person accepts the risks may be an option to explore.

14.3 Training

There was a common theme that appeared throughout the review in terms of training. Some partners referred to completing their initial “fire safety” training in respect to what they do in the event of a fire as an employee in the workplace, according to their responsibilities as an employer under the Regulatory Reform (Fire Safety) Order 2005 (known as the RRO), rather than applying it to the risk within the homes of the service user, clients or tenants. This led to the conclusion that “home fire safety” or more applicable in this report’s context, the term “home fire risk awareness” by practitioners was often confused with “fire safety”.

This misunderstanding of the term Fire Safety is having the effect of not applying the person-centred approach to risk assessment, especially with respect to fire risks in people’s homes.

The questionnaire also highlighted the majority of the practitioners (76%) that took part correctly understood the term Person-Centred Fire Risk Assessment but 24%

answered incorrectly. Only 26% knew the first element of the PCFRA. Whilst these results are encouraging, there is still work to be done to raise awareness of how to identify and assess fire risks in the home and how to apply a PCFRA.

The audits also highlighted that a number of agencies do not use a PCFRA, examples of which are freely available on the LFB website[30] and from H&F ASC. The PCFRA can be used for an initial quick and easy assessment of elderly or vulnerable residents in their own private home. It will provide specific and relevant information to aid in the completion of a full PCFRA where one is required and signpost to the LFB or ASC for further advice.

Recommendation 12

That the SAB seek reassurance from all multi-agency partners that fire risks in the home and ways to mitigate them are included in practitioner or staff training.

15 Recommendations

1. That hospitals establish a process to identify those more vulnerable to the risks of fire in their home and refer to LFB as part of discharge plans.
2. The LFB establish a standard process whereby any hospital can refer vulnerable patients directly for a Home Fire Safety visit.
3. That commissioning services, in conjunction with other agencies, lead a review of care provider risk assessments to ensure they are person-centred and include all potential fire risks in the home.
4. That all agencies and partners have a process of referring cases involving fire risks directly to the LFB and inform ASC at the same time so they can maintain an overview of the case.
5. That the High-Risk Panel and Local Authority housing teams continue to consider Personal Protective Systems to be available and appropriate people within the borough be trained to install and maintain them, for use by all partners.
6. That the DAWS Plus service is considered for clients with known substance misuse and who have disengaged, or are at risk of disengaging, with support services.

[30] https://www.london-fire.gov.uk/media/4844/pcra_v2-april-2020-final.pdf

7. That within the ASC/LFB review meetings or the High-Risk panel a process is established whereby, for those people that refuse or decline a HFSV or where the LFB are unable to access the service users property, the LFB provide relevant feedback, advice, support or training so the HFSV is completed by the appropriate agency on the LFB's behalf.
8. That, in relation to fire risks, the SAB seeks assurance that MDT meetings, decision making and escalation processes to the High-Risk Panel, are formally documented. Also, that the SAB promote best practice MDT working and expectations, and increase awareness of the High-Risk panel and its purpose as part of the Fire Safety Assurance MDT approach briefings.
9. That the SAB govern and manage any action plan devised as a result of this review.
10. That cases where it is identified that a person may not have capacity to understand fire risks in their home:
    a. a joint LFB mental capacity assessment is completed with other relevant professionals and,
    b. that the LFB are invited to future MDT or best interests meetings.
11. In cases that involve significant fire risks, the LFB lead MDT meetings.
12. That the SAB seek reassurance from all multi agency partners that fire risks in the home and ways to mitigate them are included in practitioner or staff training.

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MIFireE GInSTR DipHMO

16 Glossary

ASC	Adult Social Care
CIRS	Clutter Image Rating Scale
COPD	Chronic obstructive pulmonary disease
EPA	Environmental Protection Act 1990
EDT	ASC Emergency Duty Team
DAWS	Drug Abuse and Welfare Service
DN	District Nurse
DVT	Deep Vein Thrombosis
FRS	Fire and Rescue Service
HFSAB	Hammersmith & Fulham Safeguarding Adults Board
HFSV	Home Fire Safety Visit (completed by the Fire Brigade)
HMO	House of Multiple Occupation
ICB	Integrated Care Board (formerly the Clinical Commissioning Group)
IMR	Individual Management Review
LA	Local Authority
LAS	London Ambulance Service
LFB	London Fire Brigade
MARAC	Multi-Agency Risk Assessment Conference
MDT	Multi-Disciplinary Team
NHS	National Health Service
OT	Occupational Therapist
PCFRA	Person-centred fire risk assessment
PEEP	Personal Emergency Evacuation Plan
PHA	Public Health Act 1936
PPS	Personal (or portable) protective system (which is an automatic mist system that activates in the event of a fire)
RRO	Regulatory Reform (Fire Safety) Order 2005
SACR Group	Safeguarding Adults Case Review Group
SAR	Safeguarding Adults Review

17 Appendix 1 - Results from questionnaire and analysis

As mentioned in the methodology, two practitioner sessions were held. These sessions targeted anyone who visited people's homes and involved completing a questionnaire and were an open session where participants had the opportunity to ask the reviewer any fire safety related questions. The session was split into three parts, the first asked 10 questions and the answers followed by a small break, the second the last 10 questions and answers and the third the open session.

38 participants took part, 25 participants attended the first session and 13 the second (which was moved to attract more participants as the first was within school half term holidays). It was noted that more registered for the events than actually attended on the day.

Not all responded to every question, all 38 answered the first 10 questions but after the small break 6 participants left so only 32 answered the last 10 questions.

The percentages below are based on the actual number of respondents to each question.

Of the 38 who started the session, the majority (44%) were from Adult Social Care, 22% from Housing, 16% from Health care, 7% each from the voluntary sector and Care Provision, 2% each from Mental Health Services and others not specified.

The majority (76%) knew what a Person-Centred Fire Risk Assessment (PCFRA) was however only 26% correctly identified the first element. Also, only 27% said they have used a PCFRA to address fire risk for a client. This indicates awareness of the PCFRA but not a working knowledge of using or applying it.

It was encouraging that the majority (74%) knew what PEEP stands for (Personal Emergency Evacuation Plan) and 98% knew when it should be completed.

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

53% correctly identified that lack of Mental Capacity is not a distinct characteristic of self-neglect.

31% did not know what a Clutter image rating scale is but 23% knew that above 4 of the CIR scale is considered a significant risk and 90% correctly identified the circumstances where action can be taken to address hoarding.

In regard to smoking cessation the majority of respondents (92%) knew the methods that are available on the NHS and all knew how to contact a stop smoking advisor.

71% knew what an Assistive Technology Catalogue was (which is a catalogue that lists products and services which can help support independence)

35% of participants knew what a Personal Protective System (PPS) was (which is an automatic mist system that activates in the event of a fire), with 46% confusing it with an alarm service for the elderly. This is of concern considering a PPS is a very effective control measure for very high-risk cases. Only 7% of participants said they had recommended a PPS for a client.

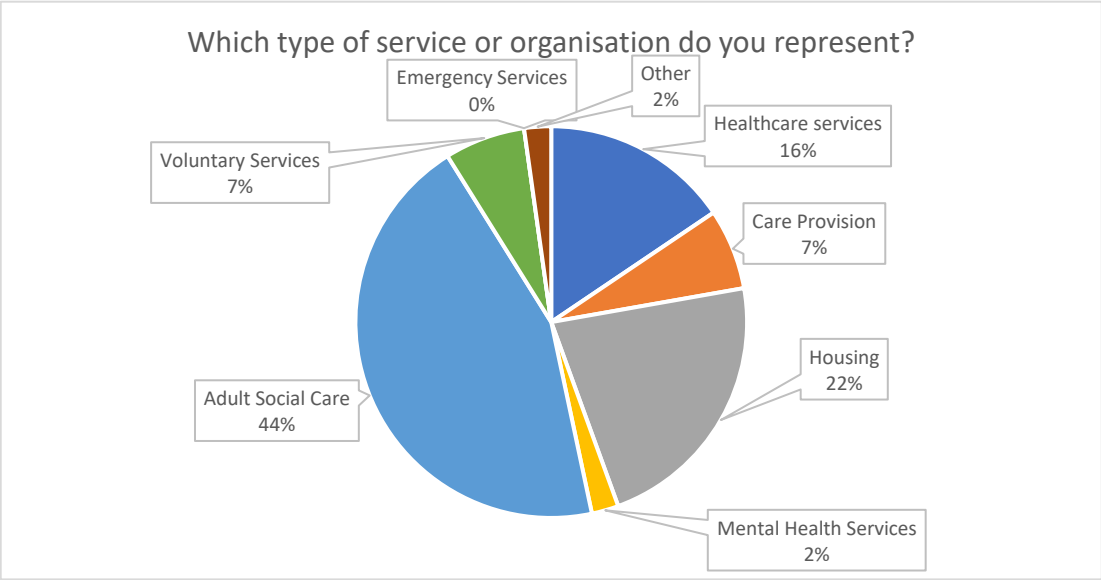
43% said they had a client with drug dependency and that it hindered or affected how their case was managed. The reasons being:

- The client would not listen or take heed of advice to address risks in their home or how to improve their health (35%)
- The service users drug dependency took priority over other more important parts of their care practitioners felt you had done all you can to help the client (31%)
- Supporting the client was pointless until their drug dependency was addressed (4%)
- The practitioner felt they had done all they could to help the service user (17%)
- Other 13%

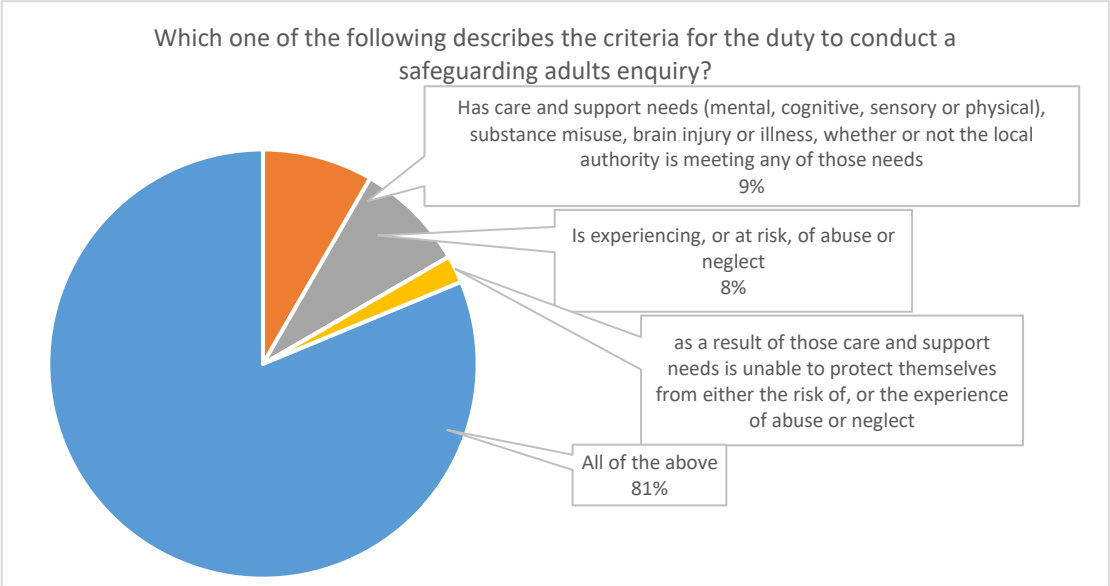
It is good that the 62% said they had a client who had an increased risk of fire, 78% said they had been offered fire prevention support

78% said where they had a client with long term care needs and/or significant fire risks, they were given sufficient support to manage their care and fire risks. 22% said that they had not been given sufficient support which is worrying. The reviewer asked to clarify why this was and a number or participants blamed the pressure that some organisations are under and increased practitioner workloads.

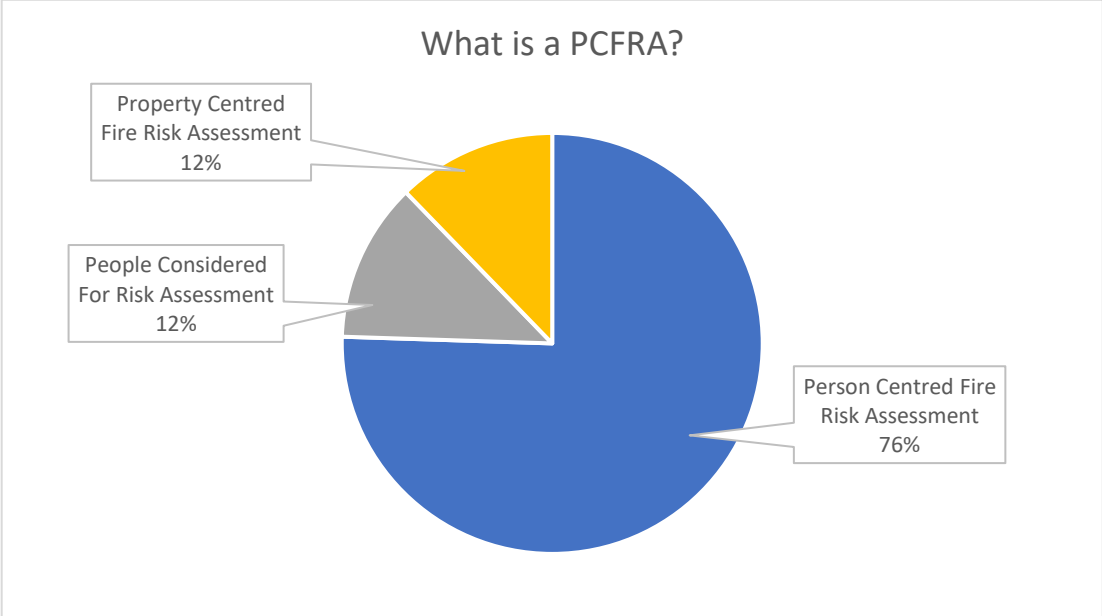
1.



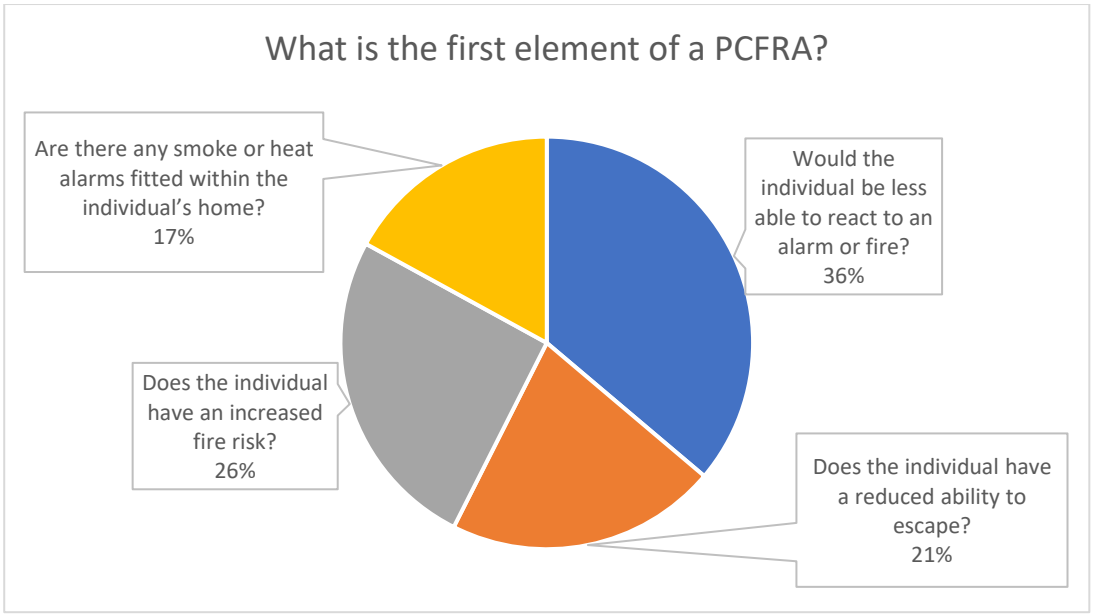
2.


Which one of the following describes the criteria for the duty to conduct a safeguarding adults enquiry?
Has care and support needs (mental, cognitive, sensory or physical), substance misuse, brain injury or illness, whether or not the local authority is meeting any of those needs
9%
Is experiencing, or at risk, of abuse or neglect
8%
as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect
All of the above
81%

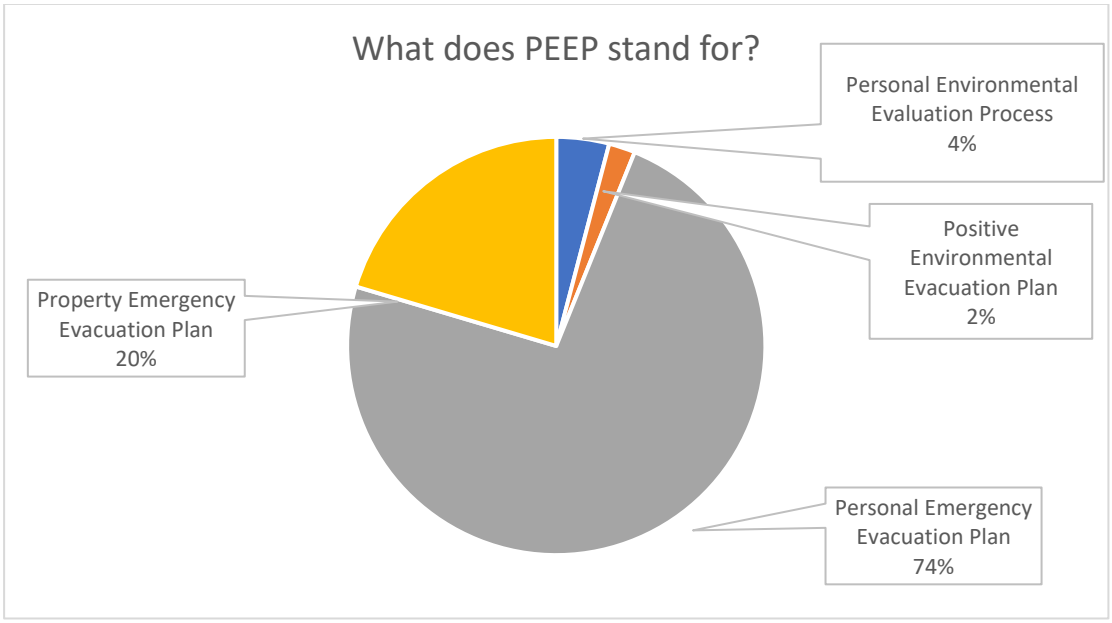
3.


What is a PCFRA?
Property Centred Fire Risk Assessment
12%
People Considered For Risk Assessment
12%
Person Centred Fire Risk Assessment
76%

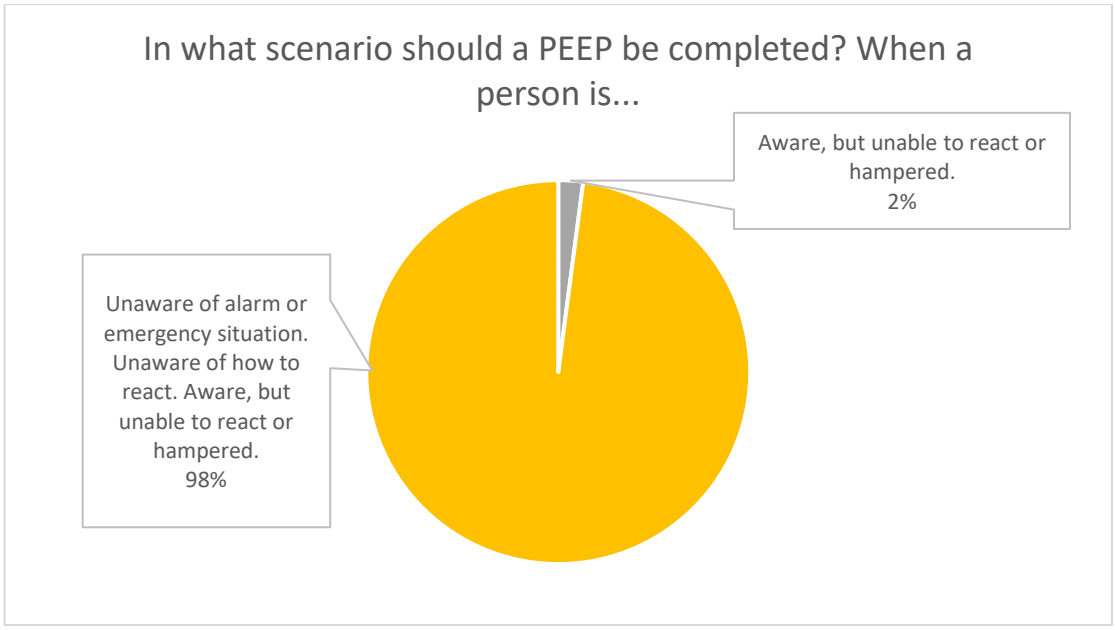
4.


What is the first element of a PCFRA?
Are there any smoke or heat alarms fitted within the individual's home? 17%
Would the individual be less able to react to an alarm or fire? 36%
Does the individual have an increased fire risk? 26%
Does the individual have a reduced ability to escape? 21%

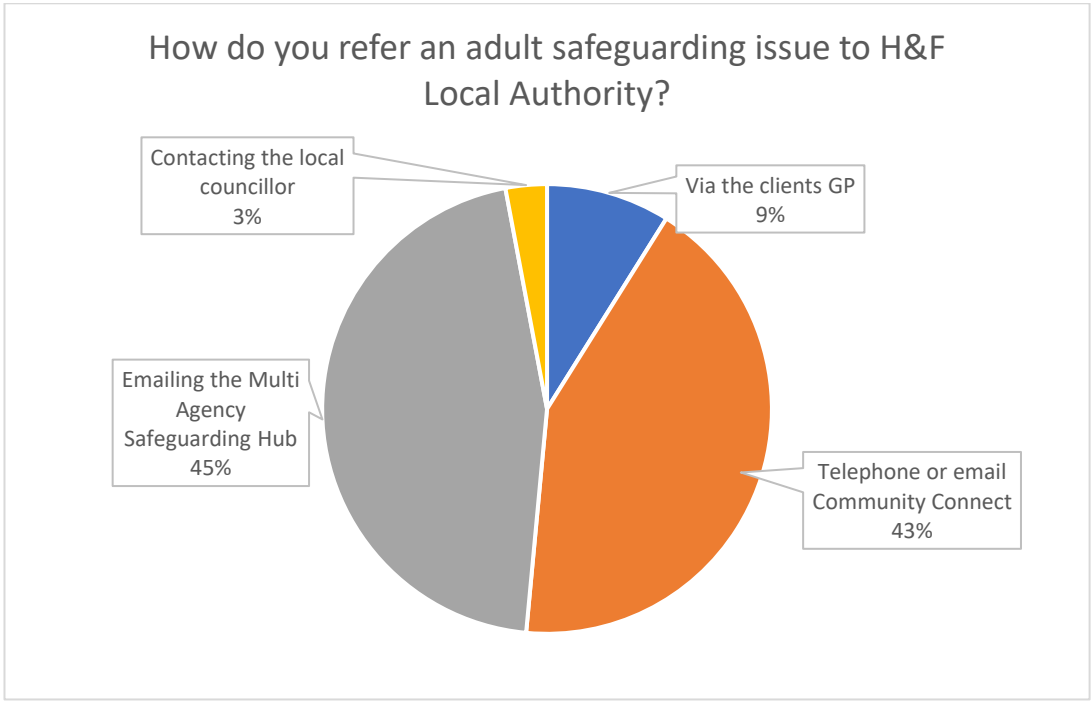
5.


What does PEEP stand for?
Personal Environmental Evaluation Process 4%
Positive Environmental Evacuation Plan 2%
Property Emergency Evacuation Plan 20%
Personal Emergency Evacuation Plan 74%

6.

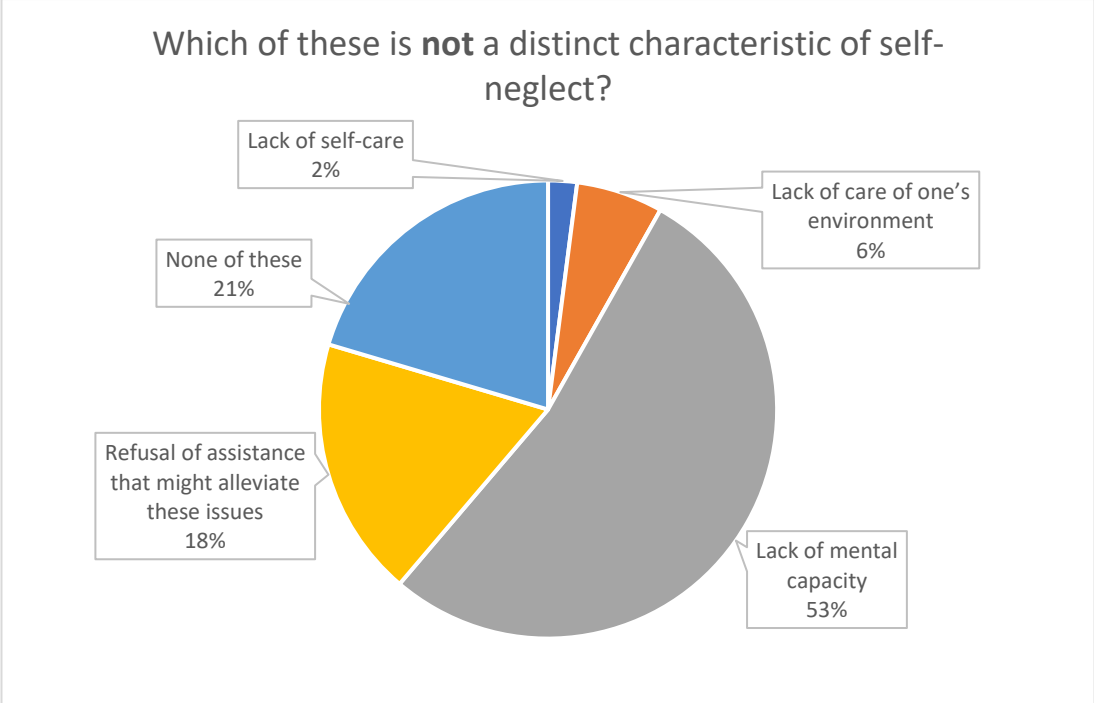


7.

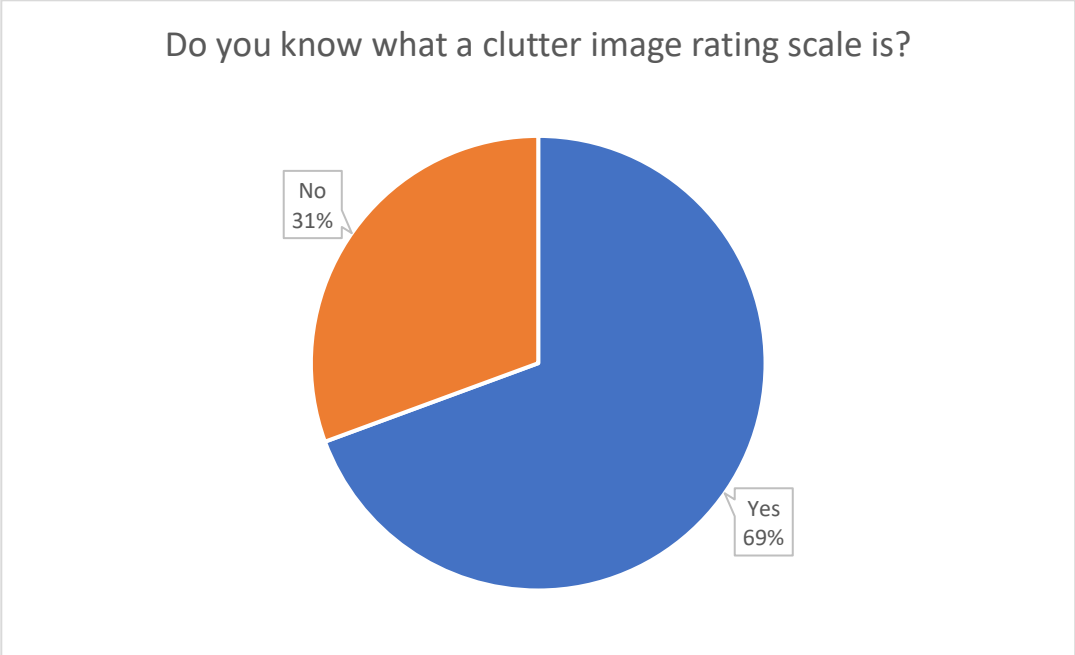


*To note: those that chose GP/local councillor also selected at least one of the correct choices

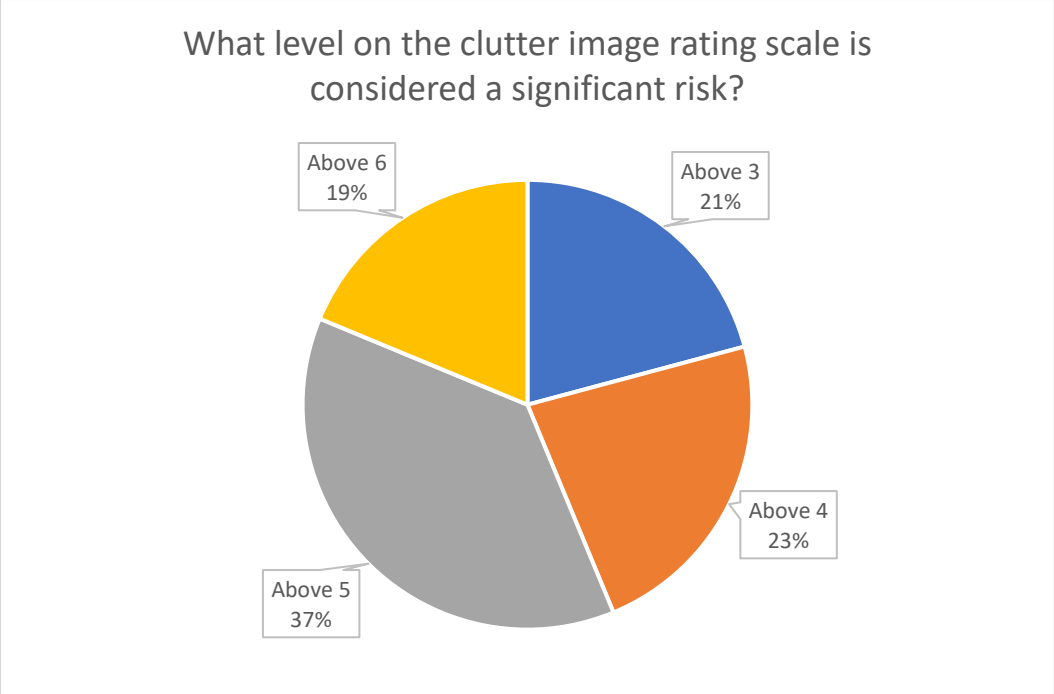
8.


Which of these is **not** a distinct characteristic of self-neglect?
Lack of self-care 2%
Lack of care of one's environment 6%
None of these 21%
Refusal of assistance that might alleviate these issues 18%
Lack of mental capacity 53%

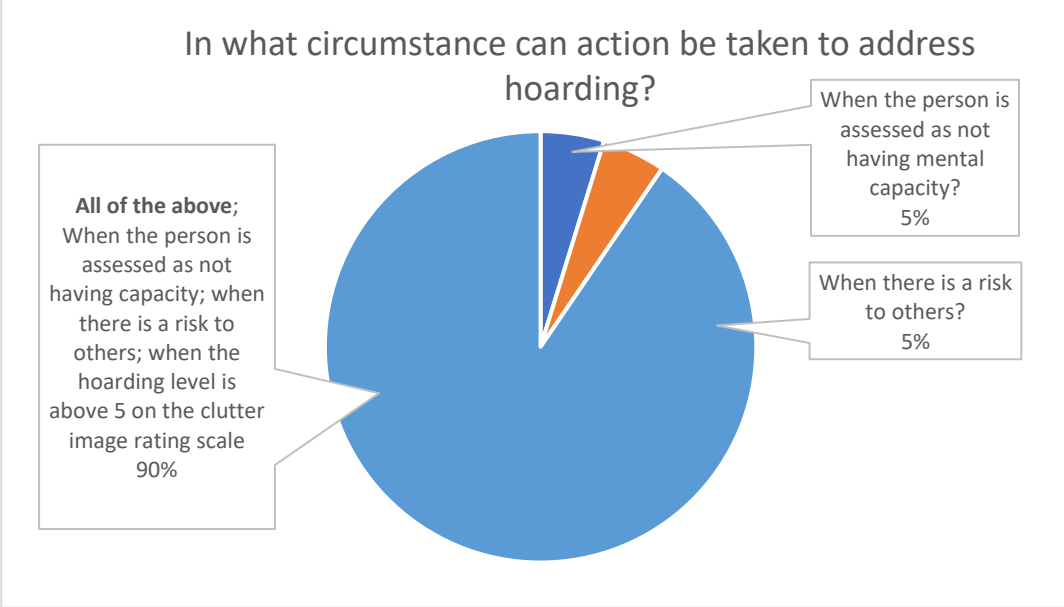
9.


Do you know what a clutter image rating scale is?
No 31%
Yes 69%

10.

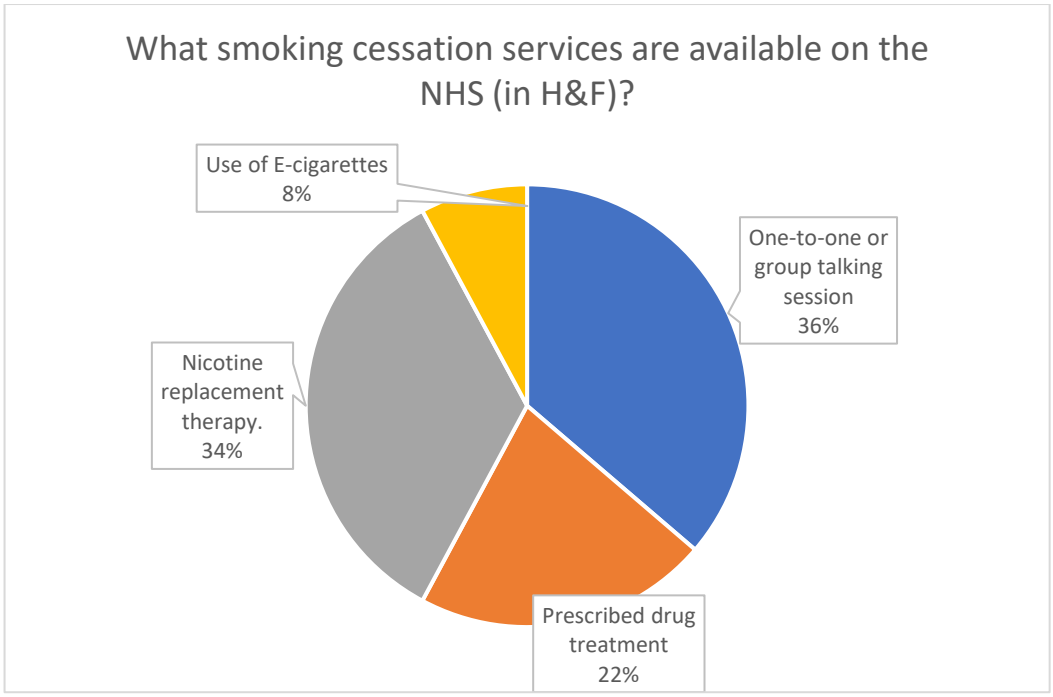


11.

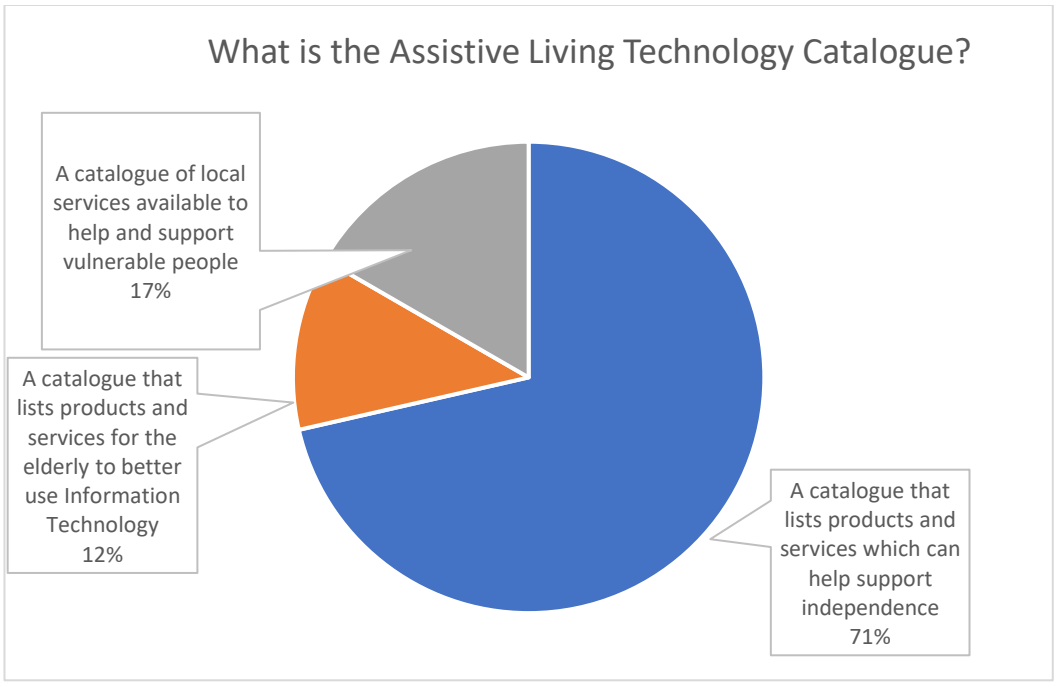


To Note: This only includes responses from Session 1. Session 2 attendees were given answer without poll question being launched.

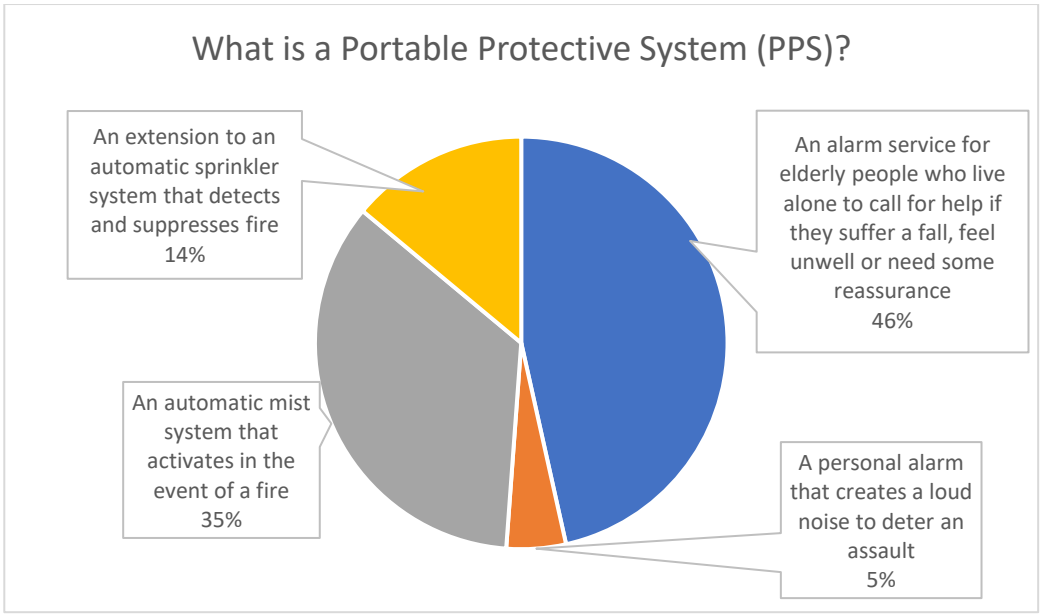
12.


What smoking cessation services are available on the NHS (in H&F)?
Use of E-cigarettes 8%
One-to-one or group talking session 36%
Nicotine replacement therapy. 34%
Prescribed drug treatment 22%

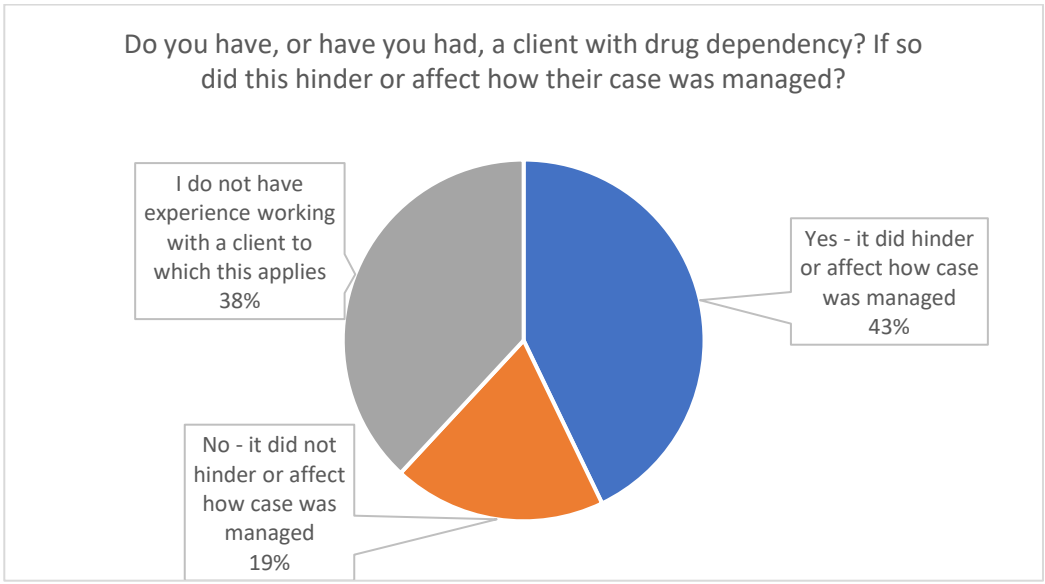
13.


What is the Assistive Living Technology Catalogue?
A catalogue of local services available to help and support vulnerable people 17%
A catalogue that lists products and services for the elderly to better use Information Technology 12%
A catalogue that lists products and services which can help support independence 71%

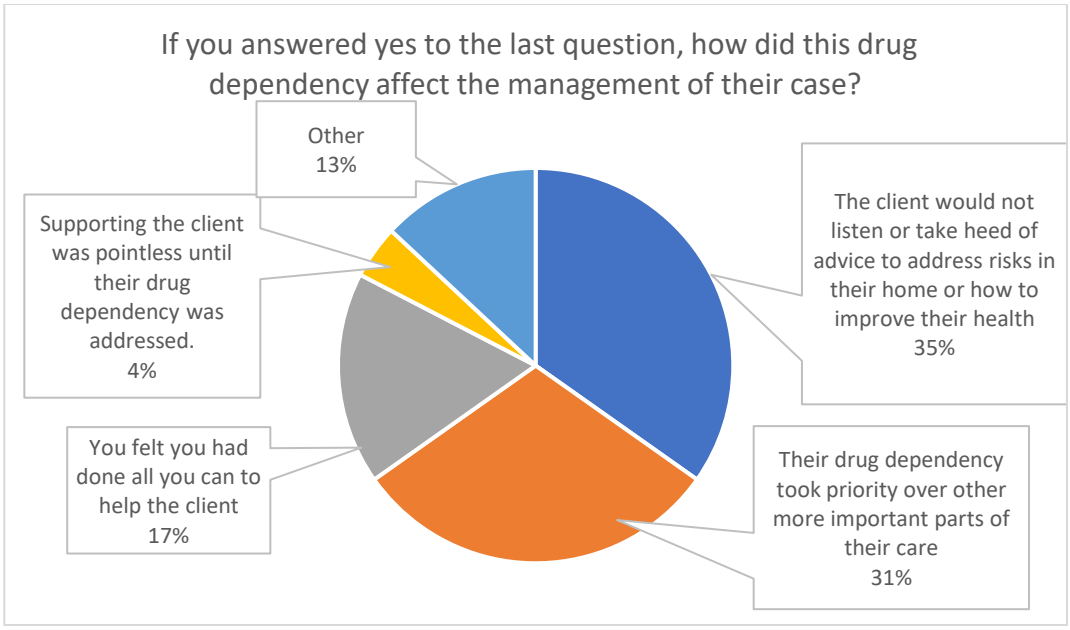
14.


What is a Portable Protective System (PPS)?
An extension to an automatic sprinkler system that detects and suppresses fire 14%
An alarm service for elderly people who live alone to call for help if they suffer a fall, feel unwell or need some reassurance 46%
An automatic mist system that activates in the event of a fire 35%
A personal alarm that creates a loud noise to deter an assault 5%

15.

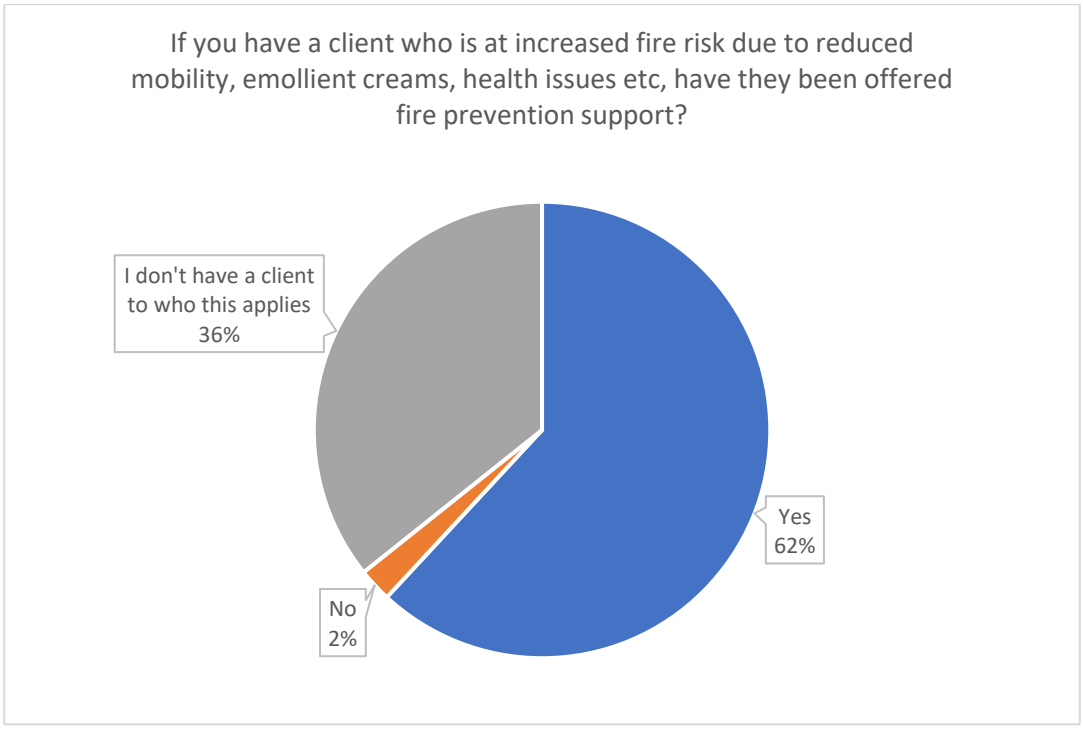

Do you have, or have you had, a client with drug dependency? If so did this hinder or affect how their case was managed?
I do not have experience working with a client to which this applies 38%
Yes - it did hinder or affect how case was managed 43%
No - it did not hinder or affect how case was managed 19%

16.

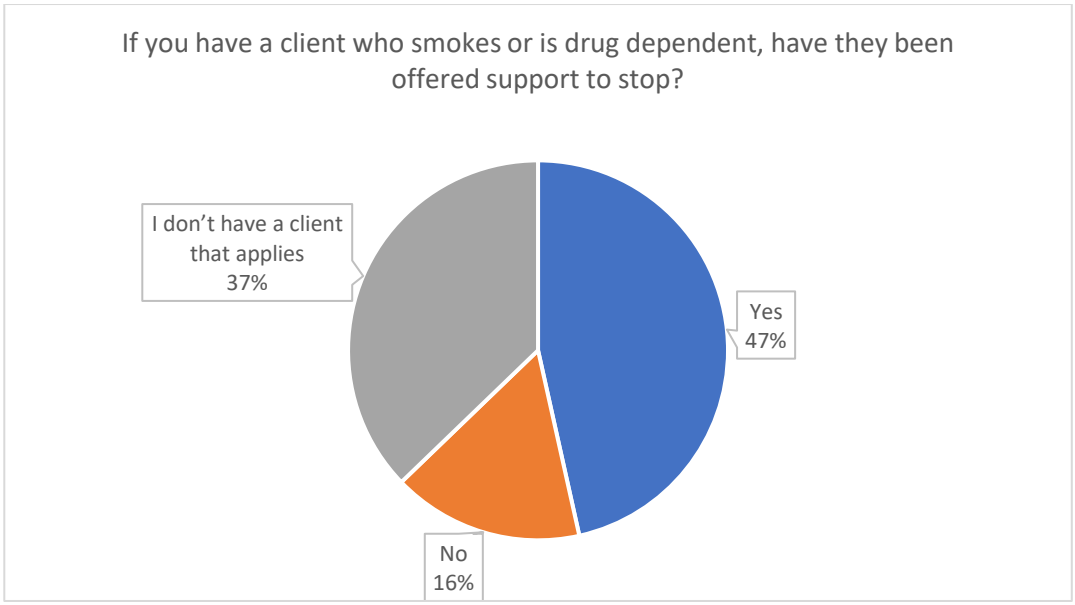


Note: respondents may have selected more than one

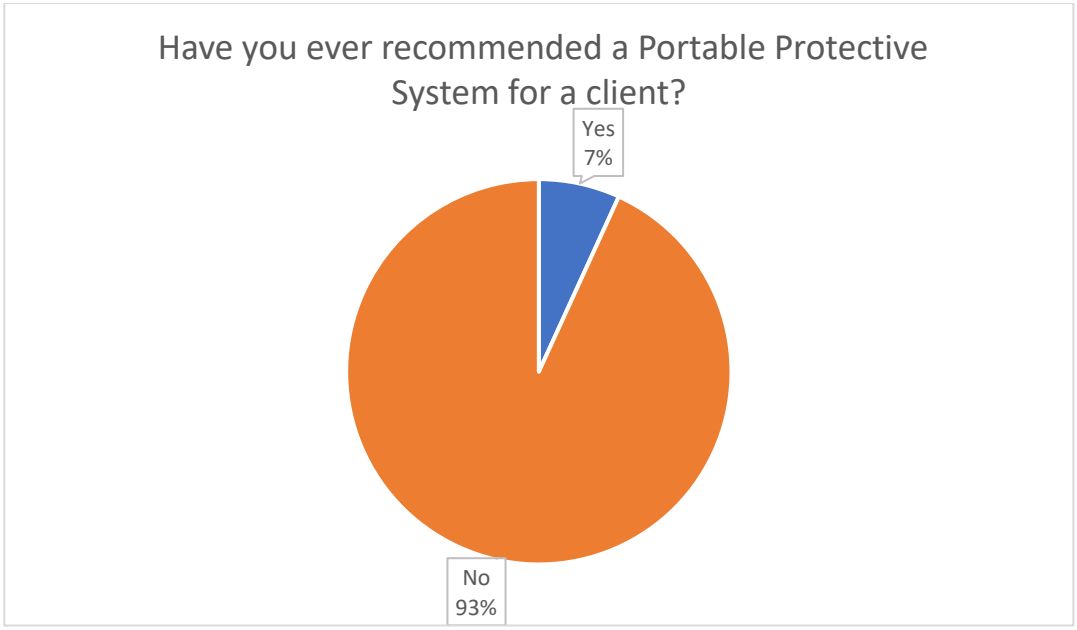
17.



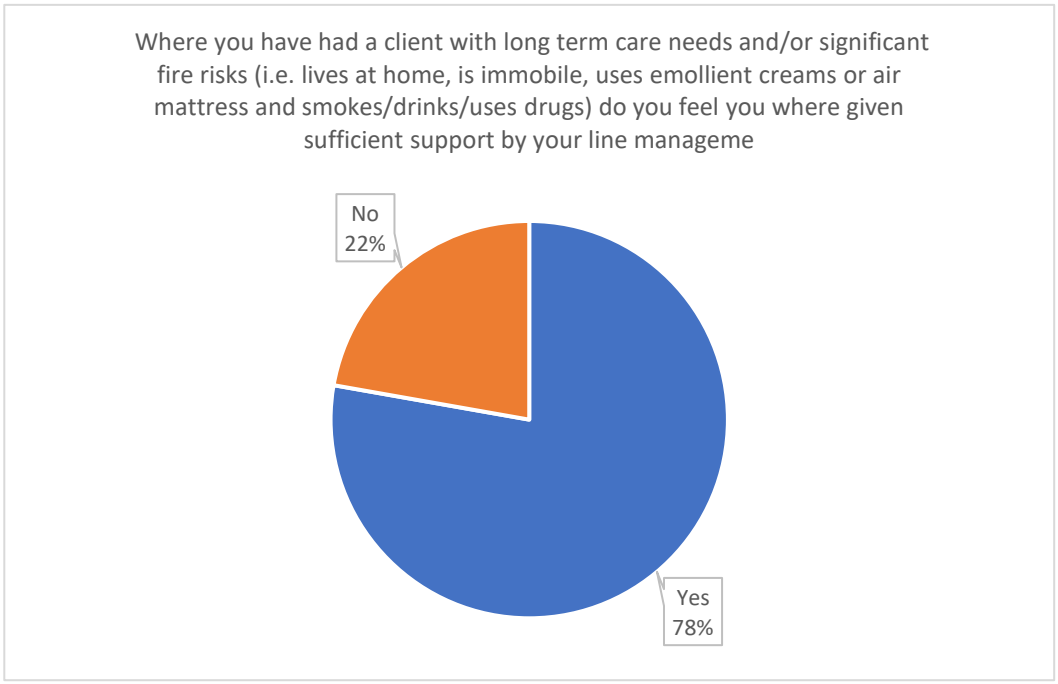
18.


If you have a client who smokes or is drug dependent, have they been offered support to stop?
I don't have a client that applies 37%
Yes 47%
No 16%

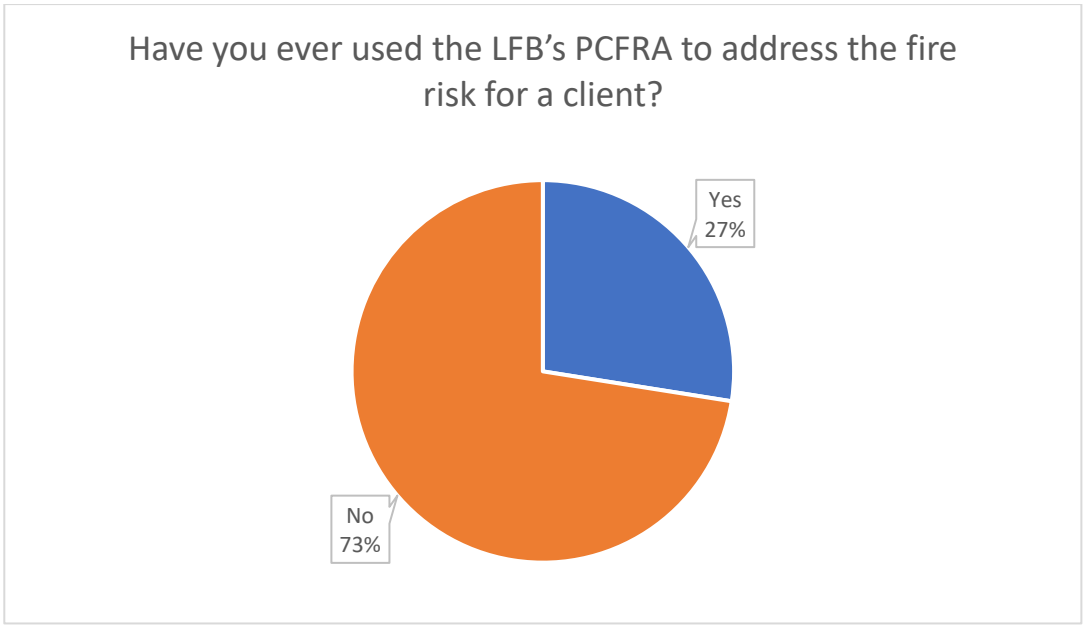
19.


Have you ever recommended a Portable Protective System for a client?
Yes 7%
No 93%

20.


Where you have had a client with long term care needs and/or significant fire risks (i.e. lives at home, is immobile, uses emollient creams or air mattress and smokes/drinks/uses drugs) do you feel you where given sufficient support by your line manageme
No 22%
Yes 78%

21.


Have you ever used the LFB's PCFRA to address the fire risk for a client?
Yes 27%
No 73%

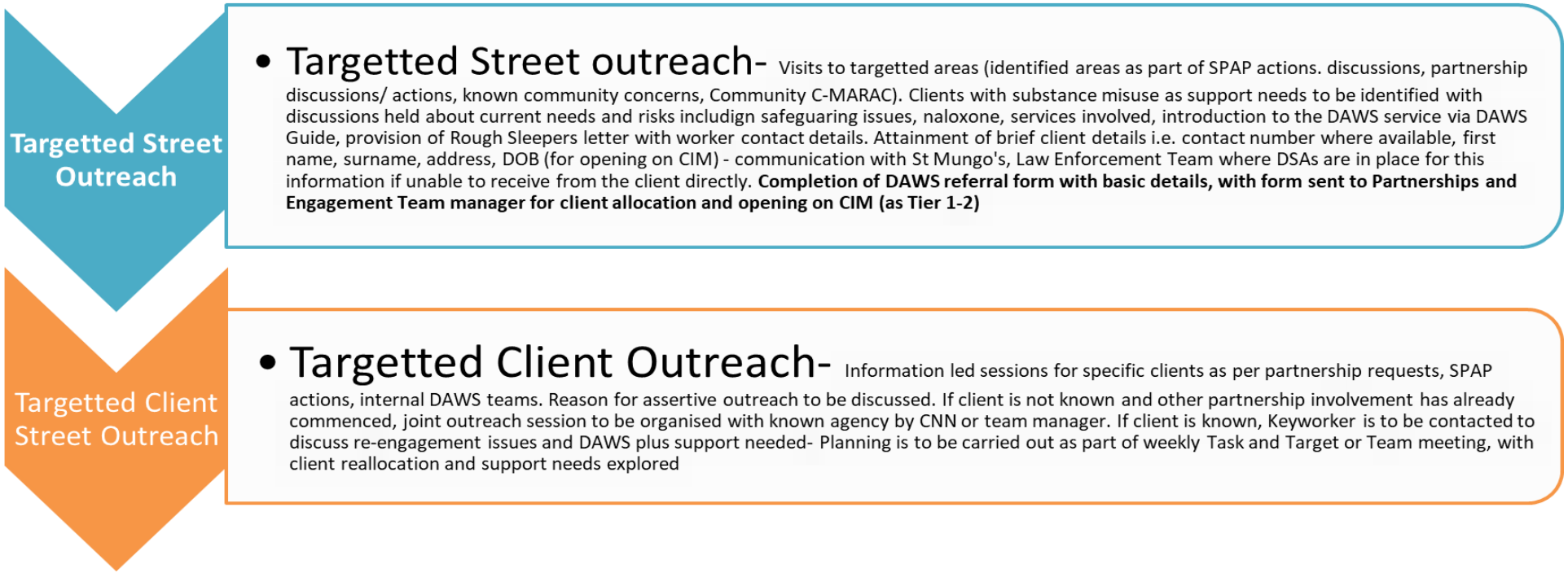
Appendix 2 DAWS Plus Assertive Engagement

Introduction/ Aims:

DAWS plus work as a dedicated outreach team, working alongside partner agencies within the Hammersmith and Fulham area, with the overall aims to support more reach of clients, raise insight into a client's own use, provide harm reduction support to ensure clients are able to make informed decisions about whether or not to engage in treatment and support. We use the assets of the client and local community to reinforce permanent change and support sustained recovery, via:

1. **Change Resistant Clients-** Joint action plan and intensive community support depending on client needs, using joint service approach where possible to have a 3way conversation with the client holding harm reduction discussions, provide the service guide and introduction to treatment, discuss what engagement would look like, check injecting sites and other harms and ensure link to health services, work with referrer to support client into treatment in a scaled way, offer community key-working and support to bring treatment to the client if barriers are in place. Address social barriers including housing, employment and other areas that may be hindering the client's engagement
2. **Street Outreach-** Targeted areas as identified during weekly **DAWS Plus Task and Target** meetings, **Street Population Action Partnership (SPAP)** monthly meetings and as requested from **St Mungo's Outreach** Team, **Rough Sleepers and Mental Health Programmes** Team and **H&F Law Enforcement** Team. Work with Peer Needle Exchange Lead and Get Connected Team Coordinator to ensure notification of street areas where high levels of needle use have been identified for additional

harm reduction outreach sessions, arrangement of litter picking or support/ signposting around community needle exchange requirements. Use of **DAWS Plus Useful Numbers** where additional support needs have been identified



3. **Case Management-** Support client once referral is accepted, by tailoring engagement according to need. This includes offering within 2-week window:
    i. Assessment
    ii. Harm Reduction
    iii. Support from our clinical team
    iv. Key-working/ casework

GREEN

v. Signposting and referring to additional recovery/ wellbeing support services within DAWS/ the CGL Alcohol Service
vi. Digital recovery packages
vii. Provide naloxone, locked boxes for medication, needle exchange.

4. **Support to Community Outreach/ Hostel teams-**
    - Consultation and support to staff on casework issues. Support in bringing clients with multiple needs into treatment
    - Substance Misuse Training
    - Naloxone Training and supply to staff and service users
    - Street outreach to any potential resident who needs extra support and treatment to take up their bed
    - . Provision of sharps bins and safe storage boxes
    - Intensive engagement of clients identified as part of hostel bed-list meetings, guided by Partnerships and Engagement Team Manager

5. **DAWS Plus Team Role/ Support Outline**

DAWS+ Wellbeing Workers:

- Building therapeutic relationships with clients
- Advocating on the client's behalf
- Onward signposting to appropriate services
- Completing referrals to appropriate services
- Attending Appointments with clients
- Coordinate client care where appropriate
- **Joint working to support client in**

GREEN