CITY & HACKNEY SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULT REVIEW: Mr EF

Suzy Braye, Independent Reviewer

FINAL REPORT: FEBRUARY 2021

1. INTRODUCTION

1.1. Mr EF, aged 89 and of African-Caribbean heritage, died in February 2019 as a result of a fire in his flat. The London Fire Brigade was alerted by two 999 calls made when neighbours in the flat above smelled smoke. Mr EF was found unconscious in his bedroom and had extensive burns; he could not be resuscitated and was declared deceased by the Helicopter Emergency Medical Service. The London Fire Brigade's investigation into the fire indicated that incense sticks were found scattered around the bedroom, propped into flammable items and therefore not used safely. The seat of the fire was on the bed and the investigation concluded that the likely cause of the fire was the use of an incense stick on the mattress, which ignited bedding and tissues – either from the stick itself or from the use of matches to light it. The door of his bedroom was closed. The Police also attended and declared the fire non-suspicious.

1.2. Mr EF had been in receipt of support from a wide range of health and social care services. His niece also visited on a weekly basis to provide assistance and support.

2. THE DECISION TO CONDUCT A REVIEW

2.1. The City & Hackney Safeguarding Adults Board (CHSAB) considered whether the circumstances of Mr EF's death met the criteria that engaged their statutory duty[1] to arrange a Safeguarding Adults Review (SAR). These would be circumstances in which:

(a) An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
(b) There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. The SAB found that the criteria for mandatory review were not met, but that there was nonetheless potential learning to be derived from a review of the circumstances in which Mr EF died[2]. In particular, the SAB wished to identify how partner agencies had implemented learning from a previous SAR undertaken by CHSAB in 2016. That

[1] Sections 44(1)-(3), Care Act 2014
[2] Under section 44(4), Care Act 2014, the SAB can at its discretion undertake a review of any other case involving an adult in its area with needs for care and support.

review had considered the case of Mr BC, who also died in a fire at his home[3]. The SAB believed it would be of value to consider whether the learning from Mr BC's death had been applied to the actions taken by agencies in Mr EF's case and therefore agreed to carry out a discretionary SAR under section 44(4), Care Act 2014.

3. THE APPROACH TAKEN IN THIS REVIEW

3.1. The terms of reference for the review were to identify how well learning from the SAR relating to Mr BC had been embedded in practice with Mr EF, and what improvements remained to be made.

3.2. CHSAB commissioned the independent lead reviewer in the previous case of Mr BC to undertake the review relating to Mr EF[4]. Administrative support was provided by the CHSAB Manager and Business Support Officer.

3.3. CHSAB undertook an initial scoping exercise to establish which agencies had been involved in providing services to Mr EF and what interventions had been carried out. Those details were passed to the independent reviewer, who also reviewed the recommendations from the previous Mr BC SAR and CHSAB's action plan arising from them. Key lines of enquiry for the Mr EF review emerged. The agencies involved responded to a further series of questions on those key lines of enquiry and their responses were mapped against the recommendations from the Mr BC SAR, which provided the benchmarks against which practice with Mr EF was evaluated.

3.4. Representatives from the agencies involved then attended a collaborative learning event, which explored further how the learning from the Mr BC SAR had influenced work with Mr EF. Present were those involved with management of Mr EF's case, along with senior staff responsible for operationalising strategic objectives around safeguarding (i.e. those in roles responsible for responding to the recommendations of the Mr BC SAR).

3.5. Based on her analysis of information from all sources, the lead reviewer then drafted this report.

3.6. The key lines of enquiry applied in this review were as follows:

3.6.1. How suitable was Mr EF's housing for his needs?
3.6.2. How has fire risk been managed since the Mr BC SAR and in Mr EF's case?
3.6.3. How were all risks in Mr EF's situation managed?

[3] A short account of Mr BC's situation is given at Appendix 1.

[4] Professor Suzy Braye is a former social work practitioner, local authority manager, academic educator and researcher. She acts as an independent adult safeguarding consultant and has extensive experience in conducting safeguarding adult reviews. She is co-author of the recently completed first national analysis of learning from SARs: Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020 forthcoming) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector Led Improvement.* London: Care & Health Improvement Programme.

3.6.4. How did agencies involved in providing services to Mr EF communicate together and coordinate their work?
3.6.5. How was the direct contact with Mr EF undertaken?
3.6.6. How was Mr EF's mental capacity addressed?

3.7. No other investigations were ongoing at the time of the review. The Coroner had previously recorded the cause of Mr EF's death as smoke inhalation and the London Fire Brigade had undertaken a fire fatality review, the report from which was made available to this review.

3.8. The following agencies provided information to this review:

Hackney Housing and Wyke Tenancy Management Organisation (Wyke TMO)	Mr EF lived in a ground floor flat categorised as general needs housing. Hackney Council was his landlord, with Wyke Tenancy Management Organisation responsible for the housing management of the estate.
Hartwig Care	Hartwig Care was the care provider agency commissioned by London Borough of Hackney Adult Social Care from 2016 to provide care and support to Mr EF. They provided 3 visits per day, each of 30 minutes duration.
Homerton University Hospital NHS Foundation Trust (HUHFT)	HUHFT is an integrated Foundation NHS Trust commissioned by City and Hackney Clinical Commissioning Group to provide healthcare in both acute and community services. Mr EF was admitted six times to Homerton Hospital between 2011 and 2018, and also received occupational therapy, physiotherapy, community nursing, diabetic specialist nursing services, community podiatry services, and support from the Integrated Independence Support Team.
London Ambulance Service (LAS)	LAS attended Mr EF at home on 12 occasions between 2011 and 2019, either because he had fallen or because he was unwell. Seven of these visits resulted in him being conveyed to hospital. An ambulance and the Helicopter Emergency Medical Service were deployed at the time of the fire in his property. Staff provided CPR and verified his life extinct.
London Fire Brigade (LFB)	LFB attended Mr EF's home on the day of the fire in his flat, following 999 calls from neighbours in the flat above. They found him unconscious with extensive burns. They had had had no previous involvement with Mr EF.
London Borough of Hackney Adult Social Care Service (ASC)	ASC is the local authority department responsible for the provision of social care under the Care Act 2014, including safeguarding, to adults with care and support needs. Following a needs assessment in 2016, ASC commissioned care and support services for Mr EF from Hartwig Care. His care package was last reviewed in August 2018, six months before he died.

GP Surgery	The GP surgery provided general primary medical care for Mr EF, diagnosing and treating where appropriate and referring to community and secondary care where necessary.

3.9. Mr EF's niece participated in the review through a telephone conversation with the lead reviewer early on in the review process. This was helpful in providing further detail of Mr EF's living situation and response to agencies. Her views and experiences directly inform the learning from this review. In a further telephone call at the end of the review process the lead reviewer discussed with her the key themes to emerge, and the recommendations being made to the CHSAB. The lead reviewer and the CHSAB are most grateful for her involvement and for her support to the learning process.

3.10. The independent reviewer also, early in the review process, carried out a telephone interview with a representative of London Borough of Hackney Adult Social Care to learn about measures taken in response to the Mr BC SAR recommendations relating to fire safety and high-risk protocols.

3.11. The review was carried out over 14 months, taking longer than might usually be the case due to the impact of the global Covid-19 pandemic.

4. CASE CHRONOLOGY OVERVIEW

4.1. Mr EF had lived in London for 60 years, since arriving from the West Indies. He had two sisters and also had children but had no contact with them. Before his retirement he had been a plumber, painter and decorator. He had a niece who visited him once or twice a week. She put him in touch with his sister, with whom he liked to reminisce, and he occasionally received visits from his cousins and friends. He enjoyed looking at old photographs and listening to music from the 1960s/70s – music was an important part of his life, described as his 'pride and joy'. His niece describes him as a proud man who regretted the loss of contact with his children; the family was close knit and she felt a strong commitment to supporting him. He had stopped going to his social club and to church because of his health, and she knew he was lonely and discontented with how he was living.

4.2. Mr EF had a number of health conditions that affected his daily functioning. Between 2005 and 2018 he had been treated by Homerton University Hospital NHS Foundation Trust for bowel cancer, chronic pain, constipation, dementia, type 2 diabetes, incisional hernia, frequent falls and osteoarthritis. He had been housebound since surgery in 2009. Mr EF's flat was very cramped due to the number of items crowded into a small space. He was not seen as someone who hoarded, nor was the flat unduly untidy, but there was little room for him to move around and this contributed to the risk of falls. In discussions about his mobility it was clear that he did not wish to be seen as disabled.

4.3. Hospital admissions in May 2016 (first for hypoglycaemia and subsequently for constipation) resulted in referral to the Integrated Independence Support Team, who reviewed his activities of daily living, motor and functionality, falls risk and cognition. The assessment showed he had some cognitive impairment and he was referred to the Memory Clinic. He was diagnosed with vascular dementia, although he remained cognitively aware and was able to converse and interact. The reablement team provided some additional equipment to support his independence at home and he received a care and support needs assessment for longer-term support from the local authority.

4.4. Within his property he mobilised with a walking stick and walking frame but he refused to participate in a falls prevention programme. He had some occupational therapy aids and adaptations in place – a perching stool and a walk-in shower – and a Telecare alarm (which records show he used, although it was not activated on the day of the fire). He was on the Frail Home Visiting register at his GP surgery, receiving 2-4 proactive planned visits a year[5]. He had last seen his GP four months before his death. He also had diabetes reviews and visits by community nursing teams. Knowing that he was housebound, the tenancy management organisation regularly made phone calls to check on him, particularly during bad weather.

4.5. From 2016, following the care and support needs assessment by the local authority, Mr EF received 3 x 30-minute visits a day from Hartwig Care, who supported his personal care, meals and household tasks. The arrangements were reviewed annually. Following a joint meeting between the care agency, Mr EF and his niece in 2017, it was agreed that all care visits needed to be made before 5pm, as Mr EF would not allow entry to the care-workers after this time. He did not allow the care-workers to log their arrival via his landline, so arrivals were logged by the care agency's monitoring officer on receipt of a call from the care-worker. His niece has indicated that he did not like having to receive care and support and would often refuse to let the care workers help him or refuse them access to parts of his flat. On occasion he had nothing to eat as a result of not wanting them to provide food. He was very exacting in his requirements and he preferred to rely on her, his niece, phoning her frequently. She would carry out the tasks he did not want the care workers to do, such as laundry and bedding, helped him manage his finance and pay bills and did his shopping.

4.6. Further hospital admissions took place in August 2017 (when he received laparoscopic surgery for a bowel obstruction) and September 2017 following a fall. On discharge, he was followed up by the Integrated Independence Support Team. Falls were the main concern and taping was installed to the mats and rugs in his home to reduce the risk. He refused physiotherapy to improve his balance. He was discharged from the Support Team shortly afterwards but continued to receive community nursing for administration of eye drops, blood sample collect, urine analysis and latterly Vitamin B12 injections. His GP referred him for memory clinic review. He was assessed by the

[5] GP reviews took place in Jul 2015, Jun 2016, Oct 2016, Feb 2017, Apr 2017, July 2017, Jan 2018, Feb 2018, May 2018, Oct 2018.

Older People's Psychiatry service in September 2017, who confirmed his dementia, and was thereafter monitored by the team and reviewed by a dementia advisor.

4.7. In August 2018 his care and support service was reviewed by a social worker. Mr EF expressed satisfaction with the level of care he received, indicating that the support with his personal care and meal preparation had improved his quality of life. The social worker concluded that the care package was meeting his support needs and was reducing the risk of self-neglect.

4.8. Following two further falls in August 2018, resulting in attendance by the London Ambulance Service, Mr EF was again admitted to hospital. London Ambulance Service noted concerns about his living conditions and self-neglect: the flat was observed to be dirty, with soiled carpets, and overcrowded with possessions. LAS made a safeguarding referral through the Emergency Bed Service.

4.9. Although Mr EF was deemed medically fit for discharge, his niece and care-workers raised concerns around his social situation. He had been refusing assistance with his personal care and would only allow certain carers to support him, refusing entry to others. There were concerns about the cleanliness of the property also. Mr EF confirmed he wished to stay in his own home. His niece agreed to assist him with a weekly shower, to which he agreed. The care-workers would encourage him to have a strip wash on days when he declined a shower, and the agency would try to ensure that only carers he knew and trusted visited. His niece would continue to carry out a weekly clean and assist with food shopping and paperwork. A friend was assisting Mr EF with takeaway meals.

4.10. The Physio Rapid Response team visited him in August 2018 to assess falls risk; they noted that he was very reluctant to consider moving to alternative accommodation. The Community Matron also visited, noting that he disliked the zimmer frame, preferred using a crutch, and wore a falls pendant. Mr EF recognised that his dementia was progressing and he agreed to a GP referral to the older people's mental health team.

4.11. In October 2018 the GP noted on a home visit that Mr EF's flat was dirty. He complained to the GP about his carers. He denied having any pain but mentioned he had had some weight loss.

4.12. In December 2018 the practice nurse undertook an annual diabetes review, noting that his feet were well kept and that the podiatrist had cut his nails, also that his niece would prepare food that his carers would then re-heat for him.

4.13. For some years Mr EF had believed there was a spirit in his property and that lighting incense sticks would eliminate it. His niece would find the incense sticks on the floor and would admonish him for using them, but he continued to do so. In December 2018 Mr EF told his GP that he felt there was something wrong spiritually. He reported that he could not get any rest and that something odd was happening to him at night when in bed. He kept seeing over his shoulder an image always in white coming across from the bed to the doorway; he could feel it pulling his sheets off him.

The GP discussed this with Mr EF's niece who was worried that he was not sleeping and the GP prescribed Promethazine to assist his sleep. The GP also discussed his situation with the community matron and the dementia advisor, to explore whether these feelings could be linked to his dementia, but it was thought they were probably not dementia-related and may be due to changes in local street lighting.

4.14. On two further occasions in early 2019 Mr EF was attended by the London Ambulance Service, declining hospital admission on both and being deemed to have capacity to make that decision. In January, following a fall, the Ambulance Service referred him to the falls service and in February referred him to the Paradoc service[6] due to abdominal pain. Paradoc found his observations to be normal but noted that he reported experiencing demons.

4.15. In February 2019 Mr EF died in the fire in his flat caused by the lighting of joss sticks.

5. ANALYSIS ON THE KEY LINES OF ENQUIRY

The following section reports findings on the key lines of enquiry. The findings reflect agencies' responses to questions designed to identify the extent to which learning from the Mr BC SAR had influenced practice in the case of Mr EF.

5.1. Housing

5.1.1. In the Mr BC SAR, questions were raised about the suitability of Mr BC's housing (which was in sheltered accommodation) given the risk levels arising from his behaviour. The SAR learning resulted in a recommendation to review how communications take place between relevant agencies when people with high-risk needs are being rehoused. Agencies participating in the present review relating to Mr EF were asked to comment on the suitability of the property in which he lived.

5.1.2. Mr EF was not in sheltered housing. His block was categorised as general needs housing and he had occupied his one-bedroomed, ground floor flat for 14 years. Hackney Council was his landlord, with Wyke TMO responsible for the housing management of the estate. Wyke and Hartwig Care (the agency providing care and support services) considered that the flat was suitable for his needs. ASC considered his housing needs when assessing him in 2016 and in subsequent reviews in 2017 and 2018. They found that the accommodation, which had level access throughout, met his functional requirements. Moving to supported housing with care was discussed with him but he was uncertain how he would 'fit in'. He was happy in his flat in a neighbourhood he knew, so the proposal was set to one side for future consideration.

[6] Paradoc is a community-based emergency GP and paramedic service aimed at reducing hospital attendance with a particular focus on admissions. It works closely with community services to assist in managing acutely unwell and complex patients at home.

5.1.3. It does not appear that there was any concern about the suitability of Mr EF's housing, and any concerns about his domestic environment that did exist – for example, loose mats that could contribute to falls – were appropriately dealt with by the Integrated Independence Support Team. It is not possible, therefore, for this review to evaluate whether communications about known risks during the housing allocation process have improved since the Mr BC SAR. This may be a matter on which the CHSAB wishes to seek assurance.

5.2. Fire risk management

5.2.1. The Mr BC SAR made a number of recommendations relating to fire risk management. These included:

- Action in response to the Prevention of Future Deaths Report issued by the Coroner in that case;
- Assurance on the quality of fire risk assessments, including housing providers' compliance with advice given in fire safety assessments;
- Active identification and monitoring of high fire risk cases across the borough;
- Fire safety advice provided by LFB in high-risk cases to be recorded in writing to those with the power to act upon it (e.g. tenant/resident and/or managing agent).

5.2.2. Agencies participating in the present Mr EF review were asked whether, at the time of working with Mr EF, they were aware of the Mr BC SAR findings and the Prevention of Future Deaths Report. The focus here was on what reach had been achieved through CHSAB's efforts to disseminate learning from the Mr BC SAR and the Coroner's concern about the need for proactive improvement measures. Awareness of both the SAR and the Coroner's report was mixed.

- The GP practice was not aware of either document.
- Hartwig Care were unable to confirm whether the registered manager in post at the time was aware, as they have since left the business.
- LAS were aware of the Mr BC SAR, and although aware now of the Coroner's report are unable to confirm whether they knew of this during the period they were attending Mr EF.
- LFB were not aware of the Prevention of Future Deaths Report or the SAR relating to Mr BC, which is surprising given the high profile of his case at the time of his death, and the significant work done in response to the SAR recommendations.
- More positively, Wyke TMO was aware of both the Mr BC SAR and the Coroner's report.
- HUHFT indicated that any recent SARs form part of safeguarding training and that staff are also directed to the local authority website for learning from SARs and reviews, but there was no internal briefing on the Mr BC case. They would expect such briefings to be led by CHSAB. This is in contrast to the process for disseminating learning from serious incident

reviews, where NHS staff attend regular 'learning lessons' seminars at which the findings from serious incidents are shared and the implications discussed[7].

- ASC had, in line with their usual practice, circulated the SAR findings and the Coroner's Prevention of Future Deaths Report to staff in their long-term team. Safeguarding information is regularly disseminated by the safeguarding team. SAR findings and safeguarding learning are discussed in team meetings and case clinics. ASC also reported closer partnership between their long-term team and the LFB, who provide fire safety training to all staff, including housing with care staff, twice a year. At each client review the long-term team identify any requirement for home fire safety visits. The team has stores of fire protective equipment, to which there is both evening and weekend access also.

5.2.3. The mixed findings on awareness of the Mr BC SAR and the Coroner's requirements on prevention of future deaths in similar circumstances indicate that more persistent efforts need to be made to embed learning and ensure that it remains within organisational memory, despite staff turnover and the passage of time.

5.2.4. Agencies participating in the Mr EF review were also asked to report on any fire safety assessments and measures that had been put in place in relation to his property and his use of it, what knowledge staff had of his practice of lighting joss sticks and whether staff had attended LFB fire safety briefings.

5.2.5. In relation to fire safety assessments of the premises, Hackney Housing provided information on the Type 1 assessment[8] undertaken in September 2018. This raised 14 recommendations, all of which were either completed individually or are being addressed as part of a capital programme of improvement works. All fire risk assessments are carried out by qualified assessors and audited[9] by the Fire Safety Manager. The assessments are available for scrutiny by LFB when required (although LFB indicated they were not aware of any assessments that had taken place or measures implemented in response). Wyke TMO conducts a visual assessment of the housing blocks every month and did not identify any concerns relating to Mr EF's property. The fire risk rating for the building was Medium, with an evacuation strategy of Stay Put.

5.2.6. The LFB fire fatality report notes that while the property had two carbon monoxide alarms it was not fitted with any smoke or heat detection and the Council had not undertaken any smoke detector installation in the block.

5.2.7. In relation to Mr EF personally, no agency identified fire risk in relation to his use of his property and therefore no referral was made to LFB for a home fire

[7] This information emerged during a CHSAB event in February 2019 to review how learning from SARs is disseminated and what changes are made as a result.
[8] Type 1 assessment uses a non-intrusive survey of the common parts of housing blocks.
[9] Against British Standards Institute PAS 79 Standards.

safety visit. Mr EF was not a smoker, he did not hoard possessions, and most agencies have stated that they were unaware that he used joss sticks. ASC case files do not allude to any risks being highlighted. None of the referrals for attendance by LAS mentioned any fire risk, and ambulance staff did not note any fire risk concerns in their patient report forms. Similarly, documentation from their visits contains no mention of Mr EF using joss sticks or of staff observing any evidence that he did so. HUHFT note that his accommodation was free from clutter, and that he had a good level of support. HUHFT staff believed that his property was categorised as sheltered accommodation, which they assumed would have appropriate fire detection equipment in situ. One member of the community team at the GP surgery did know that Mr EF had used joss sticks for many years, but it appears they were not concerned that this could be a fire risk. Although Hartwig Care routinely ensured that their staff received necessary and appropriate instruction with regard to fire safety, the care-workers attending Mr EF had not attended LFB briefings on how to carry out a basic fire risk assessment and how to make referrals to LFB for a home fire safety visit. Although ASC have stated that the care workers knew that he burned joss sticks but perhaps did not recognise the risks, Hartwig Care have indicated to this review that they did not know of his habit until told by his niece after his death.

5.2.8. Mr EF's niece was aware of his use of joss sticks. She described him as 'sly' in hiding them, but she would find them on the floor and throw them away. She does not know where he got them from but was aware of his wish to ward off spirits. She talked to him about the dangers of burning them but did not share her concerns with anyone else and was not aware of how LFB could help with home fire safety.

5.2.9. It is surprising that Mr EF had not been referred for a home fire safety visit. As a non-smoker it may have been assumed by those who could have made such a referral (Wyke TMO, ASC, Hartwig Care, community healthcare staff) that risks were low. Although his niece knew of his habit of burning joss sticks, most agencies were not aware of this and the one GP community team member who was aware did not link this with fire risk. LFB have indicated that although they had visited a few other flats in the block, the location was not considered a P1 postcode, and the property in which he lived was not therefore prioritised for routine visits. Without an external or self-referral, LFB would be unaware of Mr EF's vulnerabilities. Nonetheless, as someone in poor health with limited mobility the provision of fire safety advice would have been an important, routine preventive measure. Since his death work has been carried out by LFB to enhance care workers' awareness of the need for fire safety advice, and by Hackney Housing (see Appendix 3) to identify vulnerable residents who should be referred to LFB.

5.3. Risk and safeguarding

5.3.1. In the SAR relating to Mr BC, there was significant learning about risk assessment and the use of safeguarding procedures. Recommendations included:

- A review of safeguarding processes to ensure that risks referred to safeguarding where care and support is already being provided are explicitly addressed rather than assumptions made that protective measures are already in place. It was recommended also that referral closures should receive management oversight, that cumulative pictures of risk should be recognised and recording standards complied with;
- Introduction of a forum for interagency case coordination in high-risk cases;
- Guidance for staff on options to be considered where people with mental capacity make high-risk decisions;
- Review of the self-neglect protocol.

5.3.2. Agencies participating in the present review relating to Mr EF were asked to comment on risk assessments undertaken and risk management strategies implemented, use of safeguarding procedures and the high-risk panel, the availability of risk management guidance for staff and awareness of CHSAB guidance on self-neglect.

5.3.3. In Mr EF's case, some agencies undertook risk assessments. Medical risks were reviewed routinely by the GP, including falls risk assessments, and HUHFT also completed falls risk and mobility risk assessments, resulting in aids and equipment to support his independence. When Mr EF reported spiritual distress two months before he died, his GP took specialist advice on whether this was dementia-related and, on being advised that this was unlikely, prescribed medication to assist Mr EF's sleep. Hartwig Care undertook a risk assessment related to the provision of care and support and ASC assessment and review documentation incorporates prompts to staff to consider risk. In Mr EF's case these did not trigger a separate, enhanced risk assessment process but he did receive assistive technology (telecare and a wrist sensor) to mitigate falls risk and a key safe was installed. Risks of his non-compliance with care-workers were addressed through case management and mediation.

5.3.4. Hackney Housing Resident Safety had not visited Mr EF to assess risks, and Wyke TMO had risk-assessed the block, rather than individual residents.

5.3.5. Only one safeguarding referral was made in Mr EF's case. This was by LAS in August 2018, following a fall at home when concerns about self-neglect were noted. ASC have indicated that their records show all information from the referral was investigated and risk-mitigating action taken. Details are not given but at the learning event it was clarified that the information was explored through the care and support review rather than through section 42 enquiry. There is no record of feedback being given to the referrer or to Mr EF's niece. No agency considered Mr EF's situation to warrant referral to the High-Risk Panel.

5.3.6. Participants at the learning event, in a more general discussion of thresholds for safeguarding, indicated that the safeguarding training they had attended gave

insufficient information about details such as clutter ratings that assist them in recognising when a threshold for concern has been reached.

5.3.7. All agencies stated that their staff have access to guidance on risk management. Hackney Housing and Wyke TMO staff must report high risk situations. LFB referred to pathways set out in CHSAB safeguarding policies, as did HUHFT, along with internal policies within the Trust and incident review meetings. The GP surgery indicated that clinicians and administrative staff were regularly trained in safeguarding. LAS staff receive guidance on risk management within their safeguarding training and when on call have 24/7 access to advice from the Emergency Bed Service and the Clinical Hub. Hartwig Care staff can access a Head of Health & Safety for guidance and advice as well as a Head of Clinical Governance to whom care-related concerns can be directed. ASC staff have close working relationships with the Council's Legal Team; practitioners are able to arrange telephone calls for guidance and advice, while managers oversee referral for legal case file management. All staff can refer cases to the High-Risk Panel, a multiagency risk management forum.

5.3.8. In relation to guidance on self-neglect given in CHSAB's procedures, ASC, LFB, HUHFT and the GP surgery all confirmed that their staff are expected to access and use this guidance. HUHFT noted that self-neglect is featured in their internal safeguarding policy and training, focusing on the complexity of case management. ASC provide team meeting forums and consultant social worker oversight of cases; self-neglect training has been provided. LAS, however, indicated that guidance on self-neglect would be given in the service's mandatory training, but that staff would not be directed to CHSAB policies directly. Hartwig Care did not respond on this question, and Hackney Housing indicated that Wyke TMO had confirmed they were not aware of CHSAB policies.

5.4. Interagency information-sharing and case coordination

5.4.1. The Mr BC SAR made a number of recommendations about information-sharing and case coordination. The absence of shared knowledge and communication about needs and risk in that case meant that no one practitioner or agency knew the whole picture. Added to this, there was no shared strategy for managing the risks in his situation. The recommendations arising from the review included the establishment of a high-risk panel to which complex cases could be referred, the need for such cases to have a named coordinator to convene multiagency discussion and initiate a shared risk management strategy, awareness of mechanisms for escalating concerns about poor interagency communication, and the provision of legal advice for discussion of intervention in high-risk cases.

5.4.2. Agencies participating in the present Mr EF review were asked to comment on their awareness of other agencies' involvement with him, levels of communication and information-sharing, interagency case coordination and awareness of escalation mechanisms about interagency collaboration.

5.4.3. Some of the agencies involved with Mr EF had limited awareness of others' involvement. Hackney Housing and Wyke TMO appear not to have been involved in communications outside of their own sphere of activity. Only HUHFT appeared fully aware of the extent of his support network. Nonetheless there were some examples of information-sharing and joint work. The GP and HUHFT had a wide range of interactions with other services, particularly relating to Mr EF's medical needs. HUHFT and ASC did a joint discharge assessment and liaised about his care package. LAS patient records indicate that ambulance staff were aware of or had communication with Mr EF's GP, district nurses and care workers. Hartwig Care and ASC communicated together, particularly about some of the challenges Mr EF posed – his inappropriate behaviour towards female care workers, his care refusals and his hospital admissions. ASC and the GP did not communicate together until 2018, although ASC would have had access to medical records and information through the Health Information Exchange.

5.4.4. There was no agency or keyworker coordinating the efforts of all the agencies involved. Nonetheless, no agency reported to this review that they had any concerns about interagency communications in this case and most were aware of escalation routes should they experience such concerns while working with an individual.

5.4.5. ASC remained in regular contact with Mr EF's niece, who was recorded as his next of kin and visited him regularly, providing a significant amount of informal and practical care. She also liaised with the care agency and attended care and support review meetings, assisting (alongside ASC) in mediating between Mr EF and the care agency.

5.5. Direct work with Mr EF

5.5.1. The Mr BC SAR emphasised the importance of continuous and trusting relationships with individuals whose behaviour is risky but who are reluctant to engage, in order to understand the underlying reasons for their behaviour. It also recommended guidance on working with such reluctance and the need for accessible legal advice. Improvements to case recording were also sought.

5.5.2. Agencies participating in the present review relating to Mr EF were therefore asked to comment on the continuity of contacts with Mr EF, any experience of his reluctance to engage and the quality of their agency records on the work undertaken with him. Comment was also sought on the availability of staff guidance on working with reluctance to engage and on the accessibility of legal advice.

5.5.3. Mr EF's most consistent professional contacts were with his GP and his care workers. Contacts with others were episodic and short-term; he did not have an allocated social worker who remained in contact between annual reviews, and his district nursing services were provided by a range of nurses from the team. LAS have indicated that it is usual for ambulances to be dispatched on availability, making it likely that different crews attended at different times. They did not find

Mr EF difficult to engage during their calls. HUHFT report that he was very clear with staff what he wanted and how they should access his property; when he did not engage with care and treatment, for example when refusing to have his bloods taken, he would always provide an explanation. He did sometimes make inappropriate sexualised comments to female care workers from Hartwig Care, and sometimes refused care if his regular workers were not available, or if a male care worker was provided. Clear attempts were made to comply with his wishes about the timing of visits and to provide female workers, with ASC supporting the care agency to protect staff from his inappropriate behaviour.

5.5.4. One question that arises about the direct work undertaken with Mr EF is whether sufficient professional curiosity was shown about his spiritual distress. The GP did take advice on whether this distress was likely to result from his dementia and, when advised that this was unlikely, relied on the explanation that disturbed sleep (from changes in street lighting) was the likely cause. Greater probing of Mr EF's behaviour and distress at this point could have cast light on how he was attempting to manage his distress – i.e. through burning joss sticks – and enabled the risks from this to be recognised. It does appear that his mental health was not sufficiently investigated during this period.

5.5.5. Staff from most agencies could access guidance on working with individuals reluctant to engage. LFB, HUHFT and the GP surgery were aware of the role of safeguarding policies in escalating concerns, with HUHFT also noting the value of the high-risk panel. LAS staff have access to senior staff who are able to support and guide decision-making. Hartwig Care would escalate concerns to the local authority.

5.5.6. With regard to the availability of legal advice, most agencies have access to legal advice in complex cases. LFB, HUHFT, ASC, LAS and Hartwig Care have their own legal teams, who can be accessed with the support of managers or safeguarding advisors within the organisation. Wyke TMO are able to contact the Council's legal team.

5.5.7. With regard to case records, most agencies involved with Mr EF were able to give assurance that case records gave a clear account of interactions with him. LAS comment that staff visiting Mr EF clearly documented their decision-making on matters such as reasons to convey or non-convey on each attendance and (on occasions when he was not admitted to hospital) any worsening advice provided. When referrals were made to external agencies, staff clearly documented their reasoning and decision-making.

5.5.8. One further aspect of direct work, given the close involvement of Mr EF's niece, is whether attention was paid to her needs as a carer. Despite her attendance at meetings and her role in managing challenges that arose when Mr EF refused care, she reported that she was not offered a carer's assessment, nor did anyone enquire how she was coping. She therefore did not receive any support with what, at times, were heavy demands relating to her uncle in the context of her other family and work responsibilities.

5.6. Mental capacity

5.6.1. The SAR relating to Mr BC recommended a renewed focus on mental capacity, to include refresher training on capacity assessment and a procedure for seeking specialist advice or multidisciplinary involvement in capacity assessment where needed. Repeat capacity assessments in high-risk situations were also recommended.

5.6.2. Agencies participating in the present review relating to Mr EF were asked to comment on the attention given to his mental capacity, on their mental capacity refresher training for staff and on their awareness of procedures for securing multidisciplinary involvement in mental capacity assessment where they deemed it necessary.

5.6.3. Despite Mr EF's diagnosis of dementia, there appear to have been no concerns experienced or questions raised about his mental capacity. The GP surgery comments that he was able to tell staff his needs, recall information and understand the risk associated with his mobility, falls risk and difficulties. The GP notes that there was not very much progression in his cognitive decline, and that no concerns about his mental capacity arose in conversation. It has already been noted, however, that greater professional curiosity at this point might have resulted in a more robust understanding of the actions he was taking to manage those feelings and prompted consideration of his ability to make decisions about the safety of those actions. ASC records show an intention to undertake a capacity assessment, but it is not clear what decision or decisions were in question here and there is no evidence that an assessment was completed. LAS records confirm that when Mr EF declined conveyance to hospital in August 2018 and January 2019, he had capacity to make this decision, although a full capacity tool was not used on either occasion. Similarly, on 11th February 2019 he was deemed to have capacity in relation to a referral to the Paradoc service.

5.6.4. In relation to refresher training on mental capacity, HUHFT, ASC, Hartwig Care and the GP surgery all confirm that their staff receive mental capacity training. For HUHFT this is part of a three-yearly training programme, with updates provided at clinical meetings, staff briefings and via the Mental Capacity/DoLS-LPS Task & Finish Group. An in-service training course uses a mental capacity related scenario and a mental capacity training module is also available electronically. LAS staff undertake level 2 mental capacity training and are required to refresh this every three years. ASC have access to mental capacity training commissioned by the Council's learning and development team. Here the introduction of Hackney Adult Services Practice Academy is seen to have improved practitioners' awareness and practice under the Mental Capacity Act 2005. Staff in two agencies, however – Wyke TMO and LFB - had not received refresher training on mental capacity. Given the responsibilities of both agencies could on occasion involve them in contacts in which mental capacity gives rise to concern, and possibly also involve them as potential decision-makers in some matters, the absence of training seems to be an omission.

5.6.5. On the question of securing multidisciplinary involvement in mental capacity assessment, HUHFT noted good links with ASC (with the DoLS service in particular) and strong interdisciplinary work with East London NHS Foundation Trust and advocacy services. ASC note that practitioners are aware of the significance of multidisciplinary involvement in such assessments, and that ASC's future development into a neighbourhood model will strengthen relationships by creating stronger alignment with GP practices. Hartwig Care noted that they would raise any need to secure others' involvement with the Commissioning team responsible for their contract. LFB would refer any concerns raised by crews to ASC and LAS were confident in their pathways for engaging others in capacity assessment when required.

6. CONCLUSIONS

The following section reports the conclusions that can be drawn on the key lines of enquiry and indicates what recommendations CHSAB might consider for action.

6.1. Housing

6.1.1. It is not possible for this review to evaluate whether communications about known risks during the housing allocation process have improved since the Mr BC SAR. Mr EF's circumstances were quite different in terms of identified risk, and he had been a tenant for many years, prior to the deterioration in his health.

6.1.2. However, the lack of clarity about the status of Mr EF's accommodation is of concern. His flat was located in a general needs housing property. Yet HUHFT and ASC refer to him as being in sheltered housing. This could mean that agencies may have over-estimated the level of support he received from his housing provider. Further, HUHFT refer to an assumption that fire detection equipment would be installed, yet even in sheltered housing the responsibility for fire safety installations within a resident's own flat lies with the resident, not with the housing provider. A resident receiving health and social care services may require practitioners' support to identify the need for equipment, thus all practitioners need to have enhanced observation and awareness of hazards and should not assume housing-related safety is someone-else's responsibility. This was a key feature that emerged during the Coroner's inquest into the death of Mr BC; it was reported in the SAR and was a factor leading to the Prevention of Future Deaths Report being issued by the Coroner.

6.2. Fire safety

6.2.1. Awareness of the SAR relating to Mr BC and the Coroner's Prevention of Future Deaths Report in that case was mixed among the agencies involved with Mr EF. This provides the SAB with useful feedback on the extent to which SAR learning endures within local networks.

6.2.2. It is of concern that organisational memory appears relatively short-term. It is particularly surprising that the LFB response indicated lack of awareness of the Mr BC SAR and the Coroner's report, given their close involvement in Mr BC's case and in the actions taken in response to that SAR's recommendations. It is important for the SAB and its partners consider how learning from SARs and other reviews can be kept alive through the passage of time and staff turnover. While the improvements must be embedded in practice going forward, the human stories in SARs are what provide the impact that keeps the issues alive for staff. Thus linking practice improvements to the SAR cases that stimulated them remains a powerful way of conveying key messages.

6.2.3. The fire safety measures taken in relation to the building appear to have been largely appropriate and in line with requirements, but there remain questions about whether they went far enough. While Hackney Housing indicated that all fire risk assessments are available for scrutiny by LFB, LFB indicated they were not aware of the fire risk assessments that had taken place at the property or of any measures taken by the landlord in response. The SAB may wish to seek clarification from LFB on whether they routinely scrutinise fire risk assessments undertaken by landlords, and if not whether there is added value in doing so.

6.2.4. The LFB fire fatality report notes that while Mr EF's property had two carbon monoxide alarms, it was not fitted with any smoke or heat detection and the Council had not undertaken any smoke detector installation in the block. The SAB may wish to explore with Hackney Housing and LFB whether smoke/heat detection installation in communal areas of general needs housing is advisable particularly in properties where fire risk is elevated (here the fire risk was assessed as Medium) and/or the resident population has vulnerabilities due to age or health.

6.2.5. In relation to Mr EF himself, it seems that he simply was not seen as a high-risk individual in relation to fire safety. As a non-smoker, whose use of joss sticks was not widely known, he did not reach any threshold that would trigger special measures. Fire risk was simply not on the radar. There is nonetheless the broader point that any individual with care and support needs would benefit from home fire safety advice from the LFB. This is recognised within the LFB's prioritisation of postcodes in which people at above average fire risk, such as older people with support needs, are resident. As such it is regrettable that ASC did not refer him to LFB for a home fire safety visit. Equally, Hartwig Care staff providing care and support to Mr EF had not undertaken LFB fire safety awareness sessions.

6.2.6. Even had agencies known about Mr EF's use of joss sticks, it is questionable whether this would have triggered sufficient concern to result in action on fire risk. Learning event participants in particular reflected that they may well not have recognised the risk, and that joss sticks have not figured either in fire safety training or in risk assessment tools; risks from overloaded sockets, candles and hoarding were seen as more widely recognised. Of concern, however, is that learning event participants indicated they did not routinely look out for safety

measures such as smoke alarms. Yet the need for them to do so was a crucial piece of learning from the Mr BC SAR.

6.2.7. The one person (Mr EF's niece) who was sufficiently aware of potential risks to discuss the joss sticks with Mr EF and attempt to remove them from his flat was unaware of the LFB's home fire safety visit scheme and therefore did not share her concerns. This raises questions about how widely publicised the HFSV scheme is to non-professional yet significant groups such as informal carers.

6.2.8. These findings indicate a need for LFB fire safety training content and publicity about Home Fire Safety Visits to be reviewed, and for agencies undertaking fire risk screening assessments to review forms and templates used by staff.

6.2.9. It has further emerged that although Hackney Housing are now able to refer vulnerable residents from the Resident Insight Office to the LFB, they do not receive feedback on the outcome of the Home Fire Safety Visits that are subsequently undertaken. The Mr BC SAR recommended that the detail of fire safety advice given by London Fire Brigade to vulnerable residents should be recorded in writing to those with the power to act upon it (the tenant/resident and the managing agent). The absence of feedback to Hackney Housing indicates that this recommendation may yet warrant further exploration.

6.3. Risk and safeguarding

6.3.1. Mr EF's self-care and care of his property did not give rise to undue concern. While the LAS had made a safeguarding referral for self-neglect in 2018, the local authority review that followed did not identify any need for safeguarding action. Although practitioners noted the cramped nature of his flat due to the amount of furniture and possessions, this was not seen as amounting to hoarding. The LFB fire death report notes that his flat was relatively tidy and did not reach any trigger point for concern on the clutter image rating scale. Health risks related to the use of his property were mainly related to the risk of falls, which was addressed through the provision of aids and the safety-taping of loose rugs. He was well supported as regards care and support, receiving care-worker visits three times a day and weekly visits from his niece; this level of support served to reassure other agencies and kept him off the high-risk radar.

6.3.2. Mr EF did use a careline panic alarm as part of the falls risk management strategy. At the time of his death, Police officers attending the property noted that the system was switched on and undamaged, and Mr EF was wearing the panic alarm found his neck. This review has not received any evidence on whether Mr EF had activated the alarm in response to the fire. Of concern, however, is that the attending officers pressed the button to contact the alarm centre but there was no reply. The SAB may consider that this warrants further investigation of any records that the alarm centre holds.

6.3.3. Although it appears Mr EF's situation triggered safeguarding concern on only one occasion (the referral by LAS, to which ASC responded through the care and

support review), it has emerged during the present review that Wyke TMO were not aware of CHSAB policies on safeguarding and self-neglect. This raises concerns about whether housing providers and related services can make appropriate contributions to safeguarding actions when needed. The SAB may wish to take action to identify whether this is an isolated case or a sector-side issue. Either way, awareness-raising would be appropriate.

6.4. Interagency information-sharing and case coordination

6.4.1. There is no evidence of systemic problems in interagency communication in this case. Communications between the various health personnel involved in Mr EF's healthcare were appropriate and effective. Adult Social Care liaised with Hartwig Care and with Mr EF's niece in relation to his care and support needs.

6.4.2. There were nonetheless some missed opportunities to share relevant information:

- One significant piece of information – that Mr EF was using incense sticks – was known only to his niece and a community health nurse. That the nurse did not communicate this to anyone does raise concerns, but this appears to have stemmed from lack of fire risk awareness rather than a difficulty in information sharing – i.e. there simply wasn't enough concern to trigger a communication.
- The GP was aware of Mr EF's spiritual distress and did talk with Mr EF's niece and with health colleagues about this but did not share the information with Adult Social Care, so those working with Mr EF on a daily basis were not informed.

6.4.3. The Mr BC SAR's key recommendation was for mechanisms to assist case coordination in high-risk cases. These have been implemented but were not relevant to the circumstances in Mr EF's case, where perceived risks were relatively low and were managed appropriately.

6.5. Direct work with Mr EF

6.5.1. Contacts with Mr EF took place in line with what might be expected for someone in his position. His healthcare needs and his care and support needs were assessed and met as necessary. Adult Social Care and Hartwig Care worked together and with his niece to ensure that the daily care and support visits took place at a time and in a way that were acceptable to him.

6.5.2. There were nonetheless elements of his care that would have benefitted from greater professional curiosity on the part of the practitioners involved, notably his spiritual distress and his niece's experience and needs as a carer. The absence of an offer of a carer's assessment was a significant omission. Equally, while it was understandable that Mr EF's refusal to allow care workers into his bedroom, where he burnt the incense sticks, was respected on a day to day basis, it could usefully have been explored with him at review.

6.5.3. Professional curiosity remains an ongoing challenge for all involved in adult safeguarding, counterbalanced as it must be by a respect for autonomy and for privacy. The SAB may wish to consider whether it is a training need to be considered for future provision.

6.6. Mental capacity

6.6.1. There are no indications that Mr EF lacked capacity to make the relevant decisions about his healthcare or care and support. However, in the course of the present review it emerged that staff in Wyke TMO and the London Fire Brigade have not undertaken refresher training in mental capacity. This was a key recommendation of the Mr BC SAR. It is therefore suggested that a fuller audit of mental capacity training may be helpful to the SAB in determining the extent to which previous SAR recommendations have been embedded in practice.

6.7. Communications with family members

6.7.1. At the end of the reviewer's discussion with Mr EF's niece, the reviewer asked whether she believed anything could have been done differently to safeguard her uncle. While she believed his care workers could have been more observant and identified the risks from his practice of burning joss sticks, in general terms she felt that all involved had done as much as they could. She observed that in some respects her uncle was 'ready to go'. She was, however, very concerned that she was not informed about his death, despite her contact details being recorded in a number of agencies' records. She knew nothing until a care worker rang her to ask if her uncle was alright as there had been a fire at his flat; she had to ring a number of agencies in order to find out what had happened. She feels there is important learning for agencies here about making contact with relatives and would appreciate an apology from any agency about the failure to inform her.

7. RECOMMENDATIONS

The recommendations that follow are designed to strengthen how all agencies work together in cases similar to those of Mr BC and Mr EF in the future. It is recommended that the CHSAB takes the following actions:

Monitor agencies' own change initiatives:

7.1. That CHSAB monitors and seeks assurance from agencies on the implementation of the internal changes they have identified as necessary to strengthen their responses to vulnerable residents. These changes are listed in Appendix 2 of this report. They will make an important contribution to how the CHSAB is able to fulfil its own responsibilities

Refresh learning from SARs

7.2. That CHSAB considers how to refresh key messages from the Mr BC SAR, further reinforced by learning from this review of Mr EF's circumstances. Strategies might include:

7.2.1. The production of briefings on fire safety, informed by the learning from both reviews;

7.2.2. Consideration of whether a series of learning-lessons seminars (online) could assist in disseminating the learning from the two reviews;

7.2.3. Verification with all partners of what avenues are available within agencies for bringing SAR learning to the attention of their staff and also, where they represent a sector, to staff in other agencies in that sector;

7.2.4. Implementation of a feedback system through which partner agencies confirm what action they have taken to disseminate and facilitate discussion with staff about the learning;

7.2.5. Seek assurance from HUHFT on progress being made to integrate learning from SARs with learning from Serious Incident Investigations in NHS contexts;

7.2.6. A review event after one year for all agencies to report on progress made in relation to fire safety and how learning is embedded in practice.

Enhance safeguarding practice

7.3. That CHSAB assures itself that housing providers and tenancy management services are aware of, and know how to use, CHSAB's safeguarding and self-neglect procedures, and takes any remedial action necessary to enhance awareness.

7.4. That CHSAB seeks assurance that safeguarding training provided within partner agencies gives enhanced attention to thresholds for safeguarding referral and to the use of aids (such as clutter rating scales) to decision-making on levels of risk.

7.5. That CHSAB seeks assurance from the alarm centre linked to the careline panic alarm used by Mr EF that alarm requests receive a timely response (with a view to ascertaining whether the Police experience of activating the alarm without receiving a response, during their attendance at Mr EF's death, was an isolated incident or a matter for broader concern).

Enhance fire prevention and fire safety measures

7.6. That CHSAB requests London Fire Brigade to:

7.6.1. Clarify whether LFB does routinely scrutinise fire risk assessments undertaken by landlords (as Hackney Housing believe is the case) and, if not, consider whether there is added value in doing so.

7.6.2. Review the content of fire safety briefings that LFB offers to staff in other agencies, to ensure that

i. risks from joss sticks are included (perhaps with reference to Mr EF's situation as a case example);
ii. that the training gives a clear message about the importance of all practitioners, regardless of their prime function, being alert to the need for fire safety measures such as smoke detectors – i.e. that observation of fire hazards is everyone's, not somebody else's, responsibility.

7.6.3. Review their publicity and awareness-raising measures about Home Fire Safety Visits to ensure that information for both the public and professionals is widely distributed and gives clear information about the availability of visits and the process for securing them.

7.7. That CHSAB request that agencies (such as ASC and care providers) undertaking fire risk screening assessments review the forms and templates used to ensure joss sticks are added to examples of features that should give rise to concern.

7.8. That CHSAB explores with Hackney Housing and LFB whether smoke/heat detection installation in communal areas of general needs housing is advisable particularly in properties where fire risk is elevated and/or the resident population has vulnerabilities due to age or health.

7.9. That CHSAB requests ASC to consider routine referral of people using care and support services to LFB for home fire safety visits.

7.10. That CHSAB seeks assurance that Hartwig Care staff have now received fire safety awareness sessions from LFB.

Enhance practice relating to mental capacity

7.11. That CHSAB undertakes an audit of mental capacity training and refresher training provided to staff in agencies across the partnership, with a particular focus on how agencies have implemented the mental capacity related recommendations of the Mr BC SAR.

7.12. That CHSAB seeks assurance from Wyke TMO and LFB that mental capacity refresher training is being provided to staff.

Professional curiosity

7.13. That CHSAB considers the need for training on the use of professional curiosity in situations of risk

Work with family members

7.14. That CHSAB seeks assurance from ASC that pressures on family carers are considered routinely during care and support assessments and reviews, and (through case file audit) that carers' assessments are in place.

7.15. That CHSAB considers, as part of the resolution of this review, whether an apology should be made to Mr EF's niece for the stress she experienced through not being informed of Mr EF's death.

APPENDIX 1

Overview of the Safeguarding Adult Review relating to Mr BC's death

This Safeguarding Adult Review was published by CHSAB in 2016. It related to the death in 2014 of Mr BC, a man of African-Caribbean heritage in his early 70s, who died of smoke inhalation in a fire in his flat. Mr BC had a number of health complications that impeded his mobility and no longer left his flat. The key risks in his living situation were his smoking and his drinking, both of which he did to excess, resisting attempts to persuade him to moderate his behaviour. There were concerns about the risks this posed, both to him personally and to other residents in the sheltered accommodation block.

Mr BC had good supports from the housing scheme manager, his GP and his daughters, and a care and support package commissioned by the local authority. He also had occasional attention from the emergency services: London Ambulance Service, who visited when he had falls and conveyed him to hospital when necessary; London Fire Brigade, who undertook home fire safety visits and attended small fires in his flat; and the Metropolitan Police, who were called when his drinking with a fellow resident resulted in bullying of Mr BC by the other resident and aggression between them. Adult Social Care had explored with him whether he would consider a move to accommodation with a higher level of care, but he had declined this and been judged to have mental capacity to make this decision. The record of the assessment, however, merely records his insistence that he did not want to move and gives no evidence of how his ability to understand, retain, use or weigh relevant information was evaluated. Information about his cognitive impairment known to health agencies was not known to adult social care and therefore not taken into account.

At the inquest into his death it emerged that although he had smoke detectors in the hallway and the living room and a heat detector in the kitchen, there was no smoke detector in his bedroom, where it was known he would smoke and drink during the night. The Coroner in court in the inquest referred to the installation of a smoke alarm in the bedroom as an "*obvious and mundane*" measure and referred to its absence as a "*system failure*". She issued a Prevention of Future Deaths Report[10] to the Chief Executive of London Borough of Hackney raising concern that there was no smoke detection system in Mr BC's bedroom and requesting that action be taken to prevent future deaths in such circumstances.

The findings of the SAR provided learning about housing, interagency risk management and leadership, fire safety, escalation routes within and between agencies, relationship-based approaches, mental capacity and recording. The SAR listed recommendations for the CHSAB, which were then incorporated with CHSAB's action plan.

Further information is available on the CHSAB website: https://hackney.gov.uk/chsab-sars

[10] Under the Coroners and Justice Act 2009 coroners have a duty to make reports to a person, organisation, local authority or government department or agency where they believe that action should be taken to prevent future deaths.

APPENDIX 2

Actions taken by agencies since Mr EF's death

1. London Fire Brigade have introduced a Borough-wide project ensuring that property addresses provided to LFB from London Borough of Hackney are visited.

2. Every six months the London Fire Brigade carry out a number of presentations to Hackney-based care workers, ensuring that they know how to carry out a basic fire risk assessment and how to provide referrals to the LFB to carry out a home fire safety visit. This training is facilitated at Hackney Council offices and sponsored by them.

3. Following on from concerns that Mr EF did not have a smoke alarm, the London Fire Brigade are working with Hartwig Care to ensure their care workers have sufficient training in identifying hazards and carrying out a basic risk assessment to ensure that residents in their care are as safe as possible.

4. Hackney Housing report that in September 2019 a Resident Insight Project commenced, designed to seek referrals of vulnerable residents from housing officers and other frontline housing staff. Hackney Housing carry out a fire safety visit and ascertain whether the resident would benefit from a personal emergency evacuation plan. They are now able to make online referral to the London Fire Brigade from the Resident Insight Officer for a Home Fire Safety Visit.

5. Hackney Housing's Resident Safety Department has sent correspondence to all housing services residents over the past two years, which includes advice on contacting the London Fire Brigade for a home fire safety visit.

6. LBH Adult Social Care have indicated that a neighbourhood model of practice is returning, leading to better communications. LBH now has access to health records. Named practitioners attending GP multidisciplinary team meetings will be involved in discussions about people known to health who are unwilling to engage with adult social care and be able to consider how to provide longer term support.

7. LBH Adult Social Care are working in partnership with the Dementia Action Alliance in a scheme in which all individuals with a dementia diagnosis are (with their consent) linked into Adult Social Care to facilitate their access to other services and to support for families.

8. Hartwig Care has changed its risk assessment process and raised the risk awareness of its staff.

9. In August 2019 the London Ambulance Service created the post of Adult Safeguarding and MCA lead to drive forward and expand the Trust's MCA agenda, knowledge and practice.

10. HUHFT has a new Band 7 community post to work with staff to look at the fire risk in community services. They are working with the Quality and Patient Team to integrate the learning from SIs and SARs as part of the Trust's 'lessons learnt' s programme.

11. HUHFT use Mr EF as case study in safeguarding training and has revised Mental Capacity Act training to include learning from Mr BC and Mr EF.

12. HUHFT has asked its Fire Safety Team to revise the training they provide at Staff Induction to reflect other fire risk apart from cluttering and to promote LFB's fire safety assessment service.