**Fatal Fire SAR’s Key Messages**

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**Transcript of presentation to the LSAB regional network 12/07/23**

As we know, in London there has been over recent years a number of SAR’s that have focused on fire deaths. We've had one in in Lewisham, known as Cedric Skyers. I did one for Sutton back in 2017. They started with one fire death, but it actually eventually covered 4 fire safety incidents. More recently, Sutton have undertaken 3 involving adults, 1 involving children and families. We know that Hammersmith and Fulham are currently undertaking a Fire related SAR and Islington have just sent me one to upload into the SAR library and Bi-borough, of course have recently completed a thematic review of 2 cases.

So clearly, fire related deaths and incidents are an issue across London, what I'm less clear about is the degree to which fire related SARS may be happening elsewhere in England, there is going to be a 2nd National Analysis of SAR’s and you'll hear more about that in a week or so that is being done by the same team in fact that in the first national analysis, so that is Suzy Braye, myself and in research in practice - and I think one of the key lines of inquiry will be the number of SAR’s where fire features across England.

We have not yet formally escalated the issues arising from the SAR’s on fire related deaths in London and we've not yet escalated that to the National Network of SAB Chairs and therefore we've not escalated it to the Department of Health and Social Care yet, or indeed to other government departments that will have an interest in Fire Safety. But I think the volume of activity in London suggests that there are issues that we need to consider nationally and quite possibly to escalate to central government.

The issues that I think we need to think about - and this is where I think your intelligence as Business Managers is going to be really, really helpful are as follows:

**1**) At the moment, the Fire Service in London and the Fire Rescue services elsewhere in the country do not have a right of access into a person's own home unless a fire has broken out or they have reasonable reason to believe that a fire is imminently going to break out. So in other words, if a social worker or a district nurse were to request a home fire safety visit, if the individual refuses, there is nothing the Fire Service can do about that. Whereas they do have a power of entry to inspect premises in multiple occupation flats and maisonettes - they can enter into the public access areas there, just not into a person's own home and in fact they have a power of entry into offices – but an English person's home is their castle and a person can refuse. Now, if a person is living in a detached house that might not be so much of an issue. As we know from Grenfell Tower not many people live in detached homes they live in semi-detached homes, terraced homes, houses of multiple occupation, maisonettes, blocks of flats. So I think one of the questions to be to be debated is whether the law has struck the appropriate balance between the right of an individual to private family life and, in other words, to refuse access**.** In this case, for the purposes of a home fire safety visit, or whether we need to alter the balance in order to recognise that other individuals living in close proximity to that person also has a right to private and family life, and indeed a right to life, so is the balance appropriately constructed? This was first brought to my attention when I gave a presentation at a conference in Merseyside a number of years ago where the Fire and Rescue service in Liverpool gave a presentation in relation to the death of 2 older people who were living in conditions of extreme hoarding in a semi-detached house in Allerton in Liverpool.If you Google something along the lines of ‘fire death Allerton, Liverpool’, you may well come across the slides that they presented.

This was extreme hoarding in a semidetached house. 2 individuals, older people living in that semi-detached house and the only way either of the individuals could get out of the house was climbing through a downstairs window, such was the extreme level of hoarding and when the fire service had extinguished the fire and needed to search the premises in order to establish whether anybody had died, the only way of doing that was demolishing the semidetached house, starting with the roof. So what you see in the pictures is the semidetached house slowly being demolished by the Fire and Rescue service from the roof downwards and in fact they found the 2 older people in the front living room and who had died as a result of the fire caused by an electricity short circuit and the extreme hoarding. This was a semidetached house. Next door to that semidetached house was obviously the person living in the other semidetached house. They too have a right to life and a right to private family life.

So I think the first question to raise in each of our boards with the fire service and the question to raise nationally is, whether we have struck an appropriate balance. The coroner in the Liverpool case recommended to the then Home Secretary, who was Theresa May (at the time) that in fact the balance was not correctly constructed and that to prevent future deaths, the Fire and Rescue service needed to have a power of entry where there was reasonable reason to believe that there was a risk of fire from for example, smoking in bed. So that is the first question I would be really grateful if you could discuss this with partners in, in your respective boards and feedback to me and Fiona Bateman, who now chairs the London regional network of SAB Chairs to see what the range of views happen to be.

2) The second issue is awareness of home fire safety. Sutton have done a lot of work on home fire safety awareness and in Bi-borough with Sutton's permission we used/slightly adapted the audit questionnaire that Sutton had developed to assess the level of awareness of home fire safety issues and the need for training around home fire safety issues. We've actually explored that to some degree in Greenwich. Other boards may to some degree or a considerable degree have audited the level of home fire safety awareness and the level of referrals from different services to the fire service for home fire safety visits. But to what degree is that an issue that we might want to escalate, at least nationally**.**

3) The third issue that I can immediately think of was actually triggered by the 1st safeguarding Adult Review that Lewisham completed, the review of Cedric Skyers which is on the Lewisham website and this was a smoking fire related death in a care home. It raised a couple of issues. Cedric was in a smoking area outside of the care home and that a smoking area was not covered by CCTV and there was no member of staff supervising Cedric smoking and he was he was at risk because he had physical disabilities, which meant that he could not pick up a lighted cigarette that easily if he happened to drop it into his lap, which is in fact what happened and he wouldn't have been able to have extinguished flames because he had restricted movement in his hands and fingers.

So one issue was the oversight of the smoking in care homes, the second issue, which arose as a result of Shirley Spencer, who now works for South East London ICB, really interrogating this issue; was with the safety of evacuation procedures in care homes and nursing homes were a fire to arise - and in fact and Shirley hit the alarm bells in some care homes to trigger an evacuation and monitored how quickly residents were evacuated. The outcomes, as Martin will tell you, were really quite concerning and Shirley has provided a lot of training for care home staff and nursing home staff as a result of our concerns about evacuation from care settings.

So there are 3 issues which I think it would be really helpful if your boards could discuss and feedback the outcome of those discussions to Fiona Bateman and myself as part then of our intention to escalate.

What would finally be helpful is to have a list, a comprehensive list of those Safeguarding Adult Reviews that have featured fire because we do not have complete list, our library as good as it is, is not complete because not all boards routinely send safeguarding adult reviews. Then second national analysis will cover all published reviews that are on board websites and in the National Library but we won't have the second national analysis finished until March 2024 and I would prefer to be thinking about this issue nationally and to be escalating it to government departments when we are clear about the number of SAR that feature Fire.

Lastly, as a result of your reflections with your board partners and with each other in this and subsequent meetings, what we have learned from escalation so far to the HSC is that we need to be really clear what the ASK is and by that I mean that we need to be really clear what we are asking the Department of Health and Social Care, or indeed another government department to do as a result of our escalation. We need to be clear about that because the feedback from government departments is signed off by ministers not just by civil servants. Ministers will not be signing off a responsively ask itself is unclear.

I found these links on Allerton Fire Deaths

[Regulation 28 Coroners Letter Hoarding Fire Fatality.pdf (merseyfire.gov.uk)](https://mfra.merseyfire.gov.uk/documents/s10153/Regulation%2028%20Coroners%20Letter%20Hoarding%20Fire%20Fatality.pdf)

[Firefighters couldn't reach "excessive hoarders" because of cluttered home - Liverpool Echo](https://www.liverpoolecho.co.uk/news/liverpool-news/firefighters-couldnt-reach-excessive-hoarders-12583444)

**Suggestions from discussion that followed:**

* National Survey to capture themes and responses
* SAB’s could adapt the Sutton Tool (audit and all the questionnaire to frame the questions)
* **HB** will share - A new approach to Home Fire Safety Visits slides
* **MPS:** Here is a cast iron opportunity to engage the fire service in each board with what are the implications of the changes, what data can you provide? And how routinely can you provide that data? I would say that they want data on the number of referrals to where they're coming from and the outcome of the referrals, particularly what happens when a person declines a home fire safety visit when someone has identified the need for one. Declining home fire safety visits becomes an adult safeguarding concern, both for the individual but for also for others who live in close proximity. So I think a local conversation. The onus is on individual boards to have conversations and to use your Business Manager Network as a way of collating that information and through your representatives, making sure that the London regional Group have chairs, knows what the outcome is. **CG** shared quick tip for people if you want to track referrals to that new system, our borough commander has told us that each agency needs to have a code that they then give over. So at the moment, we only have an adult social care code, which means we need to create a code for housing and for health partners, otherwise they can't track where it's coming from.
* **MC:** My early thoughtson this are that it probably sits as well with the Right Care, Right Person debate in terms of powers of entry obviously linked to MPS and that's no doubt a national issue as well - and I think that then leads us also to the powers that social workers have, because if this is an extreme hoarding case there's going to be health and social care related issues, probably mental ill health, so in that respect as with all cases of self-neglect you have to work in a teamwork approach e.g. which agency is going to get their foot in the door to sort of speak first - so, for me it's links to that wider discussion - do we have the right powers for social workers in England as they have in Scotland and Wales? and perhaps that's the way forward to address this. Although these are fire safety issues and we're talking about powers of entry for fire services is it more general than and linked to that conversation around social work powers and I think it's going to cost to be some change in legislation if police nationally do withdraw from using their powers under the MH Act in the way that they are describing at the moment. **MPS**: Yes I agree and one of the key lines of enquiry set by DHSC for the second National SAR Analysis is an examination of those SAR’s where the absence of a social worker, adult safeguarding power of entry, has been significant and indeed that's an issue that we did escalate about a year ago now to the DHSC as a result of a SAR in Durham and the feedback from DHSC was that that they would revisit the question of power of entry. Firstly, after the Safe Care at Home Review, which highlights the absence of a safeguarding power of entry, and indeed the second national analysis of SARS. **If you have cases which may or may not have reached the criteria for a mandatory or discretionary SAR, if you have other cases where the absence of a power of entry has been a significant component of what happened, can you please let me know**.
* AE: Agree with MC we should be considering the scope of all powers of including environmental health.
* **CM:** We have a couple of reviews related to hoarding and the difficulty in accessing the homes of harder to reach individuals - Are there any examples of best practice in terms of how to meaningfully support residents who hoard?. **MPS:** Yes - there is a well-established evidence base about what does and does not work with people living in a context that we might describe as extreme hoarding. There are organisations that have had some success in working with people who are extreme hoarders, Clouds End based in Birmingham would be one example. Hoarders UK would be another and there are in some London boroughs individual practitioners or teams that have been set up to work with people who hoard. In Greenwich, for example, there is a pilot project at the moment based in adult social care designed to highlight cases of extreme self-neglect, including hoarding and to coordinate the work that is done in order to build relationships of trust that might enable us to understand what the back story is, and to address the back story. There are examples/case studies in the Journal of Adult Protection that also describe positive work that's being done, but actually if we're honest, Safeguarding Adult Reviews tend to focus on the cases that are that in a sense of tragic.We are not doing safeguarding reviews we could under section 44, of the Act, we're not doing reviews of cases where the outcomes are being good. So I think again a message for each of our boards is and indeed I've been pushing this in in Greenwich as an example is can we have case studies where the outcomes have been positive so that we can actually learn from that as much as from learning from cases where the outcomes are being negative.
* **TM:** It's not mandatory for care workers and regulated services to receive fire safety training, which was something that was highlighted in our recent Thematic SAR. Perhaps the survey should go national, Michael, to really help you to capture everything that you need to push this forward. - Agreed

**Powers of entry**

Following the meeting, Ruth Shill kindly researched the issue of powers of entry and environmental health re: fire risk.

It appears to me that there are pretty clear powers of entry, investigation and remedy of fire risk from hoarding covered by s.79 Environmental Protection Act 1990, which defines statutory nuisances, and Schedule 3 of the same act which covers powers of entry and remedy. My reading of it is that hoarding, or anything that creates a risk to health in domestic properties, counts as a 'statutory nuisance' for which there are powers to force entry and remedy (using a warrant granted by a court on a case-by-case basis).

**MPS** response: What you have found corresponds with my own digging and feedback from legal practitioners. So, whilst we might escalate a need for legislative change, we might also seek assurance about the use of existing powers and produce a briefing for practitioners and managers to consider.

Really good also to see that historical information (a SCR in 2012) has not been lost!