

## **FIRE SAFETY**

### **BRIEFING NOTE - RESIDENTIAL & NURSING CARE**

#### **INDIVIDUAL FIRE RISK ASSESSMENTS BEING INCLUDED UNDER THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005 IN THE FIRE RISK ASSESSMENT**

#### **Background**

##### **Fatal Fire in Lancashire**

An incident occurred in a residential nursing home near Preston where a Male person aged 69 died after smoking whilst covered in emollients. The episode happened on 27<sup>th</sup> December 2015 at 07:45.

This tragic event follows on from fatal fires in London, Surrey and West Sussex.

*The Coroner's reports are summarised on the following pages below.*

#### **Introduction**

##### **Care Homes – protection from fire and prevention of future deaths**

Several tragic deaths of vulnerable residents within care homes have led to the Coroner to make recommendations about the appropriate levels of fire safety within care homes.

The Fire & Rescue Services believe that some of these deaths were avoidable - and believe that the issues need urgent consideration and action by care home Directors and owners to identify critical risks associated with individual clients.

##### **Fire Safety Law**

The Regulatory Reform (FS) Order places a duty on the responsible person to carry out a suitable a sufficient FRA (Fire Risk Assessment).

Article 10 Principle of prevention to be applied specified in Part 3 of Schedule 1 appears to have been laid out in a descending order of possible application with “avoiding risks” seen as the most ideal and “instructions to employees” as the least favourable option. This train of thought is similar to that laid down in the H&S guidance insofar as it is better to avoid risks than to simply address the problem with additional protective measures.

## Regulation 28 Coroners reports

### London: Rita Dexter Deputy Commissioner

#### *Death of Mrs Parle*

In 2010 a dementia patient smoked in her bedroom where her nightwear came into contact with a naked flame.

#### *Matters of Concern*

- *Art 9(1); Failure to make a suitable and sufficient assessment of the risks to which relevant persons are exposed.*
- *Art 11(1); Failure to effectively; plan organise, control, monitor and review the preventative and protective measures.*

### Surrey: Michael Burgess Assistant Coroner.

#### *Death Vera Lillian Steele*

In 2012 a heavy smoker was taken into the Garden. She was still in her night dress with a blanket over her legs. Whilst the carer was gone she dropped a lit match onto her lap.

#### *Matters of Concern*

- *Obtain a fire apron or smock*

### West Sussex: Ian Christopher Wilkinson Assistant Coroner

#### *Death of Mr B*

In 2015 a pipe smoker was taken into a conservatory. He had his pipe lit and the staff left him alone, the presumption was that he was wearing a fire retardant smock, this was not the case and he set himself on fire. Smoke Detection alerted the staff and he was extinguished. Additionally he was covered in paraffin based cream that is also flammable

#### *Matters of Concern*

- *Centraben emollient cream is paraffin (24%) based product and does not display any fire risk warning on the bottle.*
- *Diprobase emollient cream is paraffin (21%) based product but contains fire hazard warning but had not been examined.*

- *NPSA (National Patient Safety Agency) reported in 2007 on paraffin based products but focused on 50% plus content or emulsifying ointments.*
- *NPSA commissioned the HSE to undertake fire hazard testing with SOFT WHITE PARRAFFIN. It is not clear that subsequent cases have occurred or been highlighted.*
- *There is little information conveyed or publicised about the two products.*
- **Risks should be assessed and action taken**

### London: Dr Fiona Wilcox Coroner

#### *Death of Mrs Rosina Mary McDonald*

In 2015 a mental health patient had a fire in her bedroom as a result of 2 modified cigarette lighters.

#### *Matters of Concern*

- *Current guidance is insufficient relating to RAs in Residential Care;*
- *Not required to take into account individual risk factors.*
- *Recorded in individual care plan*
- *Do not account for persons access to fire sources*
- *Include appropriate control measures*
- *Reviewed according to decline in cognitive behaviour*

### **Individual Fire Risk Assessments of residents**

Individual fire risk assessments for each resident are critical for their own safety and the safety of other residents and staff. A risk assessment will assess the needs of the individual in conjunction with care workers and family and consider their habits, physical and mental capacity, medication and their environment. This should be recorded and must also be considered alongside their care plan, other assessments and personal evacuation plans.

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person. This is particularly important when working with individuals where there is reason to doubt mental capacity in understanding fire safety and risks.

The Mental Capacity Act is intended to be supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

The five statutory principles are:

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

Where there is reasonable belief to doubt an individual's capacity relating to fire safety, it is good practice for staff to carry out a proper assessment of a person's capacity to make decisions. The findings of the assessment must be recorded within the care records.

This is critical where residents are known to be smokers and/or may be in possession of ignition sources such as lighters and matches as these add greatly to the risks of a fire starting. From this information care and sheltered home operators and other responsible persons must identify the appropriate control measures and additional equipment to best manage the risk of fire and protect individuals at greater risk. These could include:

- Supervision of smoking (only allow gas lighters, NO matches), or the removal of such ignition sources. Including the control of cigarettes.
- Fire retardant nightwear and bedding (protection apron or smock could be worn or draped).
- Additional smoke detection and telecare systems;
- Water mist or sprinkler systems.

All healthcare staff involved in the prescribing, dispensing or administration of paraffin-based skin products are also reminded that bandages, dressings and clothing in contact with paraffin-based products, for example white soft paraffin, white soft paraffin, liquid paraffin or emulsifying ointment are easily ignited with a naked flame or cigarettes.

***Any risks identified and measures put in place should be recorded in the significant findings of the fire risk assessment. These should be regularly reviewed particularly where there is a decline in cognitive ability or mobility.***