West Yorkshire
Fire & Rescue Service

1st February 2019

John Roberts
Chief Fire Officer/Chief Executive
Oakroyd Hall
Birkenshaw
West Yorkshire
BD11 2DY

Telephone: 01274 655733

Mr John Nigel Broadbridge
Assistant Coroner (Western)
HM Coroner's Office
The City Courts
Bradford
BD1 1LA

Dear Mr Broadbridge

Re: Response to a Regulation 28 report to prevent further deaths following an inquest hearing regarding the death of Barnaby Aylward, 4 Old Bank Fold, Moldgreen, Huddersfield

This response is in specific relation to Matters of Concern 1(a) to 1(d).

I refer to your report of 14th December 2018, made under paragraph 7, schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

You will have noted the content of the report submitted by the Fire Investigation Officer, [redacted], of West Yorkshire Fire and Rescue Service (WYFRS). In his report, he explains how WYFRS Control received a call from a neighbour alerting us to a fire at [redacted] at 03:11 on 4th September 2017. Of note is that there were mains powered ionising smoke alarms fitted to the living room and landing ceilings and these alarms operated and alerted neighbours to the fire.

WYFRS led a Serious Incident Review on 3rd October 2017 in relation to this incident. Representatives from WYFRS, Together Housing, SWYFT and Kirklees Council attended this meeting which resulted in a number of actions to progress. Some of the key actions included a review of the partnership arrangements with the relevant partners and to provide refresher training to staff at Together Housing and SWYFT.

It is frustrating that WYFRS was not notified of the circumstances in which Mr Aylward was living and we have found no evidence that a referral to ourselves was made. I note that Mr Aylward suffered from long term poor mental health, had large quantities of combustible waste accumulated in his living spaces and was a heavy smoker. Many fire fatalities within West Yorkshire involve certain risk factors such as living alone, having poor mental health, unsafe smoking habits or use of excessive alcohol or medication that can make one drowsy. Our new Safer Communities Strategy aims to apply more focus to individuals who are more at risk of fire and risk factors such as those listed above (often combined within the same household) have been evident in a number of fire fatalities across West Yorkshire.

Our work to target resources towards risk has evolved over time. In 2017, we launched a new strategy to build upon the success of our fire prevention programme which has seen significant reductions in dwelling fires. In 2009/10, there were 1549 dwelling fires attended by WYFRS compared to 1094 in 2017/18. The focus of the new strategy links to our strategic aim of 'Making West Yorkshire Safer' and this is achieved through improving our ability to target our resources towards those who are most vulnerable. We will achieve this by using an intelligence and risk led approach and we recognise the importance of partnership work to deliver this aim.

The traditional home fire safety visits have evolved into a new (broader) Safe and Well visit that incorporates a wider assessment of health and wellbeing that includes: risk of falls, social isolation, cold homes, crime prevention and smoking cessation. What is also worth pointing out is that if we identify someone who is assessed as being at high risk of having a fire, then our dedicated fire prevention staff may conduct repeat visits (at intervals that they deem necessary) in order to continue providing education and advice in addition to safety equipment that we deliver during the visit which include smoke detection and fire retardant bedding packs and throws.

Our list of recognised partners across West Yorkshire varies from emergency services and health and social care partners to the voluntary sector. Within the partnership agreement documents, it explains that in order to contribute to a reduction in accidental dwelling fires, staff working for such organisations can refer clients on to WYFRS if they feel that we can improve safety through education on fire safety in the home and interventions that include fitting smoke detection (where required). The purpose of the agreements is also to enable information to be shared between agencies to support the overall aim which is to improve the fire safety, health and wellbeing of vulnerable people across West Yorkshire. Referrals from partners are made through an online referral system which is accessed through a secure web link. As referrals are placed into our system, this then generates a 'case' and contact is made with the client to arrange a suitable time to conduct a home visit (previously termed home fire safety check not termed safe and well check). Home visits are prioritised based on the risk that is present at the time of referral. During the home visit, appropriate fire safety interventions and education is delivered to the occupant.

An essential element of the partnership is maintaining the awareness across the staff working for the partner agency. In regard to the partnership arrangements with the agencies involved in this case, I shall provide a summary below.

South and West Yorkshire Partnership Foundation Trust (SWYFT)

WYFRS has had a formal partnership in place with SWYFT for a number of years. There is a signed agreement dated October 2014 and we have been in the process of updating our partnership agreements following the introduction of the new Safer Communities Strategy in 2017. Our records show that WYFRS have received 86 referrals directly from SWYFT between 2016 and 2018. However, we expect the actual number of referrals from staff working across SWYFT to be higher than this figure as they may refer through their local team or department name but essentially their work falls under the SWYFT umbrella.

WYFRS started communication with officials from SWYFT in July 2017 to establish a new partnership agreement in light of the changes to our home visit programme in April 2017. A new agreement is currently with the directorate of SWYFT and they informed us that their Health and Safety and Information Governance team, would be reviewing the agreement in December 2017. As a result of this a number of queries were raised in relation to information sharing which coincided with the introduction of GDPR in May 2018.

WYFRS produced an amended information sharing and partnership agreement in June 2018 which was subsequently shared with SWYFT for comment. This in turn raised further queries which it was agreed would be resolved by meeting to discuss them. A meeting took place on 3rd October 2018 at which it was agreed to reconvene discussions in January 2019 to allow system/process changes to be implemented internally at SWYFT.

The new agreement between WYFRS and SWYFT includes a programme of reciprocal training to be delivered in 2019. Core elements of this training will be to reinforce the partnership referral mechanisms that are in place and to help front line workers to identify individuals who are vulnerable to fire risk.

Together Housing

WYFRS has had a formal partnership in place with Together Housing for a number of years within the Calderdale District and prior to this with Pennine Housing. There is a signed agreement dated May 2016 with Together Housing. We have been in the process of updating our partnership agreements across districts following the introduction of the new Safer Communities Strategy in April 2017.

Our records show that we have received 189 referrals from Together Housing between 2016 and 2018. WYFRS has delivered some excellent partnership working with Together Housing throughout 2018 and both organisations received a nomination for 'Partnership of the Year' at the National Excellence in Fire and Emergency Awards in December 2018. This nomination recognised our work with Together Housing to provide a series of 60 second fire safety films for residents of Together Housing properties.

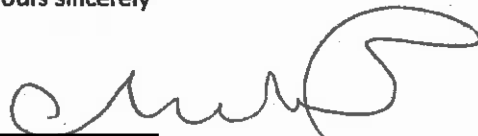
WYFRS started communication with officials from Together Housing in July 2018 to establish a new partnership information sharing agreement to cover West Yorkshire, expanding the current arrangements. Discussions also took place about the development of training for personnel within both organisations to identify the support available within each service. WYFRS Dementia Resources were also shared with Together Housing to establish whether these would be suitable for their employees to support visits and aid the provision of key fire safety messages.

The Together Housing partnership information sharing agreement is drafted and currently sat with their data protection team in relation to the GDPR element. Together Housing has given a commitment to have the updated partnership agreement signed by 31st March 2019.

There has now been a commitment given by all three organisations to deliver some training across the specific areas of identification of fire risk and the referral methods to WYFRS to increase the awareness of this across the workforce at SWYFT and Together Housing. This training is due to be delivered by June 2019.

Finally, I am assured that our teams are working with partners across the five districts in the effort to provide our prevention services to those who most need it. We accept that there is still progress to be made around information governance and sharing data across organisational boundaries, and we will continue to make an appropriate response to all of the referrals that we receive in relation to people that are identified as being at risk of fire in their homes.

Yours sincerely



Chief Fire Officer

together housing

Regulation 28 Report to Prevent Further Deaths

This response is being sent to:

Coroner John Broadbridge, Assistant Coroner, West Yorkshire

In response to a Regulation 28 Report to Prevent Further Deaths following an Inquest hearing into the death of Barnaby Aylward at [redacted] that concluded on 4 December 2018.

1. Together Housing

Together Housing is a registered housing provider, providing over 37000 homes across the North of England to over 70000 people. This response has been produced by Together Housing, Bull Green House, Bull Green, Halifax HX1 2EB.

2. Coroners Matters of Concern

The matters of concern were identified as:

2.1 The sharing of the particulars of his behaviours the burden of risk might be shared and understood and potential to reduce or eliminate the risk attempted, reviewed and managed.

2.2 The Care Plan delivered within the mental Health care did not identify those behaviours in writing and thus potential risks, nor indicate review and solutions within housing provision.

2.3 The presence of clutter was not always evidenced in clinical notes as a symptom of his illness.

2.4 There was some but not much evidence of support though family members including practical and financial help.

2.5 The appropriateness of a risk management and MHA assessment away from the patient to enable more frank discussions.

3 Action Taken

In response to the matters of concern raised in the Regulation 28 report, we have commenced a number of actions and have planned for further actions to reduce risks and improve internal processes and work with other agencies.

3.1 **Information about our customers** - We are developing further our database in relation to vulnerabilities including those related to fire risks. Annually we will update personal information from higher risk customers particularly those in supported housing and high rise flats. This database is aimed at ensuring we identify higher risk tenants and causes, it requests details on health and lifestyle issues. We request this data from tenants and where appropriate arrange joint safe and well visits with the fire service. The information is updated annually but also used at the start of new tenancies or where officers identify a safeguarding issue with a tenant.

3.2 **Reviewing processes and joint working** - We have instructed an independent investigation into this and other deaths and fire incidents. The investigation will be undertaken by a consultant, Patrick Harkness who had undertaken a similar investigation for another housing association and has been recommended. We anticipate that the work will be undertaken during February and reported back in March / April with recommendations.

3.3 **Safeguarding Training** - We have a rolling programme of safeguarding training with all members of staff to enable them to better identify vulnerable tenants including hoarding and self neglect. We are also increasing visits to higher risk, more vulnerable tenants. A review of our processes for reporting causes for concern is underway and we have recently established a learning group on safeguarding from abuse.

3.4 **Strategic Fire Safety Group** - The existing Fire Safety Group will take responsibility for monitoring, learning lessons and taking policy decisions where appropriate to reduce risks. The group consists of officers from across the Together Housing Group alongside representatives from the West Yorkshire Fire and Rescue Service.

3.5 **Hoarding** - We have introduced a new approach to hoarding and all relevant colleagues have now undergone training in how to recognise and deal with tenants in these situations. We will by the end of March 2019 have amended the hoarding procedure and included links to local arrangements including the Kirklees Hoarding panel.

4 Details of Further action to be taken:-

In addition to the actions already underway we will also undertake following actions during 2019:-

4.1 **Independent Investigation Actions** - To implement any recommendations made by the Independent Investigator to reduce the risks from March 2019.

4.2 **Tenancy Audits** - From April 2019 we are resuming regular visits to tenants, this programme of visits will focus on those where we have had no previous contact (eg via repairs or gas servicing) or have concerns regarding vulnerability. These will include a property inspection where tenants will allow access. Any issues of concern will be acted upon via tenancy safeguarding procedures.

5 Details of any Joint Groups/committees/evidence of working together

5.1 **Meeting of Partner Agencies** - We have been in contact with the CEO of the SW Yorkshire Partnership NHS Foundation Trust and have been put in contact with their lead, in order to agree a plan to share responses and agree joint approaches going forward to minimise further risks. A meeting was held on 18th January 2019 and a number of joint actions have been agreed.

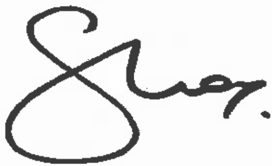
5.2 **Joint Training** – we have agreed to undertake joint training with frontline staff to discuss fire safety issues including hoarding, vulnerability and referral processes. Training has been planned for June 2019.

5.3 **Partnership Agreement with West Yorkshire Fire and Rescue Service** – the existing agreement with Together Housing and WYF&R service has been updated and includes an

information sharing protocol. The updated agreement is due to be signed week commencing 21st January 2019.

As a result of the death involving Mr Aylward and the response from the coroner we have reviewed our current practices and our work with partner agencies. We have already undertaken a series of improvements in the procedures and practices of our staff and have further plans of joint working. We will continue to review similar incidents and make any further changes that will reduce risks and improve safety for our customers including with our statutory partners.

Yours sincerely



Group Chief Executive
Together Housing Group

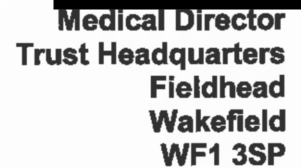
Harrison Street, Wakefield,
West Yorkshire WF1 1PS

T: 0300 555 5561
www.togetherhousing.co.uk

Together Housing Association Ltd, a charitable community benefit society registered in England and Wales at the Financial Conduct Authority with registered number 28687R.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Mr. John Nigel Broadbridge
Assistant Coroner
Coroner Office
Trafalgar House
Nelson Street
Bradford
BD5 0DX



Medical Director
Trust Headquarters
Fieldhead
Wakefield
WF1 3SP

subha.thiyagesh@swyt.nhs.uk

7 February 2019

Dear Sir

Regulation 28 prevention of future deaths – Mr. Barnaby Luke Aylward– inquest dated 3rd and 4th December 2018

In response to the regulation 28 the Trust wish to respond with the following information:-

(1a) Mr. Aylward was a social housing tenant. He exhibited certain behaviors that were in part linked to his serious mental illness. Those presented risk of death in a fire at home including heavy smoking and allowing clutter and waste to accumulate there. Those behaviors and thus risks were known to certain individuals, including his family, and agencies but they did not except in times of crisis or emergency

a) Review those potential risks with a multi-agency preventative approach and re assess those risks regularly overtime;
b) Take any collective responsibility nor for any one person or agency to take responsibility to reduce or eliminate risk by action, e.g. clearing clutter fire risk and reluctance to compel Mr. Aylward to improve his environment regularly and if needed;
c) Did not feel empowered to make property inspections regularly or at all and advise Mr. Aylward and other agencies, or have sufficient resources to the right level to inspect and assist;
d) May have been hampered by issues of confidentiality in communications between agencies,

Chair: Angela Monaghan Chief Executive: Rob Webster

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CUSTOMER SERVICE EXCELLENCE
UK
The Government Standard
With all of us in mind.

The Trust has in place guidance in various forms to assist staff in supporting service users who may be vulnerable. There are a number of partnership arrangements where both health and local authority work together to provide care and treatment to people in the community.
It is important that staff from all agencies recognise that the management of a person who may be at risk for a number of reasons is not the sole responsibility of one agency. Going forward Trust staff should be encouraged to use the knowledge and expertise of other agencies such as housing and fire and rescue services. The knowledge of family and carers is also a very important element when caring for vulnerable people.

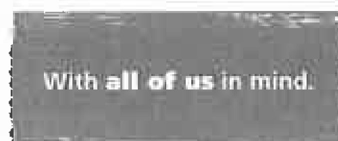
The Trust currently works in partnership with the West Yorkshire Fire and Rescue service in respect of wellbeing promotion and safety and support for our vulnerable service users. Following the death of Mr. Aylward the Trust undertook an investigation into the circumstances and it was recognised that although agreements and partnerships were in existence these needed to be strengthened. In order to strengthen these arrangements the Trust's safeguarding team set up a programme of work visiting all community teams within the Kirklees area, providing them with information and guidance relating to the different circumstances which may arise for people who are vulnerable within their own homes and advising staff how to have an inclusive and collaborative approach when supporting people.

The Trust has a commitment to providing Safeguarding training to all staff which is mandatory and requires a refresher every 3 years. In 2017 it was agreed that awareness regarding neglect and hoarding should be included in the programme of training and has since been implemented by our safeguarding trainers across the Trust.

The Trust currently has an inter-agency information sharing protocol with West Yorkshire Fire and Rescue service, this protocol is currently under review and it is anticipated that this should be agreed by the end of March 2019.

Staff do actively discuss with service users where indicated if there are problems relating to the living conditions. However the Trust is developing an information leaflet for staff to assist them in what to look for and what questions to ask when there are concerns for patient safety in their own homes.

The Trust is a signatory to "Kirklees Multi agency Hoarding Framework" which was reviewed in July 2018, and provides detailed advice to staff. A member of the Trust safeguarding team is a member of the panel which is chaired by West Yorkshire Fire and rescue service. The Trust is participating in partnership training with West Yorkshire Fire and rescue and Together housing, this will be available through the months of June and July 2019.



(2)The mental health care provided to Mr. Aylward was within a Care planning Approach. The care plan documentation did not identify his above behaviours in writing thus potential risks, nor indicate review and solutions including with housing provisions.

An alert will be distributed to all staff working in the Trust raising awareness that where there is a risk relating to hoarding and associated risks this should be included within the care plan and that interventions should be planned to manage the risk. These should be reviewed on a regular basis or as the risk changes. The alert will be distributed by the end of February 2019.

As mentioned above the Trust's safeguarding department has increased staff awareness which includes information about the multi-agency Hoarding Panel in Kirklees

Staff will be reminded through the safeguarding training and information governance training that where a service user is in rented accommodation, consent should be sought from the service user to provide information regarding the condition of the property to the housing provider.

Staff will be reminded through the alert that where there is an identified fire risk a referral should be made to the fire service.

(3) The presence of clutter and thus risk was not always evidenced in other clinical notes as a symptom of Mr. Aylward's illness of significance as were other presentations of his illness.

Mr. Aylward's untidiness would not normally be classified as a symptom of a psychotic illness. Nevertheless it is recognised that where a person is vulnerable in respect of the conditions of their property and other influencing factors such as smoking this should be included within the care plan. This should be monitored, reviewed and updated regularly and not only at times of heightened risk due to mental ill health.

(4) There was some but not much evidence of seeking to extend support to Mr. Aylward through his family members including practical and financial help.

Learning events have previously been provided by the safeguarding team which includes raising awareness to include carers and family in care planning and risk management, this will continue to be reinforced through our mandatory and core clinical training programmes. This will be reinforced through the publication of the above mentioned information leaflet and alert.

(5) "The appropriateness for a risk management meeting and also a MHA assessment to in part held away from the patient to enable frank discussions to take place between the

health professionals rather than in front of the patient where perhaps more robust views may not have been enabled"

The role of the AMHP and the medical staff within the MHA assessment process is to act as an independent assessor but additionally as part of that role it is their responsibility to ensure they have collected available information and views of all involved in the person's care. Often MHA assessments are at the point of crisis for a service user and as such opportunities for discussion are limited by time, space and urgency to preserve safety, but where possible efforts should be made for the professionals involved to have a conversation not in the presence of the service user in order to establish a plan of care.

A separate care conference to address management of risk should be considered where possible, before a crisis situation arises.

I hope the information provided is of assistance to you and provides assurance that the Trust is committed to working with our partners in supporting our community.

Yours faithfully,

Medical Director
South West Yorkshire Partnership NHS Foundation Trust

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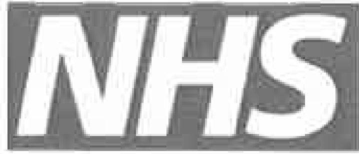
The Government Standard

With all of us in mind.



Mr John Nigel Broadbridge
Assistant Coroner
Coroners Office
Trafalgar House
Nelson Street
Bradford
BD1 1LA

Dear Sir

Re Mr Barnaby Luke Aylward

Following receipt of the prevention of future death report by our agencies, we committed to strengthening our current partnership working in respect of education and awareness. Senior members of staff were tasked with meeting to discuss current arrangements and agreeing where we need to strengthen these.

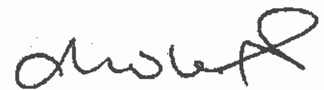
It was evident from the meeting that much work has been undertaken in respect of highlighting areas of risk and vulnerabilities within our communities. It has been agreed that further awareness and promotion of fire safety should be undertaken. A multi agency programme of awareness training provided by West Yorkshire Fire and rescue service has been agreed for the months of June and July 2019. All three agencies have committed to this awareness training being a priority for our staff.

Each organisation has set out individually in the attached correspondence, responses to the prevention of future deaths report you issued.

Should you require any further information in respect of this matter please do not hesitate to contact our organisations.

May we also take this opportunity to offer our sincere condolences to Mr Aylward's family and friends at this time.

Yours sincerely



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