REPORT REFERENCE NO.	**CSC/22/11**
MEETING	**COMMUNITY SAFETY COMMITTEE**
DATE OF MEETING	**9 SEPTEMBER 2022**
SUBJECT OF REPORT	**FATAL FIRE DEATH REVIEWS**
LEAD OFFICER	**ACFO PETE BOND, DIRECTOR OF SERVICE DELIVERY**
RECOMMENDATIONS	***That the report be noted*.**
EXECUTIVE SUMMARY	This paper explains how the Service reviews fatal fire deaths or significant fires in order to learn from previous incidents and adapt Prevention strategy to help reduce future fires, injuries and deaths.
RESOURCE IMPLICATIONS	Business as usual. No resource request
EQUALITY RISKS AND BENEFITS ANALYSIS	Complete
APPENDICES	None
BACKGROUND PAPERS	None

1. INTRODUCTION

1.1. Reviewing past incidents is one of the many steps in informing the Service's future prevention strategies, to reduce the number of accidental fires and risks to those most vulnerable to fire.

1.2. The Service undertakes a review, following a fatal fire death or serious injury, for the purpose of learning, to see if more can be done to prevent fires that lead to injuries or deaths. A referral from any significant near miss will also enter this process. Other appropriate agencies are also invited to participate in these reviews, however, there is no statutory requirement for other agencies to attend.

1.3. The objective of the review panel is to understand if any learning can take place from a Prevention perspective either by the Service or other agencies to prevent future fires, injuries, and fatalities. Collaboration between agencies is crucial in reducing fatal fires and serious injuries as often an individual is known to one or more agencies.

1.4. A review will start with an overview from the fire investigator so that the panel are able to understand the contributing factors.

2. FATAL FIRES -RISK FACTORS AND CAUSES

2.1. The Service's target is to reduce fatal fires within Devon and Somerset to zero. Sadly, the number of fatal fires within Devon and Somerset Fire and Rescue Service area varies from year to year but would normally be 10 or less.

2.2. The data in Table 1 below shows the number of fatal fires within Devon and Somerset for the past 10 years. Of the 77 fire deaths, 12 were started deliberately and of these, 10 of the deliberate fires were set by the person that perished in the fire.

Table 1

2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
10	12	8	8	6	5	4	8	10	6

2.3. The Service has previously commissioned two investigation reports into fire deaths in the South-West region to understand the most likely causes and risk factors associated with accidental fire deaths. By using data from the region, it provides a larger data set which enables a more accurate statistical analysis.

2.4. The first report covered the period 2008-2013. The second report covered 2013 to 2017. Seven risk factors were identified from these two reports, with causes of fire changing within this time period. The Service is aware that it is are unable to reduce fatal fires alone, but relies heavily on its partners who care for the most vulnerable in society. Through partnership working the Service is able to target its prevention activities at those with the highest risk factors.

2.5. From the reports commissioned, the Service has identified the following risk factors being present as a percentage of fatal fires. 72% of fatal fires had one or more risk factors present with just over half having two or more risk factors present. 28% had none of the risk factors identified.

Living alone	49%
Mobility issues	33%
Smoking	26%
Drugs (Medical or recreation)	15%
Alcohol	14%
Housekeeping/Hording	12%
Mental Health	10%

2.6. Gender and age is a contributing factor. Those in the 80+ age group are more likely to be a victim of fire. Between the ages of 40 and 70 three times more men are victims of fire than women. The two highest contributory factors in the 40-49 age group are living alone and alcohol. In the 60-69 age group the highest contributory factors living alone and mobility.

2.7. From the 2013-2017 report the causes of ignition for fatal fires were as follows: -

Smoking materials	29%
Matches/lighters	14%
Heating equipment	13%
Cooking	9%
Electrical	8%
Candles	6%
Other	11%
Unknown	10%

2.8. 31% of fatal fires between 2013-17 had no smoke detection. Therefore, smoke detection is important. However, it is not the only factor. 48% had smoke detection that raised the alarm but still resulted in a fatality. This is often due to the risk factors such as living alone, alcohol and mobility. This shows that we need to do more than just fit smoke alarms in homes if we are to reduce fire deaths. A person's behaviour and individual factors are also important. A person-centred approach in line with the National Fire Chiefs Council person centred framework is required to prevent fatalities and serious injuries.

3. RESULTS AND ACTIONS OF RECENT FATAL FIRE REVIEWS

3.1. Regular fatal fire review meeting take place once per month to review any fatal fires or fires involving serious injuries. Near misses can also be referred for a review. The actions log is also reviewed at this meeting to ensure progress on any actions taken from previous learning and reviews. A recent Coroners court acknowledged how the Service reviews and learns from fatal fires.

3.2. Examples of recent actions following reviews include: -

- Carrying out specific campaigns to raise awareness of risk, for example emollient creams campaign in pharmacies. This has followed a trend in a number of fire fatalities where emollient creams have been a contributing factor.
- In certain circumstances where there is high risk, providing specific equipment e.g., an alternative single induction hob to replace a gas hob. This has followed a number of fatal fires where a gas hob was the cause of ignition.
- Reviewing Service strategy regarding re-visits to ensure that those at risk receive another home fire safety visit at a future appropriate date. This followed a fatal fire where the Service had carried out a Home Fire Safety Visit a number of years previously to the fatal fire but the individuals circumstances had changed due to age and mobility.
- Reviewing Service cancellation policy if unable to contact the client. This followed an incident where the service had received a partnership referral but we had been unable to contact the client. The previous policy had been two attempts to contact and then cancel the visit. We now follow this up with a door knock and contact the partner agency to see if they are able to assist in making contact.

3.3. All actions have a single named owner and a completion date and are reviewed each month to ensure progress is being made.

4. RECENT TRENDS

4.1. Recent fatal fire reviews have continued the trend of age and mobility being significant factors in fatal fires. A recent theme in fatal fires has been emollient creams which can be flammable and can impregnate clothing. This is a particular risk if the person is bed bound and a smoker, and in the proximity of naked flames such as gas hobs, open fires and gas heaters.

5. CONCLUSION

5.1. Fatal fire reviews are an important part of ongoing learning and improvement, to help reduce future fires, injuries, and deaths. The Service's fire investigators will be aligning to the ISO accreditation to ensure its fire investigation standards are professional. Accurate fire investigation is crucial if the Service is to identify the causes of fire and subsequently learn the lessons needed to prevent future fires. A person centred and targeted approach using lessons learnt from the reviews to guide our strategy, will assist us to reduce fires, injuries and ultimately fire deaths.

ACFO PETE BOND
Director of Service Delivery