

Fatal Fire Discussion Paper

30.07.2021

Home Safety

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Version 4

Official Sensitive

1. Executive Summary

- 1.1. This paper has been prepared by the Home Safety Team to facilitate review of the 6 fatal fires that occurred in 2021, between 01.01.2021 and 30.07.2021.
- 1.2. This is a paper prepared for discussion, and to facilitate conversation about what can be learned from the fatal fires that have already occurred this year, and what ECFRS may be able to do in order to apply this learning to prevent fatal fire in the future.
 - 1.2.1. Specifically, the purpose of this paper is to use Strategic After Incident Response Reports (SAIR) to identify any commonality between the fatal fires that occurred between the 01.01.2021 and the 30.07.2021, with a view to:
 - 1.2.1.1. Identifying any key learning that can be used to reduce the likelihood of fatal fires occurring in the future.
 - 1.2.1.2. Identifying any improvements that can be made to the SAIR reporting template to make future comparison more effective
- 1.3. This paper makes a number of recommendations for consideration by Prevention Managers, to guide discussion. These recommendations are listed at section 5 of this paper in the context of the finding to which they relate, and in blue italics. They are listed again at section 6 in list format.
- 1.4. Points 7 and 8 of this paper provide detail of the fatal incidents considered by this paper for more detailed reference.

2. Fatal Fires Considered by this Paper

Ref	Incident No.	Location	Date	No. of Fatalities
1/21/SW	1137337	Saffron Walden	10.01.2021	1
2/21/SE	140853	Southend-on-Sea	03.01.2021	1
3/21/CI	141857	Canvey Island	05.04.2021	1
4/21/CI	142533	Canvey Island	15.04.2021	1
5/21/CL	145260	Clacton-on-Sea	31.03.2021	1
6/21/MI	147203	Mersea Island	06.30.2021	1

3. Limitations of this Paper /Notes on the Content

- 3.1. This paper takes information from Strategic After Incident Response (SAIR) reports, written in 2021. These reports are compiled following a fatal fire. Whilst SAIR reports do include some information relating to fire investigation, they do not include the full fire investigation report.
- 3.2. With hindsight, there are questions that would be helpful to ask of victims' families and partner agencies, that were not known at the time and therefore, not explored in the SAIR Reports.

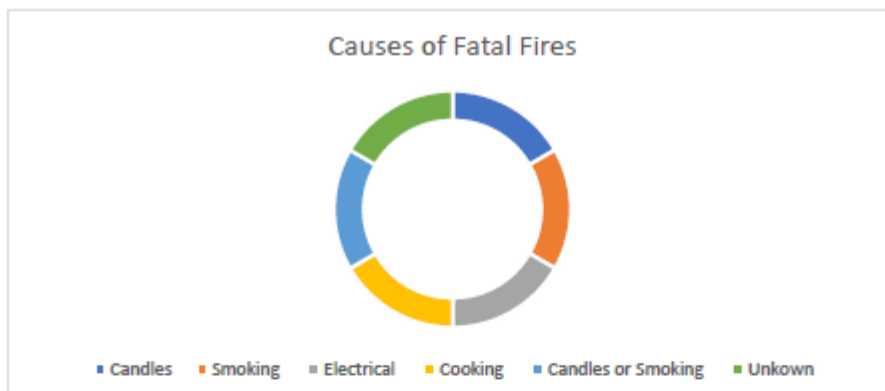
- 3.3. This paper does not include the fatal fire that occurred in Southend in June and is currently being considered part of a murder investigation. At a future date, it may be appropriate to include that incident in an updated version of this paper.
- 3.4. This paper does include a fatal fire that occurred on the 31.03.2021 in a caravan in Clacton. The caravan residents, including the deceased, were on holiday from outside of the County.

4. Overview of Fatal Fires

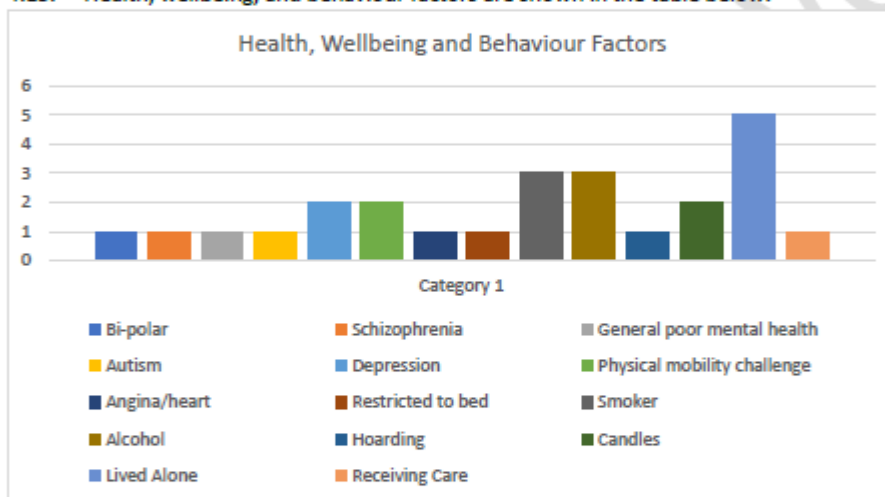
- 4.1. In 2021, there have been 6 fatal accidental dwelling fires between 01.01.2021 and 30.07.2021.
- 4.2. Of these fires, 100% occurred in properties that were privately owned, although it should be noted that one of these properties was a privately owned caravan.
- 4.3. In 5 of the 6 cases considered by this paper, the victim lived alone.
- 4.4. There were a variety of identified causes of fire across the fatal incidents, with no single cause being considered *most common*.
- 4.5. In nearly all of the incidents (83%), the resident was living with challenges relating to *more than one* of the following Core Risk Areas – their physical health and wellbeing, their mental health and wellbeing, or the condition of their home environment.
- 4.6. In 83% of incidents (5 out of 6), the victim was experiencing challenges with their mental health and wellbeing that probably increased their vulnerability to fire.
- 4.7. In 83% of incidents (5 out of 6) the resident was experiencing challenges with their physical health and wellbeing that probably increased their vulnerability to fire.
- 4.8. In 67% of the incidents (4 of the 6), the resident was living in a home environment that probably increased their vulnerability to fire.
- 4.9. In only one of the incidents was hoarding confirmed as a factor involved in the fatal fire, although in another incident there was some evidence of cluttering, it was not considered an unusual amount of clutter by fire investigators.
- 4.10. In only one of the incidents, the victim was confirmed as receiving a formal care package.
- 4.11. The victim's age and gender are shown, in order of age from oldest to youngest, in the table below. Whilst there is a wide age range, all victims are over the age of 50. 3 (50%) are over the age of 65, and therefore, sit within ECFRS' understanding of 'at risk' age groups
- 4.12. 4 of the 6 victims were female, and 2 were male.
- 4.13. All three of the female victims who were Essex residents, were over the age of 65.

F	F	F	M	M	F
82	73	72	59	59	50S.

- 4.14. Causes of the fatal fires recorded in Fire Investigation Reports are shown in the table below.



4.15. Health, wellbeing, and behaviour factors are shown in the table below.



5. Discussion Areas

5.1. Mental Health and Wellbeing played a significant part in increasing the vulnerability of the majority of victims considered by this paper.

5.1.1. In 5 of the 6 incidents considered by this paper, the victim had some form of illness or condition that was impacting their mental health and wellbeing, evidencing what we already understand at ECFRS about a critical relationship existing between mental wellbeing and risk of fire.

5.1.2. Challenges affecting the victim's mental health and wellbeing were listed for each of the five victims in turn as, depression, bi-polar, schizophrenia, general poor mental health, and suspected autism.

5.1.3. *REC1: ECFRS should consider whether there is more that can be done to understand the risk of fire associated with mental health and wellbeing, and whether there is additional prevention activity that could be undertaken to mitigate it.*

- 5.1.4. *REC2: ECFRS should seek access to data that identifies residents with conditions, illness or disabilities which impact their mental health and wellbeing, and use this in conjunction with other data to target prevention engagement.*
- 5.2. There may be an emerging risk in Essex involving individuals with learning disabilities and/or mental health concerns, who have previously lived outside of structured care systems, now adjusting to living alone following the death of a parent/carer.
- 5.2.1. In two of the incidents considered by this paper, a 59-year-old male had, or was suspected to have had, an additional need that affected their mental health and wellbeing (Bi-polar and suspected autism).
- 5.2.2. Both victims had lived with an elderly parent, and following the death of that parent, their vulnerability to fire appears to have increased significantly over a period of years.
- 5.2.3. It is possible that this is an emerging risk, created by a historic policy shift that led to individuals with significant learning disabilities/mental illness living at home, rather than in managed accommodation. Anecdotally, it is believed that many of the parents of the first generation of young people to be impacted by this policy change, are now elderly, and their children are now adults who must adjust to living alone, or who will require care.
- 5.2.4. *REC3: ECFRS should consider whether 5.2 does equate to an emerging risk in Essex, and if so, what can be done strategically, and with partners to mitigate it.*
- 5.3. In 5 of the 6 incidents considered by this paper, the resident experienced challenges to their physical health and wellbeing, that probably increased their vulnerability to fire.
- 5.3.1. In all incidents where the victim experienced challenge with their physical health and wellbeing, the impact was a decreased likelihood of escape in the event of a fire, either due to alcohol intoxication, restricted mobility, or both.
- 5.3.2. In 4 of the 6 incidents considered by this paper, consumption of alcohol is likely to have played a part in the incident being a fatal fire, either because it made ignition more likely, decreased likelihood of escape, or both.
- 5.3.3. This paper and the incidents it considers, underlines the fundamental role that an inability to escape a property in the event of a fire, or reduced capacity to escape, play in turning a survivable fire into a fatal fire.
- 5.3.4. *REC4: ECFRS should seek access to data that identifies residents with conditions, illness or disabilities which impact their physical health and wellbeing, and use this in conjunction with other data to target prevention engagement.*
- 5.4. In 3 incidents, the victim's property was found to be in a physical state that increased their risk of a fatal fire.
- 5.4.1. In all 3 incidents, the physical environment played a role in decreasing the Victim's likelihood of escaping promptly in the event of fire. Causes included damage to the property, hoarding, and a lack of easy access to keys required to open locked doors.
- 5.4.2. In 1 incident, the physical condition of the property, and damage to electrical wiring, caused the fire to start.
- 5.4.3. In 100% of cases, the victim owned, or part owned, the property they died in. As such, they were responsible for its upkeep and there were no other agencies, or organisations maintaining the property or mitigating the physical risks in the property.
- 5.4.4. *REC5: Traditionally, Prevention teams have sought data that identifies person centred risk. ECFRS should explore whether it can access any data or information that could be used to*

identify higher risk home environments and use this in conjunction with other data to target prevention engagement.

- 5.5. In only 2 cases were there found to be working smoke alarms at the property.
- 5.5.1. In 2 of the cases considered by this paper, the Fire Investigation and IRS records stated that there were no working smoke detectors present at the time of the incident.
- 5.5.2. 100% of these fatal fires occurred in properties that were privately owned and were therefore, not required by law to have smoke detection. This highlights the importance of programmes of work which aim to increase smoke alarm ownership in private properties, particularly those occupied by more vulnerable individuals.
- 5.5.3. In 2 of the incidents, there is no record of whether there were working smoke alarms. This suggests that either Firefighters were unable to determine whether smoke detectors were present, or that they failed to record this information within IRS.
- 5.5.4. *REC6: ECFRS should explore what can be done to ensure that smoke alarm data is correctly recorded following a fatal incident.*
- 5.6. In 83% of the incidents considered by this paper (5 out of 6), the victims were experiencing challenges in *more than one* of the following risk areas *simultaneously*: mental health and wellbeing, physical health and wellbeing, the home environment.
- 5.6.1. The evidence considered by this paper suggests that a key indicator of risk of fatal fire, could be identified in cases where residents are experiencing challenges in *more than one* of the risk areas used by this paper. This supports ECFRS existing understanding that individuals with complex health and wellbeing situations are at greater risk of fire, and possibly of fatal fire.
- 5.7. In the process of writing this paper, it became apparent that where a victim experiences challenge with their mental health and wellbeing, physical health and wellbeing, or home environment, the impacts relevant to fatal fire could be usefully categorised as an *increase in the likelihood of ignition, and/or a decrease in their likelihood of escape.*
- 5.7.1. In 100% of the incidents considered by this paper, there was a decreased likelihood of the victim being able to escape at the time of the fire. Causes varied, but included intoxication, hoarding, poor condition of the property and restricted mobility. As referenced at point 5.3.3, this highlights the fundamental role reduced capability to escape plays in reducing survivability in the event of fire.
- 5.7.2. In 5 of the 6 incidents, there was an obvious increased likelihood of ignition. Causes varied, but included smoking, use of candles and damage to mains electricals.
- 5.7.3. Overall, 5 of the 6 incidents considered by this paper showed evidence of a *simultaneous* increased likelihood of ignition, *and* decreased likelihood of escape, a situation this paper considers most likely to produce a fatal fire outcome.
- 5.7.4. ECFRS Home Fire Safety Checks and Safe and Well Visits broadly seek to reduce the likelihood of ignition, and increase the likelihood of escape, however this language is not currently used to describe ECFRS home safety aspirations.
- 5.7.5. *REC7: ECFRS should consider whether the language of increased likelihood of ignition and decreased likelihood of escape is a useful way of communicating the purpose and process of a Home Fire Safety Check/Safe and Well Visit and incorporate this in relevant training.*
- 5.7.6. *REC8: ECFRS should consider adding the language of increased likelihood of ignition and decreased likelihood of escape to the Fire Safety in the Home module being developed for carers, as a simple way of explaining how to assess risk of fatal fire.*

- 5.8. In 5 out of the 6 incidents, the resident lived alone.
- 5.8.1. Whilst living alone does not necessarily constitute a risk of fire on its own, it could be argued that it exacerbates the negative impacts of the other challenges faced by the victims of fire.
- 5.8.2. The Essex University Report into the ECFRS incident data, published in 2011, found that living alone was a significant indicator of risk of fire, based on 7 years of ADF data (2011 to 2017).
- 5.8.3. *REC9: ECFRS should consider whether there are any additional specific prevention partnerships or activities that can be undertaken, targeted at older individuals living alone.*
- 5.9. The causes of fire were varied, and there were no causes that stood out.
- 5.9.1. The direct causes of the fires, identified by the Fire Investigation Reports were varied (see point 4.14), however, common causes that ECFRS already understands to be prominent causes of fatal fires were recorded.
- 5.9.2. Causes included smoking, candles, cooking and electrical.
- 5.9.3. *REC10: ECFRS should seek to conduct further analysis of cause of fire, over a longer period of time and greater number of incidents.*
- 5.10. In 3 of the 6 incidents, ECFRS had previously engaged with the property and its residents over a year before the fire had occurred.
- 5.10.1. In each case, between the visit taking place, and the fatal incident occurring, the victim's vulnerability to fire had increased.
- 5.10.2. In only 1 of the 3 cases where ECFRS had previously visited the property, was the visit conducted for the individual who subsequently died in the fire. This was because 2 of the visits had been arranged for the benefit of the victim's parent, who had lived at the property previously and had died by the time the fatal incident took place.
- 5.10.3. In 1 case, a Home Safety Visit had been carried out for a vulnerable resident, alarms had been provided and advice given. The case had been closed following the visit with no further action taken.
- 5.10.4. In all cases, residents at properties visited by ECFRS had become increasingly vulnerable in the months, and sometimes years following ECFRS visits, but ECFRS had not attempted to re-engage with the resident, nor had any individuals or agencies re-engaged ECFRS for further help and advice.
- 5.10.5. *REC11: ECFRS should consider whether more can be done to ensure that key stakeholders in an individual's care, re-engage ECFRS when a resident's risk of fire increases.*
- 5.10.6. *REC12: ECFRS should consider returning to high-risk residents at intervals, following an initial visit to maintain an awareness of the residual risk following intervention.*
- 5.11. In 3 of the 6 incidents, a significant increase in the resident's vulnerability to fire can be linked to major event in their life, affecting one or more of the core risk areas considered elsewhere in this paper (mental health and wellbeing, physical health and wellbeing and home environment).
- 5.11.1. In 2 cases, the death of a parent upon whom the resident was dependant or lived with, led to a significant increase in vulnerability. In each case, deterioration in mental health and wellbeing led to higher risk behaviour including damage to property and use of alcohol that increased likelihood of ignition and decreased likelihood of escape.

- 5.11.2. In 1 case, the victim's return from hospital, in a temporary but significantly vulnerable state, led to a significant increase in risk of ignition in the home, added to an already decreased risk of escape.
- 5.11.3. *REC13: ECFRS should consider what actions ECFRS may be able to take to encourage the identification of, and mitigation of risk following major life events that exacerbate existing vulnerabilities.*
- 5.12. SAIR Reports are excellent records of the circumstances of fatal fires, however, there may be some improvements made to the template that would improve ECFRS capability to analyse multiple fatal fires.
 - 5.12.1. It may be useful to create consistent question sets considered by SAIR documents, in order to ensure that there is easily comparable information collated. This will make future comparison and analysis easier to undertake and more effective.
 - 5.12.2. *REC14: ECFRS Prevention should consider the creation of a more specific question set to answer for each SAIR report, that would facilitate more effective comparison of fatal fires in future.*

The remainder of the paper has been redacted as the contents are listed as Official Sensitive.