Hampshire & Isle of Wight
FIRE & RESCUE SERVICE

4LSAB Fire Safety Development Group Thematic Review 2022-2024

May 2025

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SUMMARY

Hampshire & Isle of Wight FIRE & RESCUE SERVICE

FSDG Fire Fatalities and Injury Analysis

Report Brief:

- The 4LSAB Fire Safety Development Group (FSDG) is a subgroup of the Four Local Safeguarding Adults Boards (4LSAB) in Hampshire, Southampton, Portsmouth and Isle of Wight.
- A primary aim of the FSDG is "*to implement an event learning strategy as a means of reducing avoidable fire deaths and near miss fire incidents, ensuring a 'systems learning' approach is applied by all members for the development of effective fire safety practices within their own agencies / organisations*."
- In order to achieve this aim, the 4LSAB FSDG completes a multi-agency review of any fire incident which results in a serious injury or fatality.
- The aim of this multi-agency review is to identify key risk factors and vulnerabilities that the individual(s) involved with the fire incident was experiencing prior to the fire, and to identify if they were known to or in receipt of any support from services within the 4LSAB area.
- This multi-agency review enables the identification of learning, which is then shared across the 4LSAB area for all partner agencies to consider.
- This thematic review analyses data from **35 fire incidents** reviewed by the FSDG which occurred between 1st January 2022 and 31st December 2024. For context, This is approximately 14% of the number of fire incidents that HIWFRS responded to, 256, in the same period, that were recorded as having fatalities or casualties.
- The key risk factors and vulnerabilities identified within this thematic review will support the multi-agency understanding of the fire risk and vulnerabilities that are present and experienced within the 4LSAB area.
- Where possible, comparisons have been made to previous thematic reviews of fire related fatalities and injuries which was conducted on data from **2019-21, where 39 cases were reported on**, and again where possible comparisons have been made against national data which has been highlighted in blue text throughout the slides.

Note: The cases reviewed in this analysis do not include all fire-related injuries that HIWFRS attended over the period. The FSDG review includes confirmed, or initially thought to be, fatalities, near-miss or life changing injuries and/or incidents whether there is an indication partner agencies were involved with the individual(s). Therefore, the figures may appear lower than expected. For queries on fire casualties more widely please contact organisational.performance@hantsfire.gov.uk.

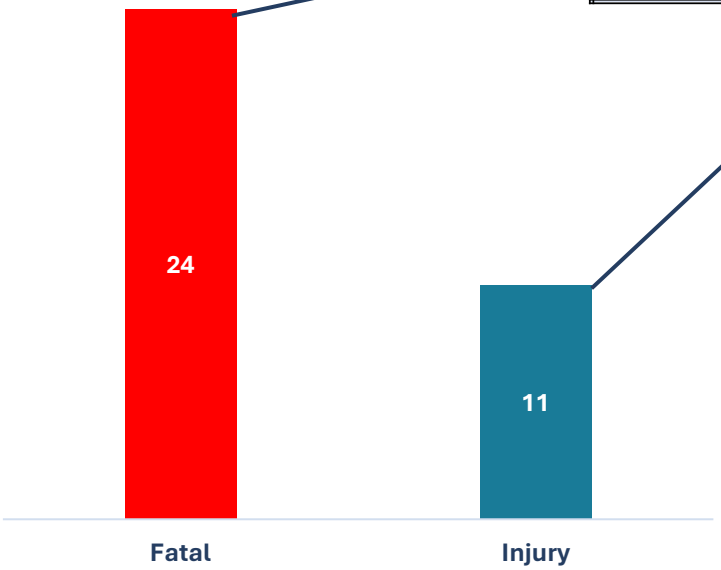
Highlights

- At the time of this review being completed, out of the 35 incidents included in this review, 24 of those were fatalities. Of the 24 fatalities, not all are confirmed as fire deaths, with 13 awaiting coroners reports and 2 confirmed as non-fire death incidents.
- The two most common vulnerability factors identified in the review, both present in 44% of all incidents was an individual having care needs, and an individual with poor physical health. This was followed jointly by physical impairment and poor mental health, both present in 42% of incidents, and then alcohol and substance use (36%). Compared to the previous report, 2019-21, where 'care and support needs' was most common (79%), followed by 'smoking' (64%), and in receipt of care and support services (56%) (see Slide 10).
- For incident types, deliberate acts were the most common with 10 incidents. This is followed by unknown causes with 6 incidents. In 2019-21, the most common incident types were 'carelessness with smoking materials, 16, and deliberate acts, 6 (see Slide 16).
- Over two thirds of incidents (25) occurred to individuals who were living alone (71%). In the previous report, 2019-21, these figures were 88% for living alone (see Slide 17).
- The 66 to 75 age range had the highest number of incidents. The percentage of incidents in this age range has increased by 14% compared to the previous thematic review (see Slide 18). In the previous report, 2019-21, the age range with the highest number of incidents was 51-65.
- 23% of cases involved an individual who was in receipt of care and support services, in comparison to the previous thematic review where 56% of the individuals were in receipt of care and support services (see Slide 20).
- No smoke detection was identified in 4 incidents. This accounts for 11% which is a decrease on the previous thematic review where 18% of incidents had no smoke detection. 11% of incidents in the current review had a nonfunctioning smoke detector present (see Slide 21).
- GP was the most common agency that these individuals were known to, with 16 out of the 35 cases (44%). The second most common was H&IOW Healthcare – Mental Health Services with 11 out of 35 cases (28%). 4 cases out of the 35 (11%) were not known to an agency (see Slide 22).

INJURIES AND FATALITIES

Fire Fatalities and Injuries

Totals



Fire Fatalities and Injuries

Fire Death	9
Awaiting Coroner	13
Not Fire Death	2

Severe Burns	3
Smoke inhalation	3
Severe Burns and Smoke Inhalation	1
Near Miss	4

Out of the total of 35 incidents reported here, **24 were fatalities , 11 resulted in injury, including 4 near misses. As mentioned in the report brief, this is only a small proportion, 14%, of the total number of incidents that resulted in a fatality or casualty.**

However, not all fatal incidents are confirmed fire fatalities as the Fire Investigation team are still awaiting coroners' outcomes on 13 incidents.

The below table shows total incidents by local authority.

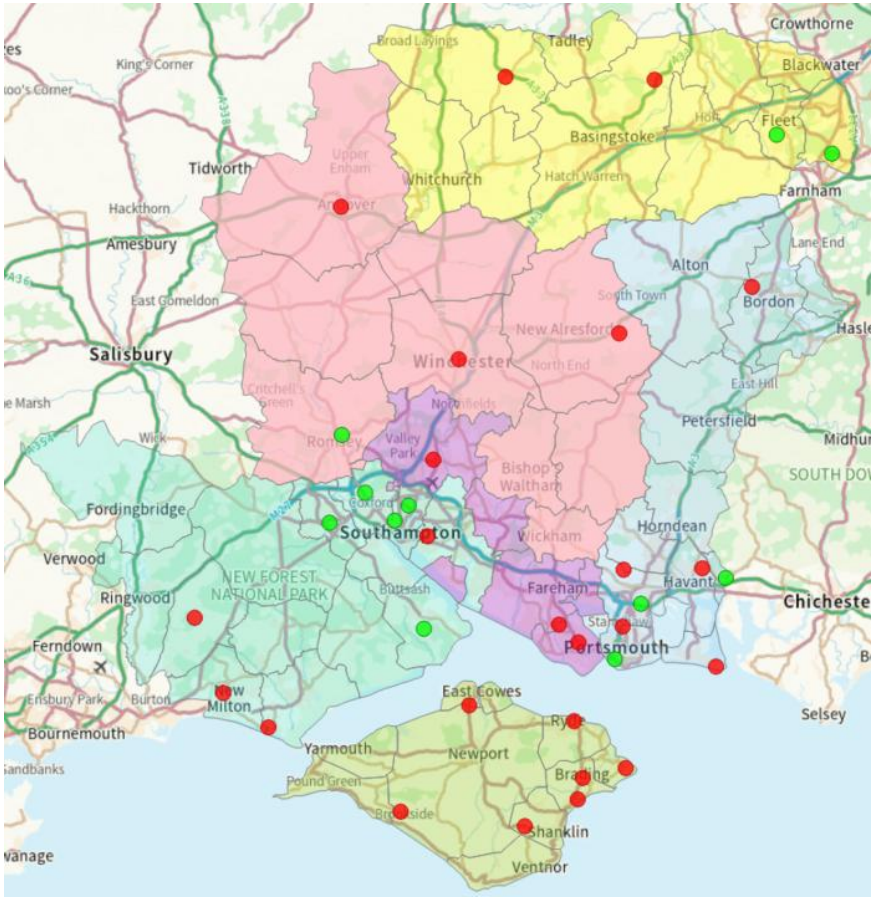
Local Authority	Total Incidents	Total Incidents %	Total Fatal	Total Injuries
HCC	21	**60%**	15	6
SCC	4	**11%**	1	3
PCC	3	**8%**	1	2
IOW	7	**19%**	7	0

Fire Fatalities and Injuries

Fatal/Injury

Fatal

Injury



VULNERABILITIES AND RISK FACTORS

Hampshire & Isle of Wight FIRE & RESCUE SERVICE

Circumstances, Vulnerability and Risk Factors

Overall Comparison

Care needs and **poor physical health** were the most **common risk factors** relating to individuals within the review (44% each of all incidents). This is followed by **physical impairment** and **poor mental health** (42% each)

Care needs, in receipt of care and support services, smoking and **unable to self evacuate** have all seen significant **decreases** compared to the previous thematic review.

Oxygen, sensory impairment, electrical safety concerns, poor cooking practices, poor fire safety practices & multiple ignition sources were present in previous reviews but not this current review.

Risk Factors and Vulnerabilities	2015/18 Thematic Review (26 Cases)	2019/21 Thematic Review (39 Cases)	Current Review (35 Cases)	Change (% pts, current to 2019/21)
Care needs?	-	79%	44%	-35%
Poor Physical health	-	41%	44%	3%
Physical impairment	26%	54%	42%	-12%
Poor Mental Health	11%	38%	42%	4%
Alcohol / Substances	23%	46%	36%	-10%
Smoking	46%	64%	31%	-33%
Previously known to HIWFRS	-	49%	25%	-24%
In receipt of care and support Services?	-	56%	22%	-34%
Hoarding	23%	13%	19%	6%
History of non engagement	-	33%	11%	-22%
Unable to self evacuate	-	44%	11%	-33%
Non functioning detection	-	18%	11%	-7%
No smoke detection	-	13%	11%	-2%
Self Neglect	-	8%	8%	0%
Evidence of previous fires / burn marks	-	23%	8%	-14%
Dementia	-	5%	8%	3%
Emollient creams	8%	5%	8%	3%
Cognitive impairment	-	13%	6%	-7%
Inability to raise an alarm	-	3%	6%	3%
History of fire setting	-	0%	6%	6%
Candles Safety concerns (previous)	8%	10%	3%	-7%
Flammable liquids in use	4%	5%	3%	-2%
Oxygen	15%	5%	0%	-5%

Circumstances, Vulnerability and Risk Factors

Multiple Risk Factors

67% **Of individuals who had evidence of previous fires** were also in **receipt of care and support services**
(Evidence of previous fires – 3, in receipt of care and support needs – 8)

Of these 3, all were previously known to HIWFRS

57% Of individuals where **hoarding was present,** also had **alcohol/substances as a risk factor**
(Hoarding – 7 incidents, alcohol/substances – 13 incidents)

38% Of individuals who had **alcohol/substances** as a risk factor also had **smoking** as a risk factor
(Alcohol/substances – 13, smoking – 11)

29% Of individuals where **hoarding was present, smoking** was also a risk factor
(Hoarding – 7, Smoking – 11)

63% Of individuals in **receipt of care and support services were** also **previously known to HIWFRS**
(In receipt of care and support services – 8, previously known to HIWFRS – 9)

When viewing multiple risk factors, it is evident that some risk factors are more common with each other.

Circumstances, Vulnerability and Risk Factors

By Injury Type

Risk Factor	Fatal	Injury	Total
Care needs?	12	4	16
Poor Physical health	12	4	16
Physical impairment	13	2	15
Poor Mental Health	7	8	15
Alcohol / Substances	6	7	13
Smoking	9	2	11
Previously known to HIWFRS	8	1	9
In receipt of care and support Services?	6	2	8
Hoarding	4	3	7
History of non engagement	3	1	4
No smoke detection	3	1	4
Unable to self evacuate	2	2	4
Non functioning detection	2	2	4
Evidence of previous fires / burn marks	3	0	3
Self Neglect	2	1	3
Dementia	2	1	3
Emollient creams	2	1	3
Inability to raise an alarm	2	0	2
Cognitive impairment	1	1	2
History of fire setting	1	1	2
Candles Safety concerns (previous)	1	0	1
Flammable liquids in use	1	0	1

When analysing vulnerability and risk factors by severity **inability to raise an alarm, evidence of previous fires/burn marks, candles safety concerns (previous) and flammable liquids in use were** all risk factors who had 100% of incidents that resulted in a fatality. Consideration needs to be given to low incident numbers but the table provides an indication of the more serious vulnerability and risk factors when compared to others.

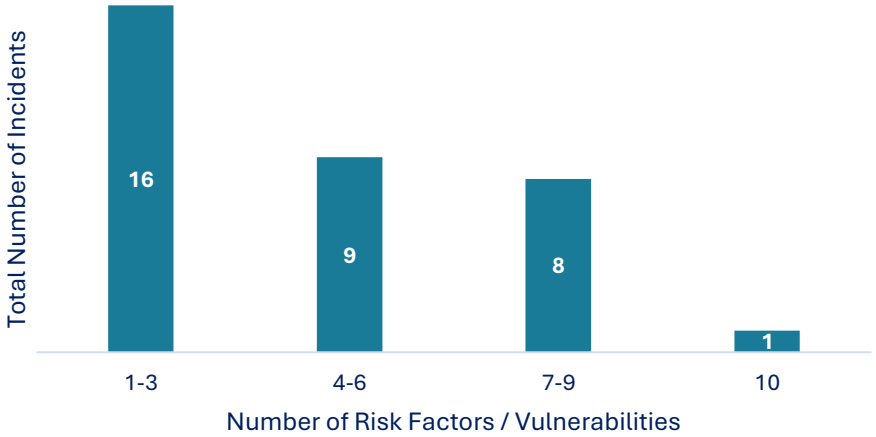
However **care needs, poor physical health, physical impairment and poor mental health** all had higher volumes of fatalities overall compared to other risk factors.

Circumstances, Vulnerability and Risk Factors

When viewing total number of incidents by number of circumstances/risk factors/vulnerabilities grouped into 2's, the most incidents (13) had 1 to 2 risk factors associated with those individuals, followed by 8 incidents with 3 to 4 risk factors. Compared to 2019-21 where the most incidents (12) had 3 to 4 factors followed by 5 to 6 (10). When grouped by 3s, the most incidents occurred with individuals who had 1 to 3 associated risk factors (16 incidents), compared to 2019-21 where those with 4 to 6 risk factors had the most (17)

Total incidents by risk factors - grouped into 2's:

Total incidents by risk factors - grouped into 3's:

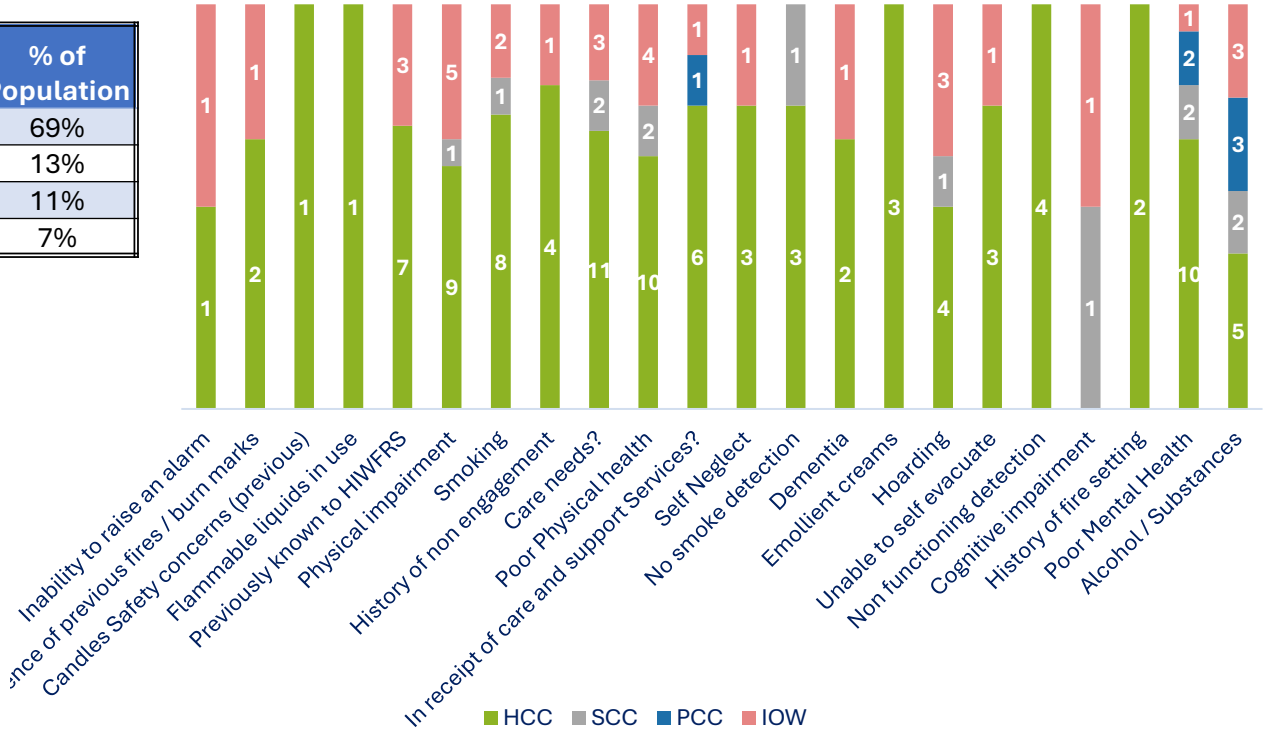


Vulnerability and Risk Factors

Per Local Authority

Local Authority	Total Incidents	Total Incidents %	Population Estimate	% of Population
HCC	21	60%	1.4m	69%
SCC	4	11%	260k	13%
PCC	3	9%	213k	11%
IOW	7	20%	140k	7%

When viewing incidents by local authority and compared to population, **Hampshire, Southampton and Portsmouth** had a **lower percentage** of incidents compared to population, whereas **IoW** had **more**.

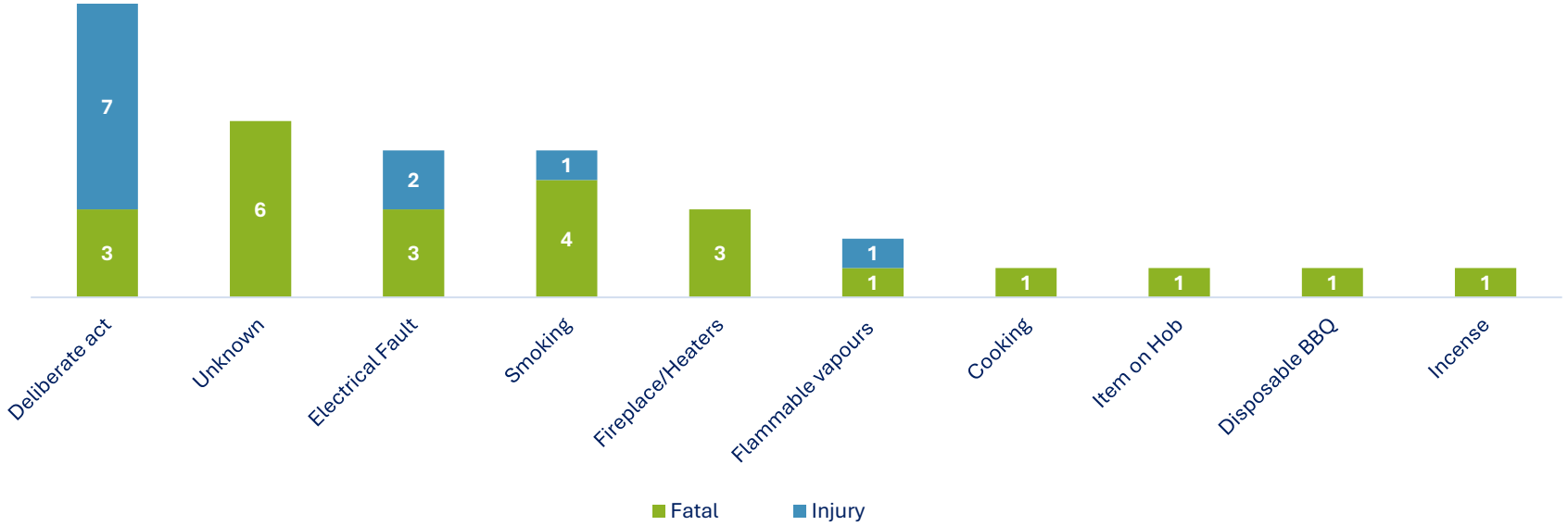


DETAILED FINDINGS

Fire Causes

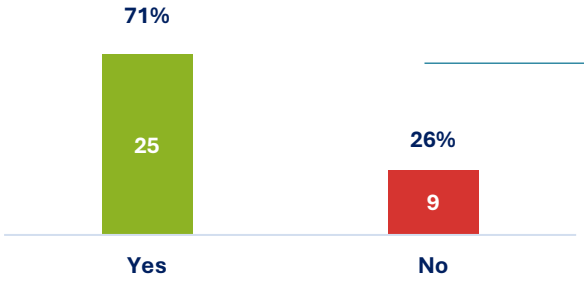
Deliberate Acts were the **most common** incident type amongst both fatalities and injuries, with 10 incidents (29%). This is followed by **Unknown** causes. In the previous review, smoking was the most common cause of incidents, 41%, followed by deliberate acts, 15%.

Nationally, cooking appliances were the largest ignition category for accidental dwelling fires (44%) in the year ending March 2023 and smokers' materials were the source of ignition in 9% of accidental dwelling fires, for the same period. Also, for the year ending March 2024, 30% of fatalities and casualties for all fires were caused by cooking appliances and smokers' materials accounting for 7%.



Living Alone

The **majority of incidents** occurred to individuals who were **living alone** (25, 71%). Nine incidents involved individuals who were not living alone and a single incident where it is unknown if the individual lived alone or not. In the 2019-21 review 28, 88%, of incidents occurred to individuals who were living alone, 2 incidents involved individuals who were not living alone, 2 involved homeless individuals and 7 incidents where it was undetermined.

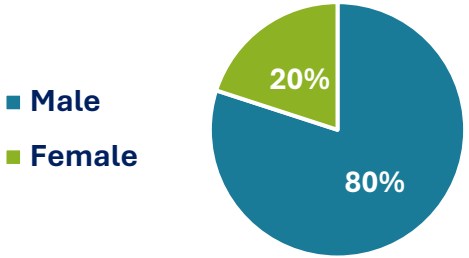


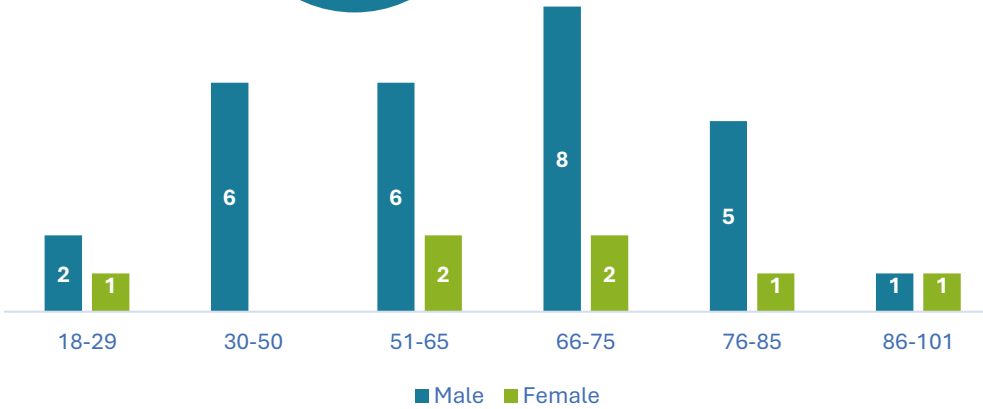
Local Authority	Living Alone Incidents	Total Incidents %
HCC	15	**60%**
SCC	3	**12%**
PCC	2	**8%**
IOW	5	**20%**
Total	**25**	**100%**

Age and Gender

The 66-75 age range had the highest number of incidents (10) and this has **increased by 15%** compared to the previous thematic review. Also, the gender split has **widened** compared to the previous thematic review where **54% of the cases were for males** and **46% for females**, compared to **80% male** and **20% female** in the current review.

When compared to the national split of 56% male and 44% female, for the year ending March 2024, and the highest proportion of incidents, 22%, occurred in the 25-39 age bracket.





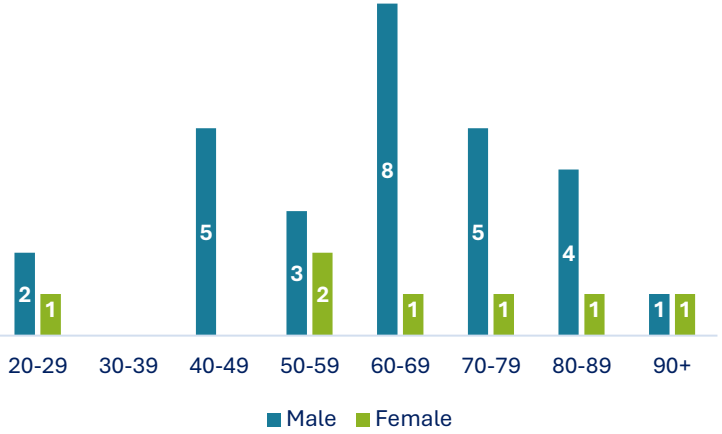
In the table below those figures in red denote where the percentage has increased and those in green signify a decrease.

Age Range	Total Incidents	Total Incidents %	2019-21 thematic review %	2015-18 thematic review %
Under 18	0	0%	7%	0%
18-29	3	9%	2%	8%
30-50	6	17%	21%	19%
51-65	8	23%	31%	19%
66-75	10	29%	14%	15%
76-85	6	17%	10%	24%
86-101	2	6%	14%	15%

Age and Gender by incidents by groups of 10 years

When incidents are grouped by 10-year age bands, the band which had the highest number of incidents was the **60 to 69 age range** (nine incidents), with eight being for males and one for females. When comparing this to the previous review, **the 0 to 39, 50-59 and 90+ age groups all showed a drop in incidents.** Whereas the **40-49 and 60-89 age groups all experienced an increase.**

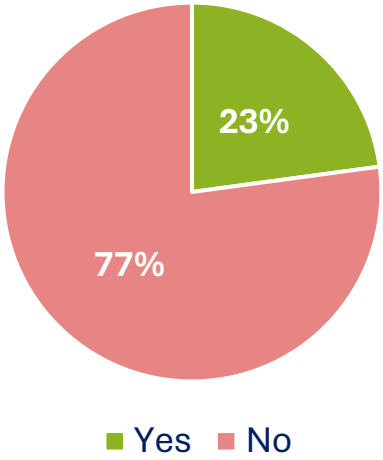
Age Range	Male	Female	Total Incidents / Individuals	% of Age Group	% 2019-21 Review
0-9	0	0	0	0%	5%
10-19	0	0	0	0%	2%
20-29	2	1	3	9%	2%
30-39	0	0	0	0%	10%
40-49	5	0	5	14%	12%
50-59	3	2	5	14%	24%
60-69	8	1	9	26%	12%
70-79	5	1	6	17%	14%
80-89	4	1	5	14%	7%
90+	1	1	2	6%	12%



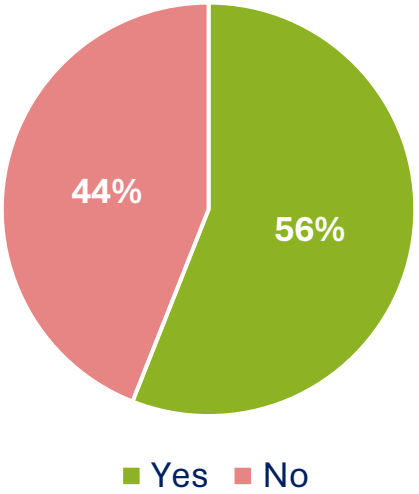
Male and female were the only genders identified in the cases reviewed

Care and Support Services

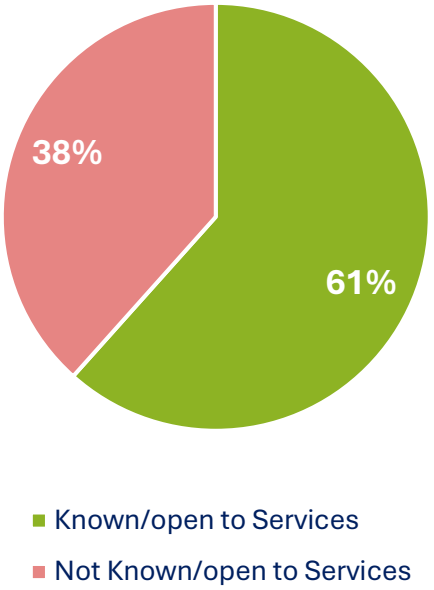
In receipt of care and support services - 2022/24



In receipt of care and support services - 2019/22



Persons known to Local Authority / Care and Support services – 2015/18 Thematic Review



Smoke Detection

No smoke detection was found in 4 incidents. This accounts for 11% and is a **decrease** on the previous thematic review where 18% of incidents had no detection. Also, **11%** of incidents had a smoke detector present but it **wasn't functioning**. This is slightly **more** than the last thematic review where 8% of incidents had a detector that failed to operate.

For the year ending March 2024, the national benchmark was 22% for incidents resulting in a fatality, or casualty, where an alarm was not present and 12% where an alarm was present but did not operate.

No smoke detection

4

Incidents (11%)

Non-functioning detection

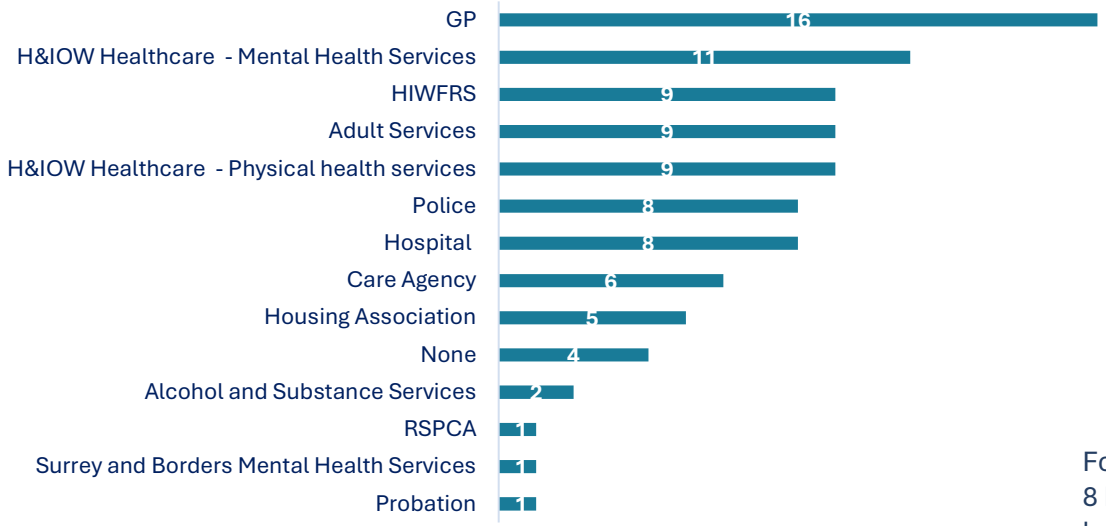
4

Incidents (11%)

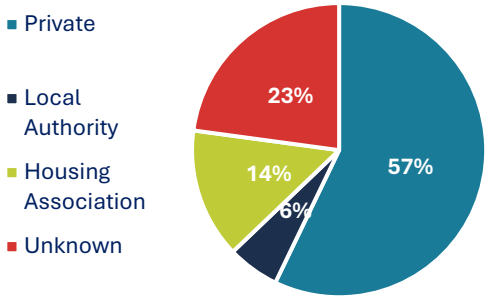
Known to Agency

GP was the most common agency that these individuals were known to, with **16 out of 35 cases.** The second most common was **H&IOW Healthcare – Mental Health Services** with **11 out of 35 cases**, followed by **HIWFRS, Adult Services and H&IOW Healthcare – Physical Health Services, with 9.**

The level of involvement agencies had with the individuals varied greatly – from agencies being actively involved with supporting the individual and having regular contact, to minimal or no direct engagement but the individual being registered with their Service. Data on which agencies knew the individuals is based only on the information available at the time the incident was reviewed at the FSDG.



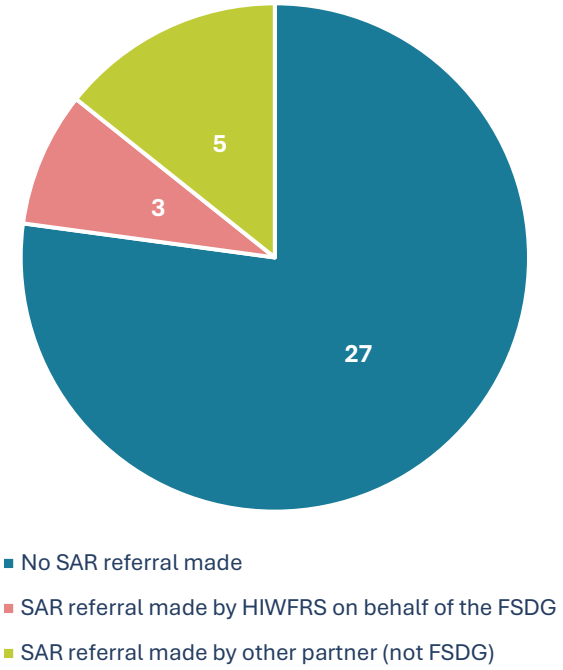
Housing Breakdown



For all the 35 cases, 20 lived in private housing, 8 had an unknown housing situation, followed by 5 who lived in a property owned by a housing association.

Referrals for Safeguarding Adults Reviews

FSDG cases are each considered for a referral to the Local Safeguarding Adults Board for consideration of Safeguarding Adults Review (SAR)



THANK YOU