Resources and Fire and Rescue Overview and Scrutiny Committee

26 September 2019

Warwickshire Fire Deaths January 2018 - December 2018

Recommendation

The Resources and Fire and Rescue Overview and Scrutiny Committee receive and note the contents of this report.

1.0 Key Issues

1.1 Between January and December 2018 Warwickshire Fire and Rescue Service (WFRS) attended 187 accidental or deliberate dwelling fires, six of which had fatal consequences for the occupants of the properties.

N.B. Some of the incident details are very complex and still under investigation by Warwickshire police, therefore this report will only provide generic details of the areas where the fires happened. All names have been removed for confidentiality reasons.

1.2 The increase in fire fatalities in 2018 was in stark contrast to the performance data for previous years which showed that the County had very low numbers of fire related deaths:

2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
1	2	0	3	2	6

1.3 There are many Community and Local Government publications, as well as independent research documents, which demonstrate the beneficial effect that preventative work carried out by fire and rescue services and partners nationally has had in helping to reduce dwelling fires and fire deaths.

1.4 It is acknowledged and recognised by Government that the proactive community fire safety work undertaken by fire and rescue services (FRSs) with local partner agencies has helped to reduce these numbers significantly.

1.5 WFRS take a very proactive approach to its prevention activities and has a broad range of initiatives in progress. This number of fatalities across a twelve-month period is unusual in recent history.

1.6 The fires occurred in separate districts of the County, namely North Warwickshire, Nuneaton and Bedworth, Stratford and Rugby. They occurred at differing times of the day (or night) and the causes varied, meaning that no clear trend or incident pattern is evident. The first fire engine attendance times to all the fires in question were within our current emergency response standard of ten minutes from the initial call being received by Service Control.

1.7 Following each incident the District Commander with responsibility for the area undertook a review of the incident to implement fire safety initiatives relative to the risk and impact, details of which are highlighted and contextualised later in this report.

1.8 Notwithstanding normal day to day business is that all staff in all districts drive forward the importance of fire safety by offering Safe and Well Checks to the most vulnerable in our communities. Our teams will use demographic data to identify higher risk communities and target prevention campaigns, often where high footfall rates will allow high interaction opportunities. In partnership with WCC communications team we promote national, regional and local campaigns using social media and press releases, addressing general or specific fire safety issues. We ensure our staff are visible and approachable in high risk areas; we fit smoke alarms, provide resources and advice where appropriate and work in partnership with other agencies to ensure the most vulnerable of our community are supported to the best of our abilities. All such initiatives are managed, funded and supported by the fire prevention team.

1.9 In all fatal cases, a full fire investigation is undertaken by a specialist Fire Investigation Officer and a report is compiled detailing the cause and origin of the fire. The Fire Investigation Officer is normally required to attend the Coroner's Court and present their findings, which assist the Coroner's Office to determine and understand the cause of death.

1.10 A WFRS Serious Fire Incident Review (SFIR) meeting is also undertaken with partner agencies, such as adult social care, Warwickshire Police, individual case workers and drugs and alcohol teams. Any actions discussed or identified are then fed into the place-based partnership teams. Across all the SFIRs conducted for 2018, the conclusions highlighted that in almost all circumstances, communication and data sharing between the teams was vital. This is reflected in the County Council ICT / data development plans.

2.0 Details of the individual incidents are listed below:

2.1

Address	North Warwickshire
Name	Male N/A (Deceased as a result of the fire).
DOB or AGE	Believed to be age 60
Date of Incident	23.06.18
Incident Number	0007394
Time of Call	17:27 hrs

Incident Summary

2.2 The incident occurred in a modern construction mid-terraced domestic premises. On arrival there were no external signs of fire. Whilst a crew donned breathing apparatus, another crew without breathing apparatus broke into the premises via the back door and made their way through the property and up the stairs to the first floor, to undertake a quick check of the property. It was at the top of the stairs when the crew first encountered smoke. The occupier was in a first-floor bedroom. The occupant was on the bedroom floor, covered in a blanket, adjacent to the bed. The breathing apparatus crew then carried the occupant downstairs and passed him through the lounge window to a crew outside who then commenced Cardiopulmonary Resuscitation (CPR). The cause of death for the occupant was carbon monoxide poisoning and smoke inhalation from fire.

Previous Knowledge & Vulnerabilities

2.3 The Community Fire Safety (CFS) Department had information provided to them after a Safe & Well visit to this address. This was initiated after crews were called to a kitchen fire at the property. Due to the nature of the individual concerned a Home Fire Safety Check (HFSC) was carried out by Community Safety Officers (CSOs) in the prevention team.

2.4 A 10-year smoke detector was installed by WFRS and advice provided by the CFOs. Neighbours confirmed this actuated two hours before the call but no early 999 call to the emergency services was placed; after two hours neighbours rang the Police on 101 who then called the Fire Service.

Actions

2.5 WFRS personnel carried out hot strikes* in the local vicinity following the fatality to ensure the local community were reassured and had the best advice available.

2.6 **Hot strikes are where the local fire crews visit properties door to door directly after a serious or fatal incident, dropping leaflets and offering immediate intervention and advice to those in the immediate vicinity.*

2.7 The Station Commander in charge of Nuneaton carried out a radio interview with a local media channel and used this opportunity to promote the importance of fire safety in the home.

Conclusions

2.8 This is a tragic incident due to the personal circumstances, health and lifestyle of the gentleman.

2.9 He was a heavy drinker, smoker and was prescribed medications for depression. A combination of all these may have resulted in the individual falling asleep whilst smoking. Ultimately this led to his death. WFRS had provided advice, smoke detection equipment and recorded all the details. They also advised him to see a GP for further depression support.

2.10 WFRS/ CFS teams could have registered the visit via the Multi Agency Safeguarding Hub (MASH) but felt the intervention provided was adequate and ensured that the gentleman was "on the radar" of all the other supporting agencies, for further intervention and support.

2.11 A further visit was arranged to reassess his personal circumstances, but no access or contact was achieved despite numerous attempts.

2.12 A serious fire incident review (SFIR) has been conducted for this incident. The actions arising from the SFIR for both Fire & other partners highlighted the inappropriate use of the 101 number and the need for WFRS to revisit the level of community work with known drug or alcohol users.

3.0

Address	Nuneaton and Bedworth district
Name	Male N/A
DOB or AGE	78 Years old
Date of Incident	17.07.18
Incident Number	008872
Time of Call	18:22 hrs

Incident Summary

3.1 Male with dementia, had accidently left an old-fashioned style chip pan on the cooker. This was left unattended when he went back into the front room (lounge) to watch television and forgot about the chip pan. He then went back into the kitchen to switch the cooker off when he discovered the smoke coming from the chip pan. He also went looking for his dog, taking in some smoke before being led out by the neighbours. Fire crews administered first aid until the ambulance arrived.

3.2 The Station Commander (SC) arrived as the gentleman was being transferred to hospital. There were no reported complications at the incident and the gentleman was talking coherently in the back of the ambulance. He was only taken to hospital as a precautionary measure by the ambulance crews.

3.3 Neighbours reported back to crews approximately two hours after being taken to hospital that the gentleman was doing well and was ok.

3.4 The duty Group Commander received a letter from the County Coroner 8-9 days post incident to state the gentleman had passed away and requested the details of the incident. The Station Commander who attended the scene forwarded those details on immediately.

Previous Knowledge & Vulnerabilities

3.5 WFRS held no knowledge of this gentleman, and no HFSC or Safe &Well (S&W) had been carried out prior to the accidental fire.

Actions

3.6 S&W checks offered to the local community. No media or radio interviews as this was not known to be a fire death until the Coroner's letter arrived. CFS were not informed of the incident and are not generally notified where no injury or death had occurred, which was believed to be the case by attending crews.

3.7 Actions for partners and WFRS have been produced on completion of the SFIR. This has now been captured and fed into the overarching action plan, which in turn is fed into the MASH and place-based partnership teams.

Conclusions

3.8 Post fire death; the gentleman's death was recorded as fatal injury as a result of the smoke inhalation. The time elapsed before he passed away from the actual incident is not known, but likely to be less than one week due to the postage of the letter and Coroner's request for information.

3.9 A SFIR will be conducted for this incident as it is classed as a fire death. CFS teams are liaising with the local MASH to gather information and to ascertain the delay in informing the Fire Service of the death. Partners have been invited to comment and to date no information has been received.

4.0

Address	Stratford district
Name	Female N/A
DOB or AGE	48 Years old
Date of Incident	01.11.18
Incident Number	014508
Time of Call	21.08 hrs

Incident Summary

4.1 Fire in a touring caravan (with a large awning fitted) sited at a touring site in the Stratford district.

4.2 CCTV evidence supported the conclusions drawn by the Fire Investigators. The fire is most likely accidental and believed to have started from drying clothes inside the awning on a gas fire. Clothes then fell or caught light and spread the fire through the extremely cluttered awning. The deceased was under the influence of alcohol in the caravan and was in a seated position. Either she did not wake due to the alcohol consumed or she was overcome by the smoke.

The suspicion of alcohol consumption has been confirmed by a previous telephone conversation to the Police by other caravan site occupants and voice recordings of the occupant discussing an earlier dispute with her partner. The lady's partner was in the local pub at the time of the fire and not on the scene.

4.3 All evidence supports this conclusion; even though there is a history of alleged arson related crime against the partner this is not believed to be a factor for this incident. A SFIR has not taken place for this incident, due to the nature of the fire and CCTV evidence that supported the Fire Investigation Officers opinion of the event.

Previous Knowledge & Vulnerabilities

4.4 Well known to Arson Reduction and Police for previous arson convictions, threats by fire setting and other offences. A Housing association evicted the couple a few months previously and all updates via the MASH from that point on were lost due to them moving location.

Actions

4.5 Immediate action was taken by the Duty SC and the district SC to task Gaydon Fire Station to lead an initiative to target caravan parks in the district. Alcester were also asked to deliver caravan fire safety leaflets to other surrounding parks outside of their normal district. The district Station Commander is supporting and co-ordinating this initiative.

4.6 Alcester Station will report their activities to the district SC with a focus on carrying out a S&W check at each occupied caravan they find, unfortunately a low level of uptake has been reported so far, but crews will persist with their efforts.

4.7 From March 2019 the district SC will ensure this is a yearly objective to complete across the summer months. The plan, which also covers the Stratford district reflects this approach.

Conclusions

4.8 We have received no confirmation that the Police have finished investigating this case. There are some complications to this incident, involving other crime related suspicions and potential criminal offences.

WFRS did know about the individuals concerned and monitored their previous address, until the individuals relocated following a housing association eviction. Unfortunately, we then lost track of them as they adopted a pattern of itinerant living in touring caravans at sites across Warwickshire.

4.9 A SFIR has not taken place for this incident, due to the nature of the fire and CCTV evidence that supported the event.

5.0

Address	Nuneaton and Bedworth district
Name	Female N/A
DOB or AGE	82 years
Date of Incident	02.11.18
Incident Number	014519
Time of Call	05.30 hrs

Incident Summary

5.1 Persons reported (turn out sheet information- house fire, black smoke from top front bedroom, bedridden lady).

5.2 Note: -This was the third fire call to this address over a two-year period. It is important to note the checks in homes and for individuals changed from HFSC to S&W during the second and third incident to incorporate the wider health agenda work we have adopted.

5.3 First incident - 02.9.16 - 08:34 hours – one casualty rescued and treated by ambulance for smoke inhalation. The cause of the fire was smoking in bed. An elderly man (husband) was escorted from property with no effects from smoke. A Home Fire Safety Check (now called Safe & Well) was carried out and smoke detectors fitted. Advice was given around smoking in bed, smoking cessation, smoke alarms and general fire safety.

5.4 Second incident - 04.6.17 - 15:00 hours – one casualty rescued and taken to hospital with severe burns to her legs and side. The cause of fire was smoking in bed.

5.5 A S&W was carried out with fire retardant sheets and duvet provided. Smoking cessation advice was given but refused by the occupant. The woman was bedridden and widowed, so confirmed as a single occupancy. Further smoke detection fitted, and the occupant received daily care.

5.6 The cause of the third incident on 02.11.18 was the occupant smoking in bed. The fire investigation officer is certain that due to her heavy smoking habit and the previous history associated with this person, that this was the cause of the fire.

5.7 The occupant was bedridden on an electric bed with an air mattress fitted. She did have fire retardant duvets and fire-retardant sheets (provided by WFRS) however if uncovered the air mattress burned readily under test. It is suspected that she fell asleep whilst smoking or dropped a cigarette on the exposed air mattress / bed which led to the fire and her death.

5.8 Warwickshire Police hold CCTV footage which supports this supposition, though it is not available for wider viewing.

5.9 The occupant had received several ongoing visits from the Fire Service regarding prevention, wellbeing advice and S&W checks. The Fire Service had fitted smoke detection in each room apart from the room she was in due to the heavy smoking habit.

Previous Knowledge & Vulnerabilities

5.10 The occupant was known to all agencies because of her health-related problems and she received visits from carers daily. No 'official' cause of death has been confirmed by the coroner to date. WFRS prevention department have provided advice and equipment to support the local risk area.

Actions

5.11 WFRS Prevention department started a process to gather information regarding previous history. Compiled and completed on 20.11.18.

5.12 Nuneaton district SC immediately started a hot strike; leafleting at Asda and Tesco's in Bedworth and Nuneaton and other areas of high footfall in the risk area. Initial local media release and further social media releases took place when the time was right to reinforce messages around fire safety. This was implemented with immediate effect on the 2/11/2018.

Conclusions

5.13 Actions for partners and WFRS have been produced on completion of the SFIR. This has now been captured and fed into the overarching action plan which in turn is fed into the MASH and place-based partnership teams.

5.14 It is known from previous case studies, that certain emollient creams used for bedridden patients can accelerate fires if used in households where there are enhanced smoking risks (although emollient cream was not the case in this circumstance, they are used readily with air mattresses). However, this type of mattress, when exposed to a naked flame or heat source, will still burn readily. Discussions are ongoing with partners on how best to flag when and where this type of mattress is fitted and the patient is a bedridden smoker, so appropriate action can be taken.

6.0

Address	Rugby district
Name	Male N/A
DOB	Unknown – aged 5
Date of Incident	15.11.18
Incident Number	15174
Time of Call	02:48 hrs

Incident Summary

6.1 WFRS Fire Control received a 999 call to this incident from the Police. Calls were also received from residents in the same street. Upon arrival the house was completely involved in an intense fire due to conditions within the house and fire loading.

6.2 There were four people in the property, some of whom received severe burns. Casualties in the property were confirmed to be located at a residence opposite, and under the initial care of the Police due to severe burns. On arrival of the ambulance service, they took over the care of the casualties from the two Police officers who were providing emergency first aid using WFRS trauma packs.

6.3 One of the occupants of the house was a 5-year-old child and was being treated by Police and Ambulance staff and was subject to an estimated 90-95% burns, his injuries were extensive. Unfortunately, he passed away approximately 4 months post incident in the hospital burns unit.

6.4 It is believed that another of the occupants was the mother of the child and approximately 28 years old. Anecdotal evidence suggests she was a smoker. This injured party was subject to approximately 30-40% burns to legs and lower torso. The details are recorded in this report as this is classed as a serious fire injury and to provide some additional substance to the fire death.

6.5 The fire was deliberately ignited. This has been independently confirmed by fire investigation officers, a forensic specialist from Prometheus forensics (appointed by the Police) and a specialist fire investigation dog that identifies accelerants (hydrocarbons).

Previous knowledge & Vulnerabilities

6.6 Known to all agencies, due to the complex nature of this case no further information can be provided at this stage.

Actions

6.7 This is a complex and harrowing case where firefighters and officers have been involved in Police investigations and have provided statements. We do not have all the details at present. This case is now a fire death but subject to a wider Police investigation and Coroners inquiry. The SFIR will take place upon completion of any court cases.

NB. Currently under Police control due to the sensitivities around this incident hence the limited detail provided.

7.0

Address	Nuneaton and Bedworth district
Name	Male N/A
DOB	87 years old
Date of Incident	29.11.18
Incident Number	15782
Time of Call	14.24 hrs

Incident Summary

7.1 Fatal fire - on arrival crews found an elderly gentleman deceased. Burns to the gentleman initially suggested he had died as a result of the fire; however, toxicology reports have proved that he died of a heart attack pre fire.

7.2 At approximately 11.00 hours on the 29.11.2018 the occupant activated his care line; a family member responded and found him ok. They recalled care line and reset the care line alarm. He was bedridden and had daily carers.

7.3 At approximately 14.20 hours crews were notified of a house fire. On arrival the occupant was found deceased in his bed with approximately 10% burns to his body, burns to the bed and floor.

7.4 He was a heavy smoker. A fire investigation has taken place, details from that investigation suggest that a cigarette started the fire, therefore the initial findings suggested this was WFRS third smoking related fire death, however since then it has now been confirmed by the Coroner as a pre fire death. The fire was a result of the owner passing away from a heart attack and dropping the cigarette which then led to the fire.

Previous Knowledge & Vulnerabilities

7.5 No previous knowledge to the fire and rescue services, however he was on the ASC profile on firm step. Discussions are ongoing with partners on how best to flag bedridden vulnerable people who are heavy smokers to the Fire and Rescue Service so we can take appropriate action.

7.6 Progress is being made to ensure vulnerability / risk data is safely shared with all essential partners. A meeting took place on 3/12/2018 to enable sharing data more widely with WFRS via the MOSAIC system. Action plans have been developed and implemented to address these issues, Good progress is being made to ensure data protective security arrangements are in place to enable such data to be safely shared and compliant with General Data Protection Regulations.

7.7 Main vulnerabilities unidentified to WFRS were: bedridden in a downstairs room, heavy smoker and elderly. Again, the gentleman lived alone with a carer attending daily.

Actions

7.8 Pop up banners located in prominent areas. Hot strike, press release produced for councillors, press release for general public drafted and approved. A SFIR would have taken place if the coroner had not confirmed this was a pre-fire death.

7.9 Presentation developed by Group Commander Sargent and delivered to the Safeguarding Board on what to look for in a property (called advice for carers). This is also on the safeguarding website. Wallet size cards have been produced by Prevention, giving advice for carers, telephone numbers, referral emails and other useful advice; this will enhance carers knowledge. These have been shared to the safeguarding board for distribution to partner agencies.

7.10 Age Concern UK; have also expressed an interest in fire providing additional training to their carers which we will support.

Conclusions

7.11 Unfortunately the gentleman passed away as a result of a heart attack prior to the fire. As this was not a fire death any direct preventative actions on fire safety would have not assisted with changing the tragic outcome; however, further opportunities are being explored to work with partner agencies, to better understand the 'up-stream' causal factors behind fire deaths and injuries.

8.0 Areas of concern which span across the cases

The following areas of concern were highlighted within the reports: -

- All the casualties possessed or lived in potentially vulnerable circumstances.

- Some of the casualties were trapped and unable to self-rescue, due to either mobility issues and/or the effects of alcohol/drugs.
- Some of the casualties lived in council, district, and borough or housing association properties.

- All but one of the properties had smoke detection facilities which were not linked or monitored. It is believed one also had CCTV linked to relatives /carers, but this was not working as effectively as it should have been.

- Four of the casualties were known to be heavy smokers, two of which were bedridden and had daily carers.

- Five casualties suffered with some form of ill-health including mental illness.

- Two properties had received a Home Fire Safety Check (HFSC). One of which had fire prevention intervention to support the needs of the individual occupant; however, the prevention resources provided were not being used or utilised effectively.

9.0 Following each of the six fatal fires, immediate action was taken at all the locations to raise awareness and to provide guidance and resources to the local community about fire prevention. Where applicable Safe & Well checks were carried out providing fire prevention resources such as fire-retardant sheets, smoke alarms and guidance materials. WFRS completed 5933 Safe & Well checks in 2018/19.

10.0 It is recognised that our MOSAIC system could be used more effectively to share risk data across County Council and with partners.

10.1 MOSAIC provides WFRS and MOSAIC users with enhanced data sharing capabilities on the most vulnerable in our society. It allows us to target even more robust preventative measures to reduce the risk of serious injury or death.

10.2 As part of the wider WCC ICT data sharing project, the MOSAIC tool is being enhanced further to allow system integration allowing effective data sharing between all partners. Providing all partners with the opportunity to widely share identified risks and information will enable speedy and appropriate action to be taken, with the overarching aim of reducing the overall risk.

11.0 Proposals

11.1 1. WFRS will continue to use the MOSAIC system under current working arrangements for data sharing. As aforementioned, a number of system and functional improvements have been identified that will optimise data sharing between key partners. This will further enhance the vital need for continued cross checking / uploading of files to the system for all partner's awareness and in turn allowing WFRS key staff the ability to cross check names and ensure appropriate timely action is taken.

11.2 MOSAIC wider data sharing will continue to be role based and limited to eight WFRS Prevention staff to cross check data against names from the Insight Service list forwarded for assessment. This is for confidentiality and control purposes.

11.3 WFRS will produce our visit record, along with any identified concerns, which will be uploaded into MOSAIC providing reassurance, cross checking of data and safe systems of work for WFRS and partners attending properties and support efficient enhanced data sharing where appropriate (in line with WCCs data sharing and system integration project).

11.4 2. Scope full or partial collaboration with WCC's Community safety department at a shared location suitable to house all prevention partners.

11.5 Develop the relationship further with WCC's Community safety teams and partners to allow WFRS Prevention teams to have direct links to community safety issues and vice versa; this would encompass road safety, fire prevention, trading standards and education services, giving a wider opportunity to share learning, resources and bridge any gaps and aid communication between teams immensely.

11.6 With a longer-term vision to build a Safer Warwickshire hub, where prevention advice, specifically designed scenarios, coaching and mentoring for all aspect of prevention work can take place. West Midlands Fire Service and Gloucestershire Fire and Rescue Service have excellent examples of this already in place.

See link for more detail https://www.safeside.org.uk/

11.7 3. Continue to build on the enhanced Safe and Well checks carried out by fire prevention teams, as wider data and analysis is collated WFRS will be able to develop our Safe and Well check to meet trends.

11.8 Our Safe and Well check and referral process is being evaluated by our health and wellbeing advisor and the results will provide beneficial and informative data sets, enabling us to build on the current advice provided, our existing frailty pathway, and collaborate more effectively with other partners.

11.9 With a longer-term vision to integrate systems between partners as the wider WCC IT data sharing project is implemented, therefore ultimately efficiently resourcing and reassuring those who need it most in our community.

12.0 Financial Implications

12.1 This section of the report is for information however there is dependency based on the venue selected to house a collaborative team. Currently we are unable to provide an estimate, although it is unlikely there will be any cost implications if the venue chosen is a WCC owned premises. If not, then funding will need to be identified from within WCC's existing budget to meet the costs of an appropriate venue and team operation.

12.2 Campaign costs for property fires are included in our day to day business.

13.0 Timescales associated with the decision and next steps

13.1 This section of the report is for information however if the proposals are supported then, following further discussions, work to identify a suitable venue will progress with immediate effect. We have already started to scope out some potential buildings that might be suitable.

13.2 It is estimated that to fully collaborate teams would take some time; it is likely this could be achieved within twelve months providing a suitable venue can be found. Immediate direction to collaborate would be needed to drive forward the change.

Background papers

No supporting background papers for this report.

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The report was circulated to the following members prior to publication:

Local Member(s): none
Other members: none