4LSAB Fire Safety Development Group
Thematic Review 2019-2021
September 2022

Together We Make Life Safer

HAMPSHIRE & ISLE OF WIGHT FIRE & RESCUE SERVICE

Hampshire & Isle of Wight FIRE & RESCUE SERVICE

FSDG Fire Fatalities and Injury Analysis

Hampshire & Isle of Wight FIRE & RESCUE SERVICE

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 39 fire incidents which were reviewed by the FSDG between 1st January 2019 and 31st December 2021.
- 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 the previous thematic review of fire related fatalities and injuries which was conducted on data from 2015-18, 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 injuries that HIWFRS attended over the period. The FSDG review includes confirmed, or initially thought to be, serious injuries and/or incidents where there is an indication partner agencies were involved with the individual(s). Therefore the figures may appear lower than expected at first sight. For queries on fire casualties more widely please contact organisational.performance@hantsfire.gov.uk

Highlights (1)

- **39 incidents have been analysed** which were reviewed by the 4LSAB Fire Safety Development Group between January 2019 and December 2021; **21 fatalities, and 18 injuries**. Of the 21 fatalities, **not all were confirmed as fire deaths**, with **7 awaiting coroners reports** (at time of this review being completed), **2 non fire death incidents and 1 suicide** (see slide 5).

- Within the review, an individual with **care and support needs was the most common vulnerability and risk factor** identified (79% of all incidents). This was followed by **smoking** (64%) and in **receipt of care and support services** (56%) (see slide 6).

- **Multiple ignition sources, dementia and poor electrical safety, appear to be the most severe** vulnerabilities and risk factors as incidents involving these all resulted in a fatality (however consideration needs to be given to low numbers – see slide 7).

- When viewing multiple risk and vulnerability factors, **89% of individuals who had evidence of previous fires were also in receipt of care and support services** (see slide 9).

- **For incident types, smoking was the most common** with **16 incidents** being attributed to **carelessness with smoking materials**. This is followed by **deliberate acts with 6 incidents** (see slide 10).

- For prevalence in local authorities, **Hampshire and the IOW had a lower percentage of incidents compared to population**, where as Southampton and Portsmouth had more (see slide 11).

Highlights (2)

- The **majority of incidents occurred to individuals who were living alone** (88%). 2 incidents involved individuals who were not living alone and 2 involved homeless individuals (and for 7 incidents whether the individual lived alone or not was undetermined) (see slide 13).

- The **51 to 65 age range had the highest number of incidents**. The percentage of incidents in this age range has increased by 12% compared to the previous thematic review (see slide 14).

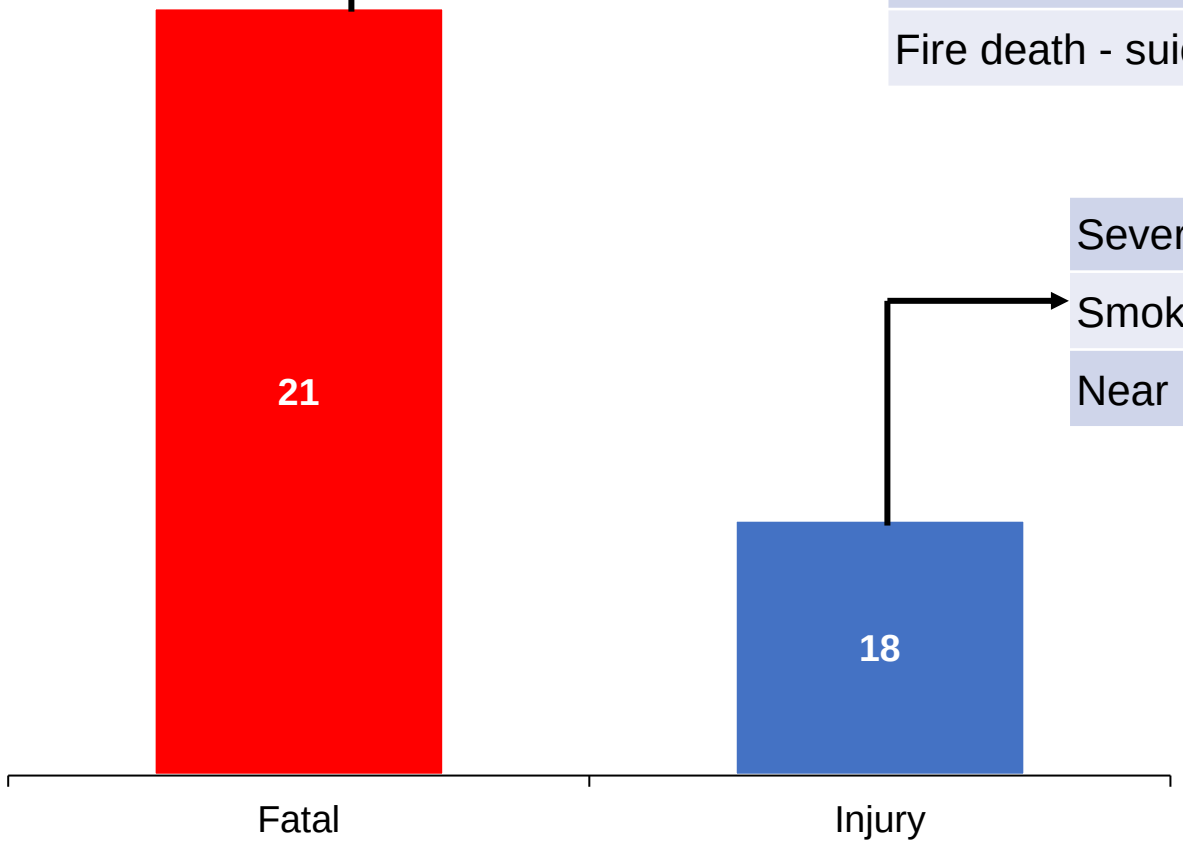
- When comparing incidents to age groups (grouped by 10 years), **50 to 59 year olds had 10% more incidents when compared to the Hampshire and Isle of Wight population for that age group**, indicating this is the highest risk age group to experience a fatality and casualty (see slide 14).

- **56% of cases involved an individual who were in receipt of care and support services**, in comparison to the previous thematic review where 61% of the individuals were in receipt of care and support services (see slide 15).

- **No smoke detection was identified in 7 incidents**. This accounts for 18%, and is an increase on the previous thematic review where 11% of incidents had no smoke detection. 8% of incidents in the current review had a non functioning smoke detector present (see slide 17).

- **Adult Services** were the **most common agency** that these **individuals were known to**, with 27 out of the 39 cases (69%). The second most common was HIWFRS, with 19 out of 39 cases (49%), followed by Police (46%). 4 cases out of the 39 were not known to an agency (see slide 18).

Fire Fatalities and Injuries – Totals



Fire Death	11
Awaiting coroners	7
Not a fire death	2
Fire death - suicide	1

Severe burns	10
Smoke inhalation	5
Near misses	3

Out of the total of 39 incidents recorded since the beginning of 2019, **21 were fatalities** and **18 resulted in injury.**

However, not all fatal incidents are confirmed fire fatalities as the Fire Investigation team are still awaiting coroners outcomes on 7 incidents.

The below table shows total incidents by local authority.

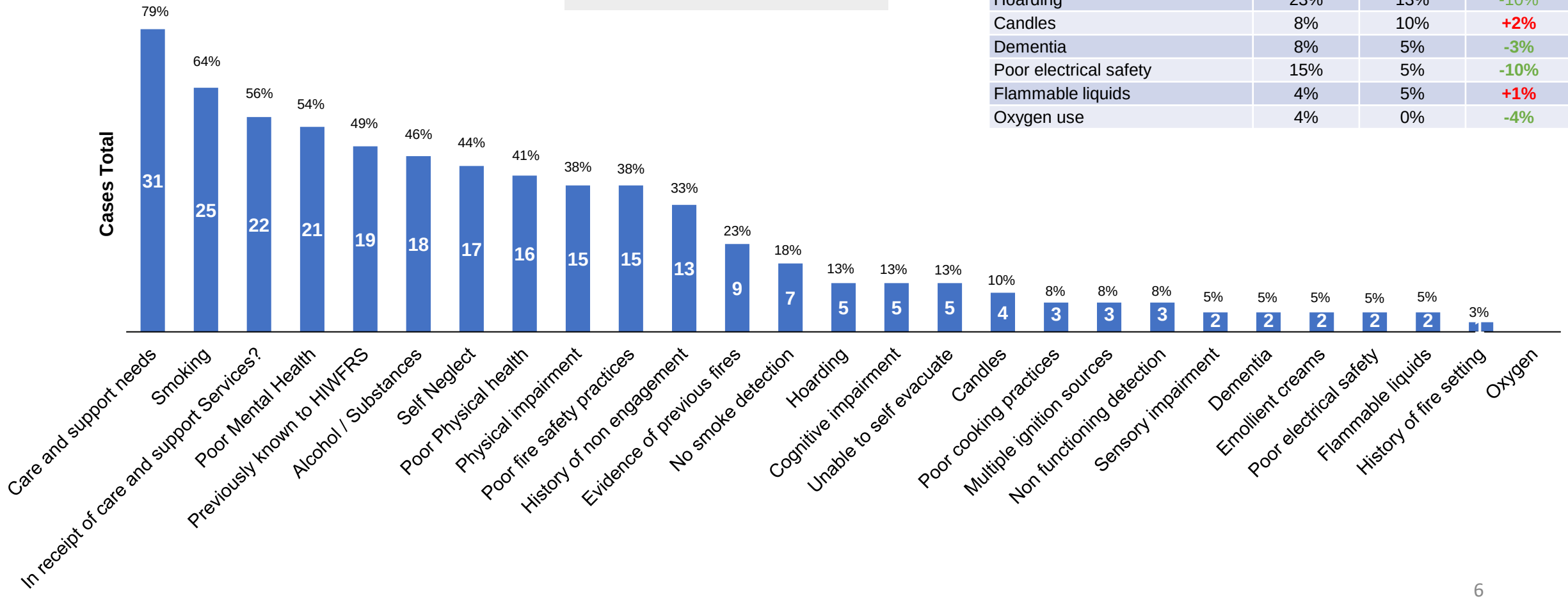
Local Authority	Total Incidents	Total Incidents %	Total Fatal	Total Injuries
Hampshire	21	**54%**	13	8
Southampton	9	**23%**	3	6
Portsmouth	7	**18%**	3	4
IOW	2	**5%**	1	1

Vulnerability and Risk Factors

Care and support needs was the **most common risk factor** relating to individuals within the review (79% of all incidents). This is followed by **smoking** (64%) and **in receipt of care and support services** (56%).

Smoking, poor mental health, alcohol/substances and poor mobility/physical impairment have all seen significant **increases** compared to the previous thematic review.

Vulnerability and Risk Factors	2015/18 Thematic Review	Current Review	Change (% pts)
Smoking	46%	64%	+18%
Poor mental health	26%	54%	+28%
Alcohol/Substances	23%	46%	+23%
Poor mobility/Physical impairment	11%	38%	+27%
Hoarding	23%	13%	-10%
Candles	8%	10%	+2%
Dementia	8%	5%	-3%
Poor electrical safety	15%	5%	-10%
Flammable liquids	4%	5%	+1%
Oxygen use	4%	0%	-4%



Vulnerability and Risk Factors by Injury Type

Risk Factor	Fatal	Injury	Total	Fatal %	Injury %
Multiple ignition sources	3	0	3	100%	0%
Dementia	2	0	2	100%	0%
Poor electrical safety	2	0	2	100%	0%
Cognitive impairment	4	1	5	80%	20%
Poor fire safety practices	11	4	15	73%	27%
No smoke detection	5	2	7	71%	29%
History of non engagement	9	4	13	69%	31%
Poor Physical health	10	6	16	63%	38%
Poor cooking practices	2	1	3	67%	33%
Non functioning detection	2	1	3	67%	33%
Care needs?	18	13	31	58%	42%
Physical impairment	9	6	15	60%	40%
Hoarding	3	2	5	60%	40%
In receipt of care and support Services?	12	10	22	55%	45%
Smoking	13	12	25	52%	48%
Alcohol / Substances	9	9	18	50%	50%
Self Neglect	9	8	17	53%	47%
Previously known to HIWFRS	10	9	19	53%	47%
Poor Mental Health	10	11	21	48%	52%
Sensory impairment	1	1	2	50%	50%
Emollient creams	1	1	2	50%	50%
Flammable liquids	1	1	2	50%	50%
Evidence of previous fires	4	5	9	44%	56%
Unable to self evacuate	2	3	5	40%	60%
Candles	1	3	4	25%	75%
History of fire setting	0	1	1	0%	100%
Oxygen	0	0	0	-	-

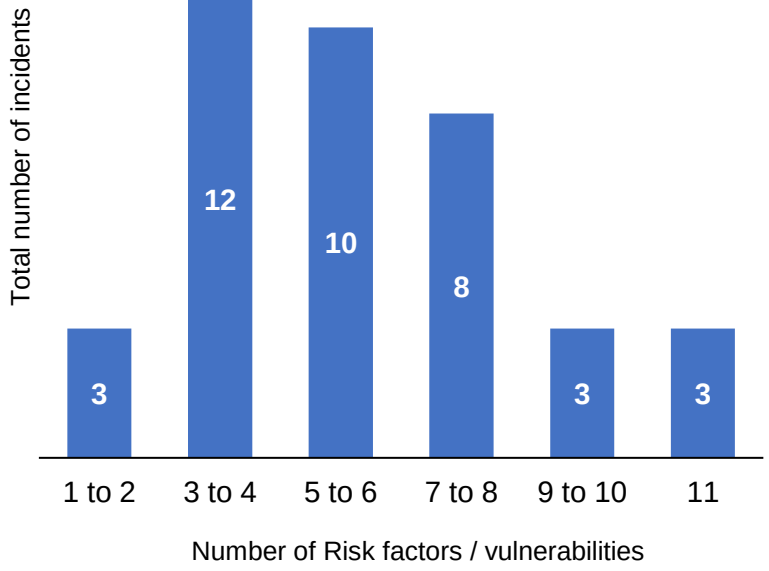
When analysing vulnerability and risk factors by severity, **multiple ignition sources, dementia and poor electrical safety** all resulted in fatalities. Consideration needs to be given to low incident numbers but the table provides an indication of the more serious vulnerability and risk factors when compared to others.

However care needs, smoking, receipt of care and support services, poor fire safety practices, previously known to HIWFRS and poor mental and physical health all had higher volumes of fatalities overall compared to other risk factors.

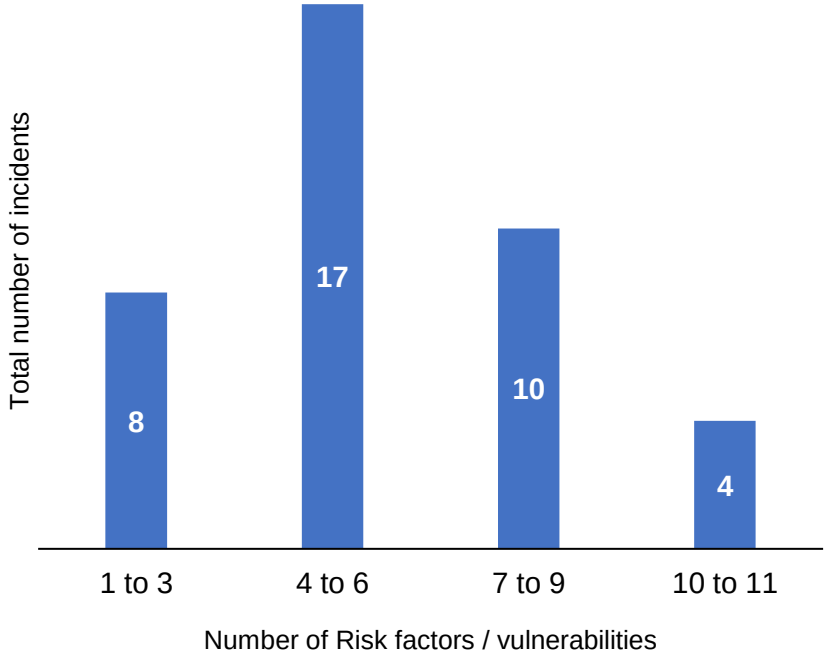
Number of risk factors / vulnerabilities by incident

Case Number	Risk factors / vulnerabilities
Case 1	7
Case 2	4
Case 3	5
Case 4	11
Case 5	1
Case 6	9
Case 7	6
Case 8	7
Case 9	N/A (not fire related)
Case 10	10
Case 11	4
Case 12	4
Case 13	4
Case 14	2
Case 15	3
Case 16	3
Case 17	8
Case 18	7
Case 19	8
Case 20	4
Case 21	6
Case 22	6
Case 23	4
Case 24	5
Case 25	9
Case 26	8
Case 27	6
Case 28	5
Case 29	4
Case 30	2
Case 31	8
Case 32	11
Case 33	11
Case 34	5
Case 35	6
Case 36	3
Case 37	3
Case 38	3
Case 39	6
Case 40	8

Totals incidents by risk factors – grouped into 2's:



Totals incidents by risk factors – grouped into 3's:



When viewing total number of incidents by number of risk factors/vulnerabilities grouped into 2's, the most incidents (12) had 3 to 4 risk factors associated with those individuals, followed by 10 incidents with 5 to 6 risk factors. When grouped by 3, the most incidents occurred with individuals who had 4 to 6 associated risk factors (17 incidents).

Multiple Risk Factors

89% **Of individuals who had evidence of previous fires** were also in **receipt of care and support services**
(Evidence of previous fires – 9, in receipt of care and support needs – 8)

→ Of these 8, 7 were previously known to HIWFRS

80% Of individuals where **hoarding was present,** also had **alcohol/substances as a risk factor**
(Hoarding – 5 incidents, alcohol/substances – 4 incidents)

72% Of individuals who had **alcohol/substances** as a risk factor also had smoking as a risk factor
(Alcohol/substances – 18, smoking – 13)

60% Of individuals where **hoarding was present, smoking** was also a risk factor
(Hoarding – 5, Smoking – 3)

43% Of the cases where there was no smoke detection present were also in receipt of care and support services
(No smoke detection – 7, in receipt of care and support services – 3)

59% Of individuals in **receipt of care and support services were** also **previously known to HIWFRS**
(In receipt of care and support services – 22, previously known to HIWFRS – 13)

→ Protective factor

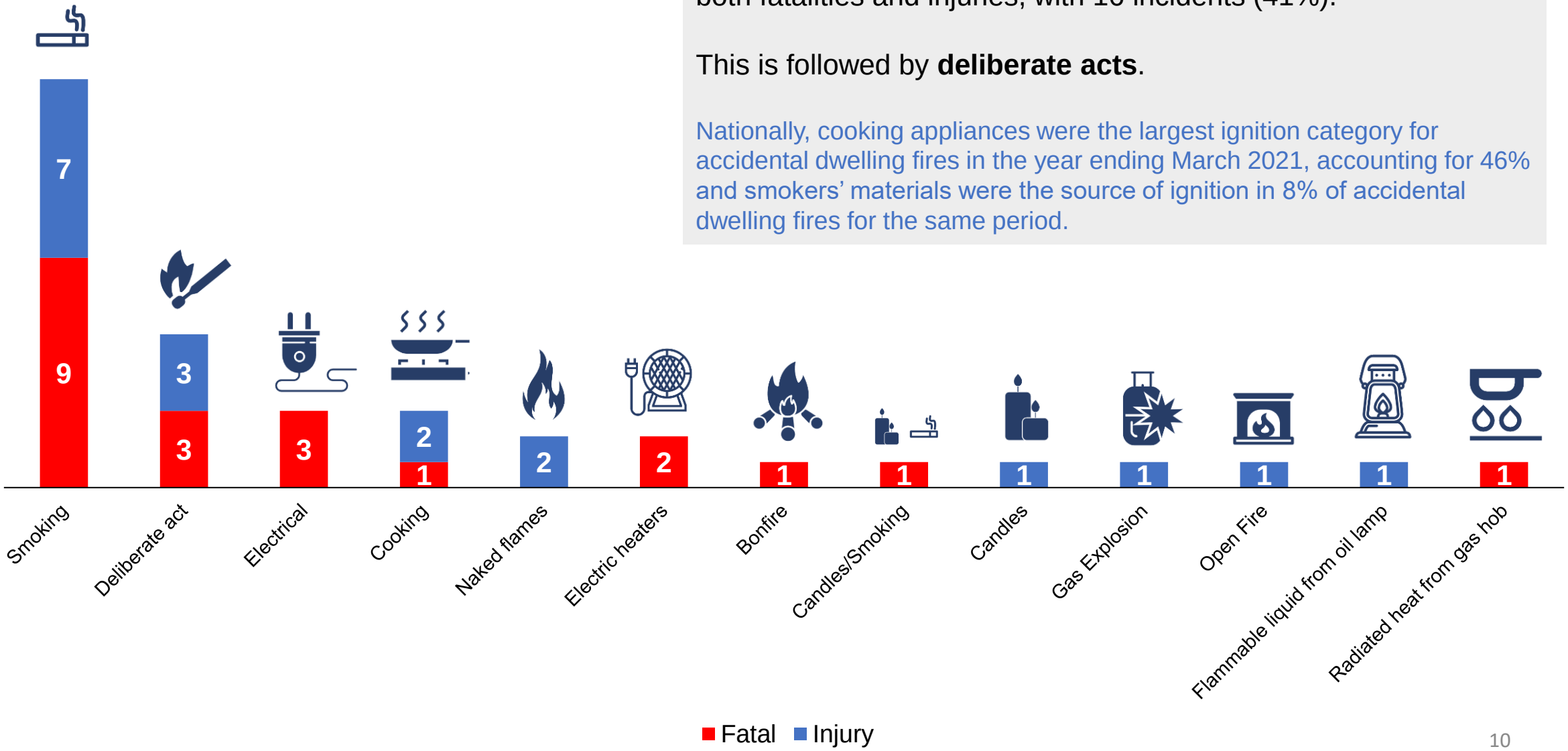
When viewing multiple risk factors, it is evident that some risk factors are more common with each other.

Fire Causes

Smoking related incidents were the **most common** type amongst both fatalities and injuries, with 16 incidents (41%).

This is followed by **deliberate acts**.

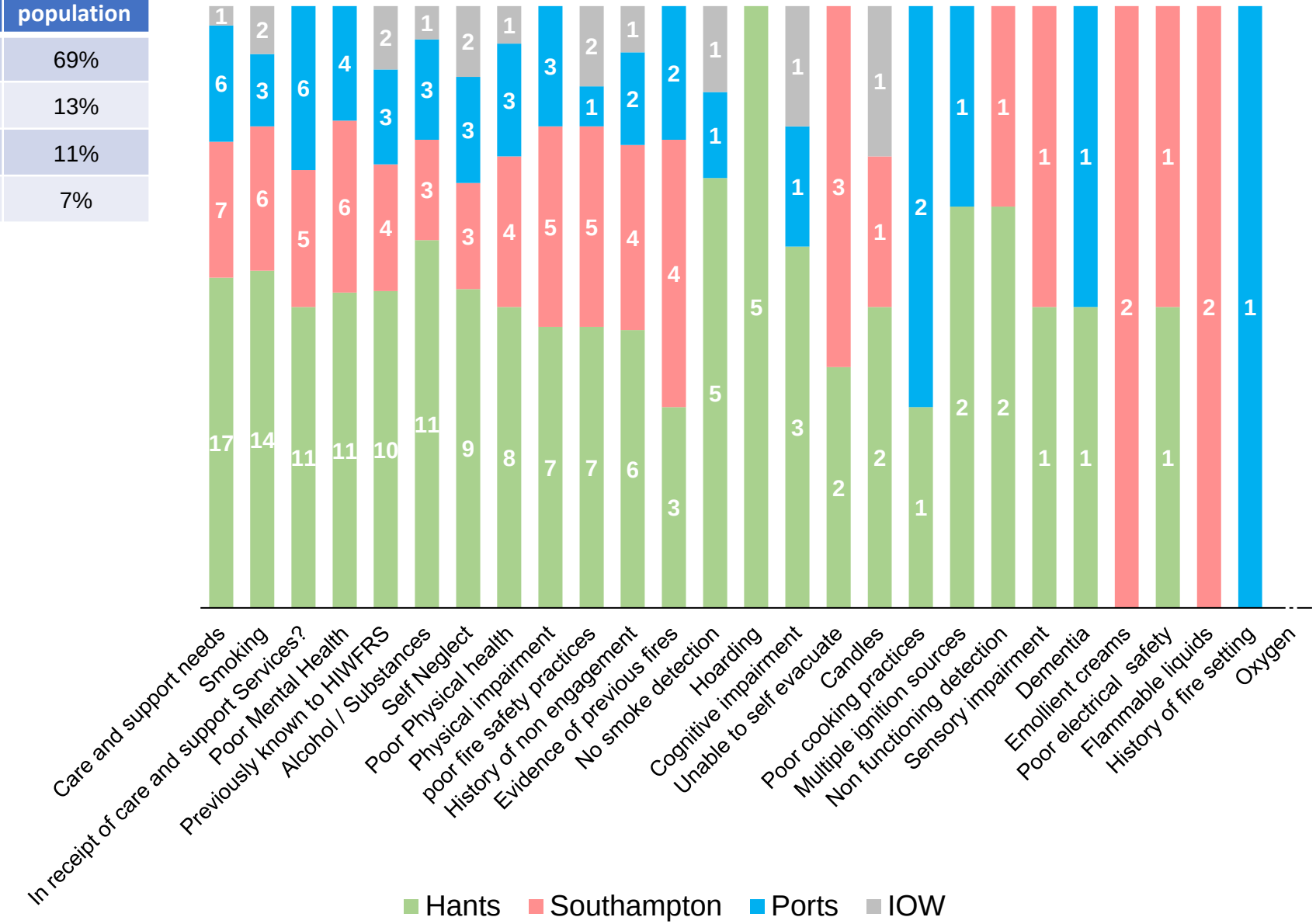
Nationally, cooking appliances were the largest ignition category for accidental dwelling fires in the year ending March 2021, accounting for 46% and smokers' materials were the source of ignition in 8% of accidental dwelling fires for the same period.



Vulnerability and Risk Factors per Local Authority

Local Authority	Total Incidents	Total Incidents %	Population estimate	% of population
Hampshire	21	**54%**	1.4m	69%
Southampton	9	**23%**	260k	13%
Portsmouth	7	**18%**	213k	11%
IOW	2	**5%**	140k	7%

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

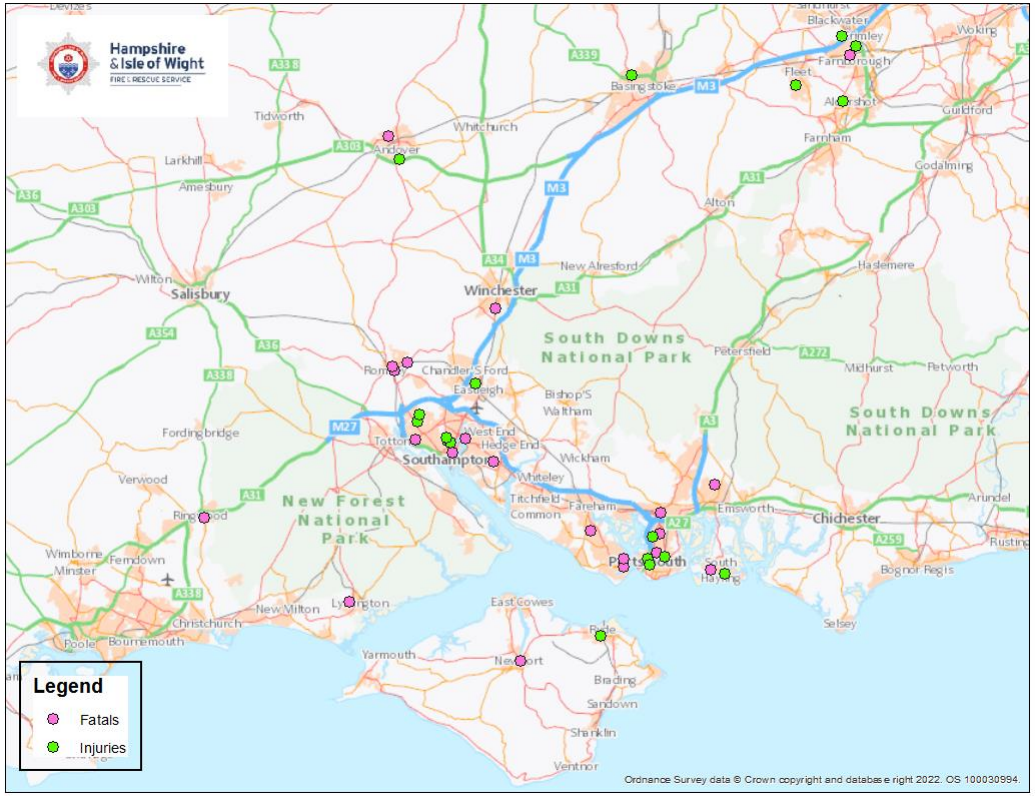


Source for population data:

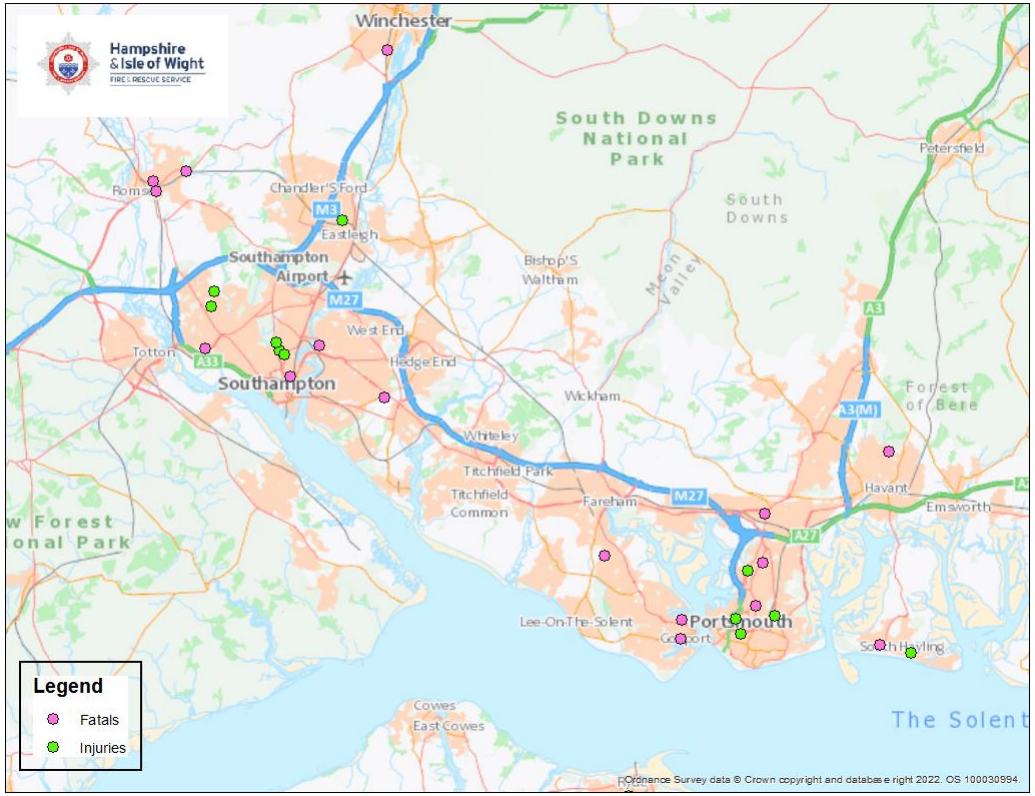
- *Census 2021 – census.gov.uk*

Fire Fatalities and Injuries – Mapped

Full Map

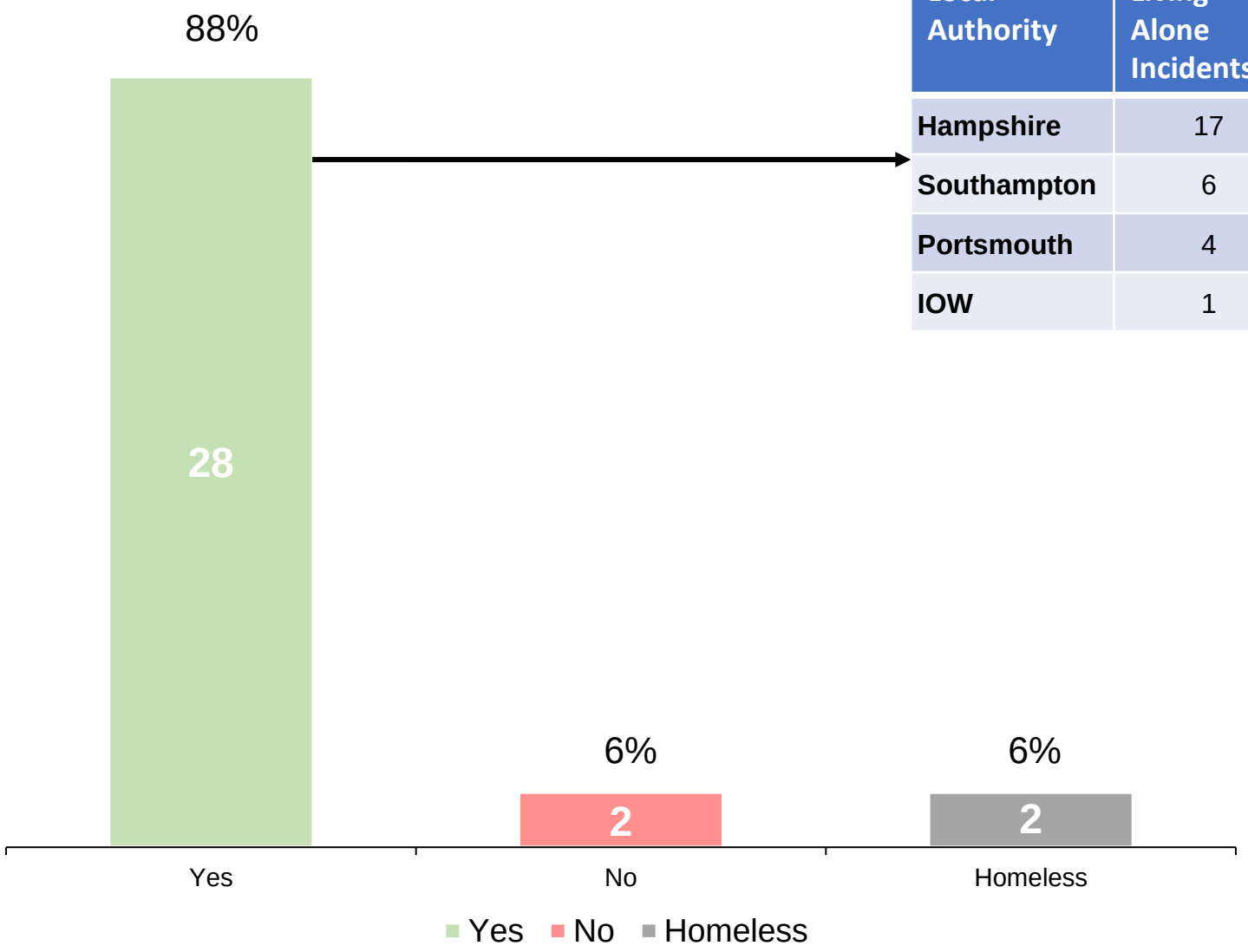


Zoom to Southampton and Portsmouth



There is a slight cluster in the Inner Avenue area of Southampton with 3 injuries, and 2 injuries in the Somers Town area of Portsmouth.

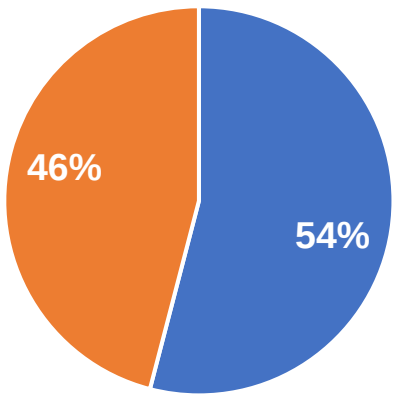
Living Alone



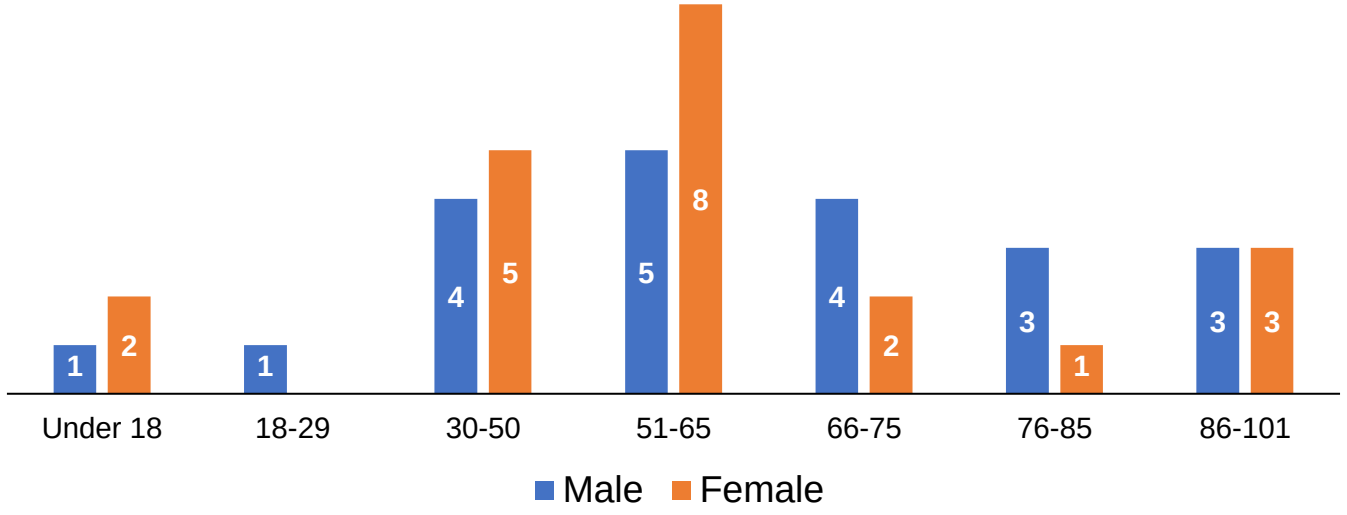
Local Authority	Living Alone Incidents	Total Incidents %
Hampshire	17	**61%**
Southampton	6	**21%**
Portsmouth	4	**14%**
IOW	1	**4%**

The **majority of incidents** occurred to individuals who were **living alone** (28, 88%). 2 incidents involved individuals who were not living alone and 2 involved homeless individuals (and 7 incidents where it was undetermined).

Age & Gender



Male Female



Age Range	Total Incidents	Total Incidents %	2015-18 thematic review %
Under 18	3	**7%**	0%
18-29	1	**2%**	8%
30-50	9	**21%**	19%
51-65	13	**31%**	19%
66-75	6	14%	15%
76-85	4	**10%**	24%
86-101	6	**14%**	15%

The 51 to 65 age range had the highest number of incidents (12), and this has also **increased by 12% points** compared to the previous thematic review.

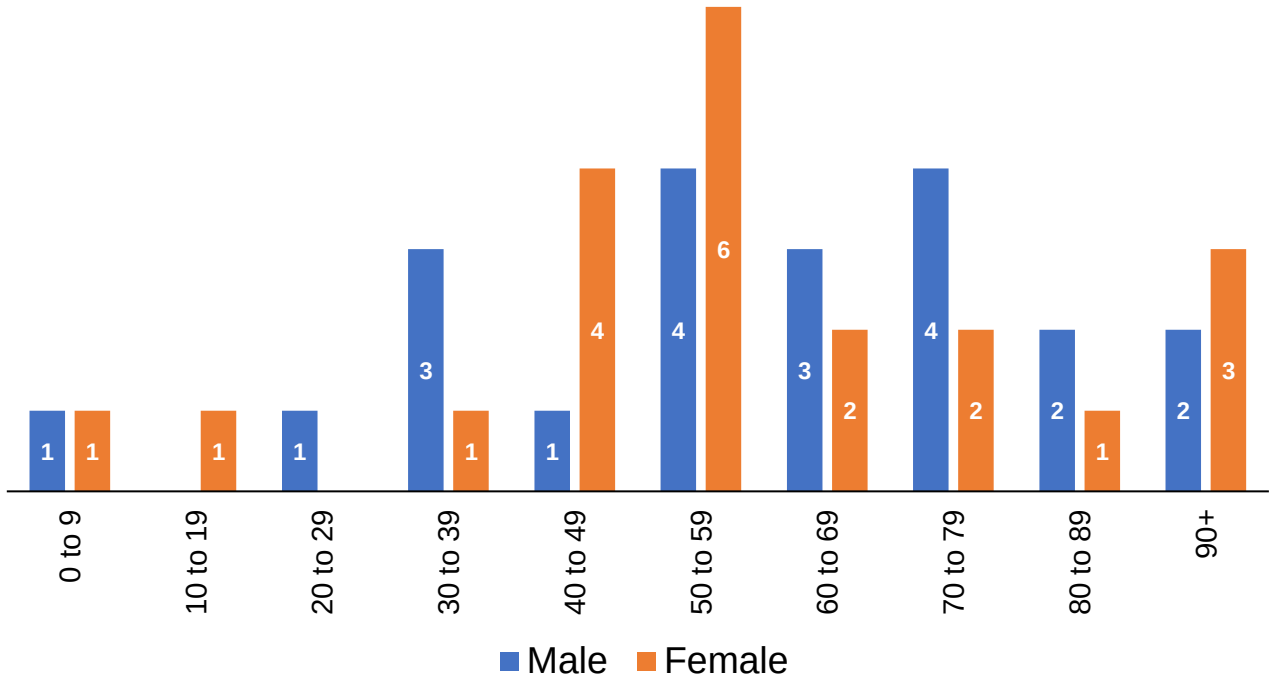
Also, the gender split has levelled compared to the **previous thematic review where 73% of the cases were for males** and 27% for females, compared to 54% male and 46% female in the current review.

Nationally, 44% of all fire-related fatalities were 65 years old and over in year ending March 2021, compared to 38% for our current review.

Note – there are more than 39 individuals as 2 incidents involved more than 1 person

Age & Gender by 10 years

Age	Number of incidents/ individuals	Males	Females	% of age group	% vs population
0 to 9	2	1	1	5%	11%
10 to 19	1	-	1	2%	11%
20 to 29	1	1	-	2%	10%
30 to 39	4	3	1	10%	12%
40 to 49	5	1	4	12%	12%
50 to 59	10	4	6	24%	15%
60 to 69	5	3	2	12%	12%
70 to 79	6	4	2	14%	11%
80 to 89	3	2	1	7%	5%
90+	5	2	3	12%	1%



When incidents are grouped by 10-year age bands, the band which had the highest number of incidents was **the 50 to 59 age range** (10 incidents), with 4 being for males and 6 being for females. When comparing this to the Hampshire and Isle of Wight population, **the 50 to 59 group had 9% more incidents when compared to the population**, indicating that this is the highest risk age group to experience a fatality and casualty.

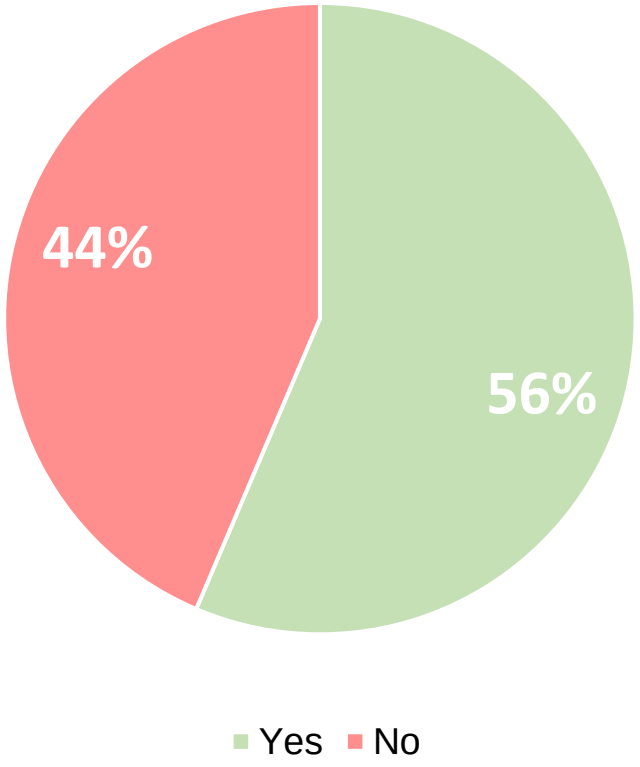
Note – there are more than 39 individuals as 2 incidents involved more than 1 person

Source for population data:

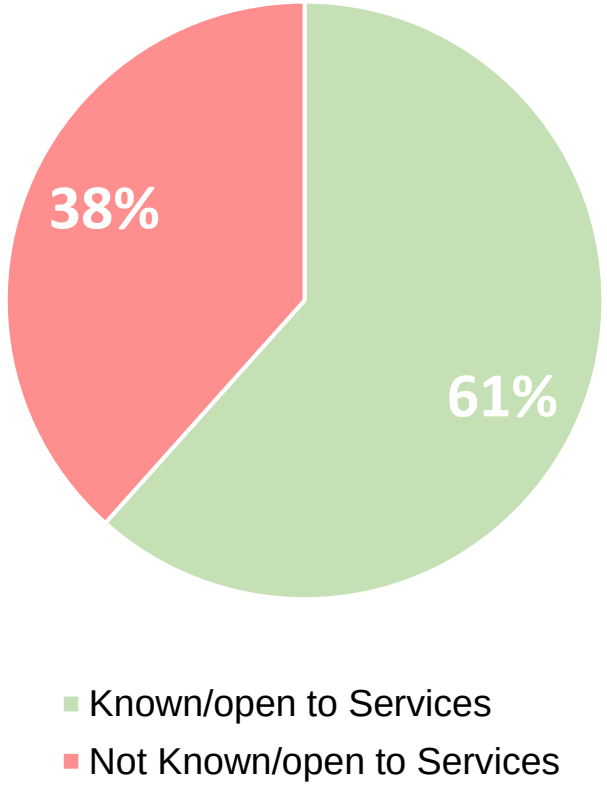
- *Census 2021 – census.gov.uk*

Care and Support Services

In receipt of care and support Services – 2019/22 Thematic Review



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



Smoke Detection

No smoke detection

7

incidents (18%)

Non functioning detection

3

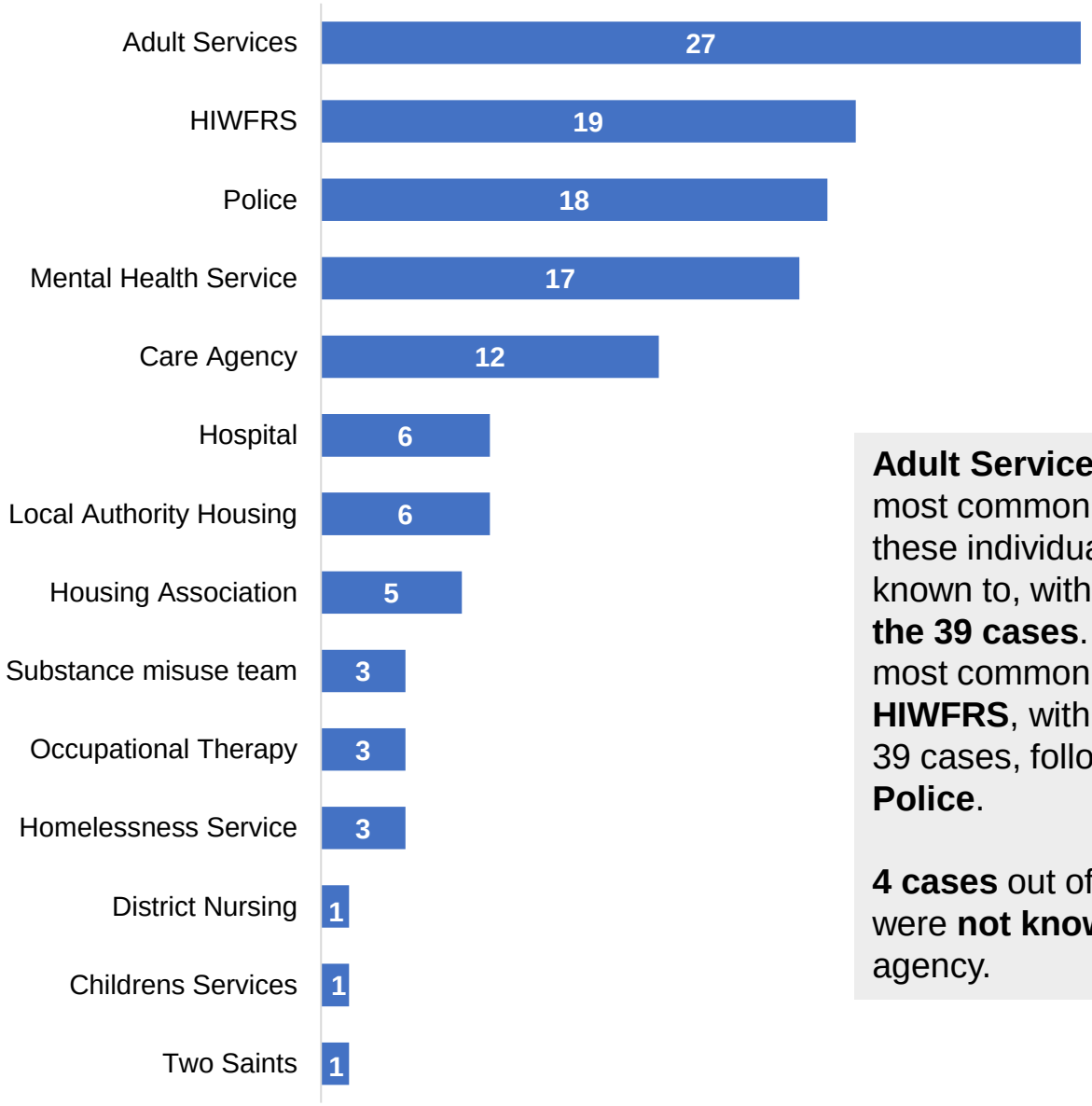
incidents (8%)

No smoke detection was found in **7 incidents**. This accounts for 18% and is an **increase on the previous thematic review** where 11% of incidents had no smoke detection.

Also **8% of incidents** had a **smoke detector present** but it **wasn't functioning**. This is slightly **less than the previous thematic review where** 10% of incidents had a smoke detector which failed to operate.

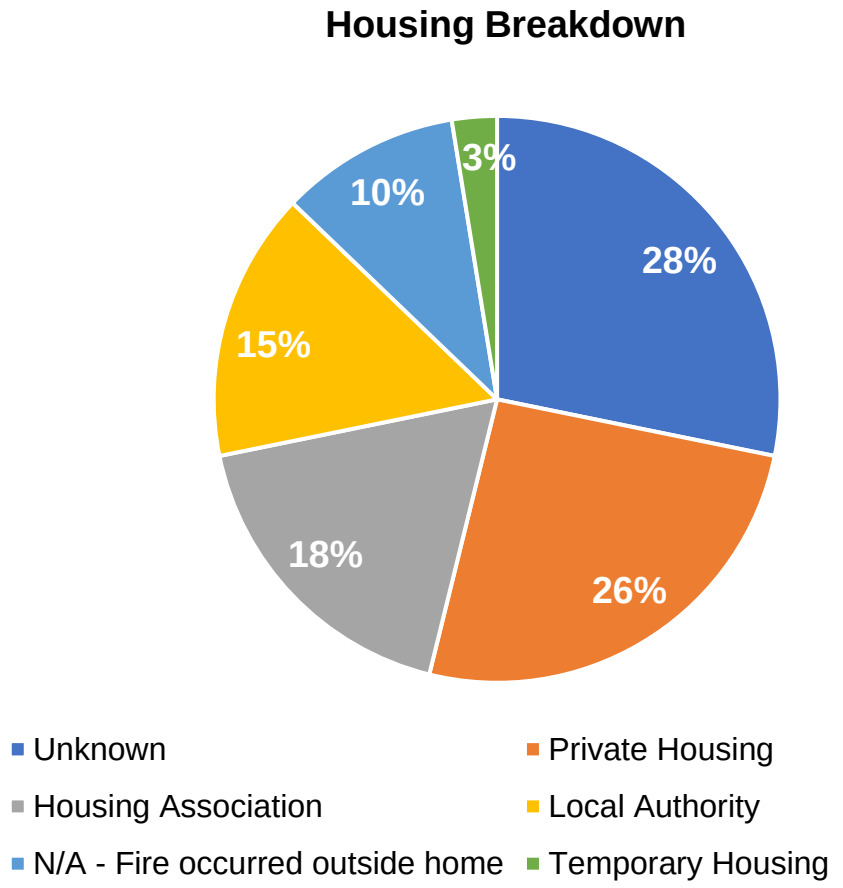
Nationally, fires where a smoke alarm was not present accounted for 25% of all dwelling fire-related fatalities in year ending March 2021 which is similar to this current review where fatalities with no smoke/non functioning detection was 26%.

Known to Agency



Adult Services was the most common agency that these individuals were known to, with **27 out of the 39 cases**. The second most common was **HIWFRS**, with 19 out of 39 cases, followed by **Police**.

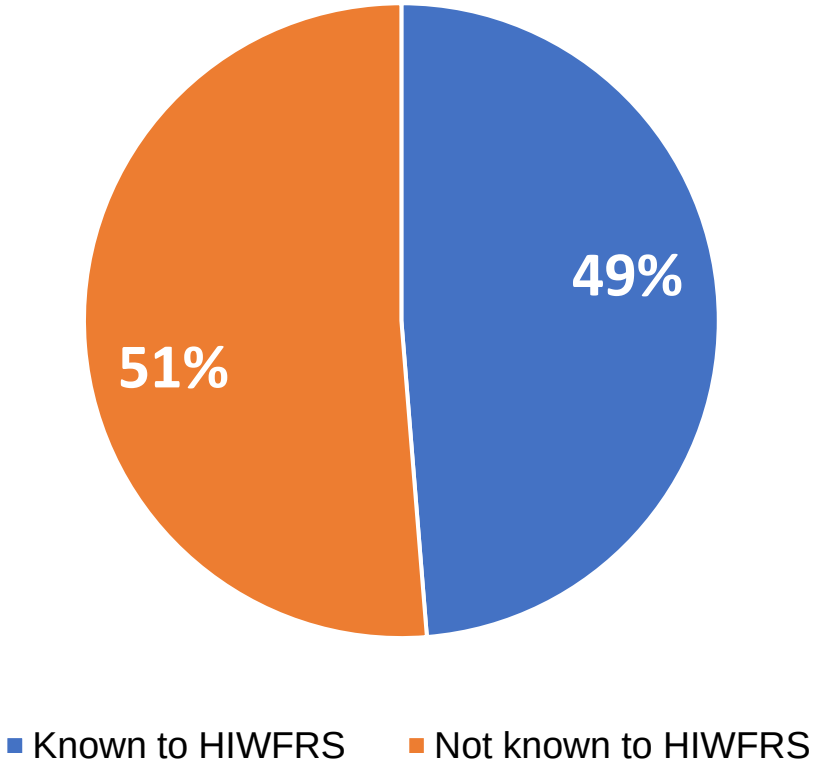
4 cases out of the 39 were **not known** to an agency.



For all the 39 cases, 11 had an unknown housing situation. 10 lived in private housing, followed by 7 who were housing association.

HIWFRS Involvement

Previously known to HIWFRS:



Safe and Well recommendations for additional control measures were in place at time of incident:

- Total - **14**
- HIWFRS did not make any recommendations - **4**
- Recommendations HIWFRS made were not implemented - **2**
- Recommendations were partially implemented - **1**
- Recommendations were refused by the individual - **2**
- Unknown if HIWFRS recommendations were implemented - **5**

FSDG case was referred to LSAB or LSCP for learning and review:

- No learning and review referral made - **30**
- L&R referral made by HIWFRS - **3**
- L&R referral made by other FSDG partner - **6**

Cases involved in 2019 - 2021 thematic review

FSDG case 1 – Fatal - Hampshire

Identified vulnerabilities – Needs of care and support; smoking; alcohol / substance use; history of non-engagement; poor mental health; poor fire safety practices; no smoke detection.

FSDG review identified male was known to Police; Mental Health Services; Adult Services and HFRS.

FSDG case 2 - Fatal - Hampshire

Identified vulnerabilities – Needs of care and support; alcohol/substance use; poor mental health; non-functioning detection.
FSDG review identified female was known to Mental Health Services.

FSDG case 3 – Fatal - Hampshire

Identified vulnerabilities – Needs of care and support; poor physical health; physical impairment; unable to self-evacuate; electrical risks, older person (over 65 years of age).
FSDG review identified male was known to a Care Agency; Adult Services; Occupational Therapy; SCAS and HFRS.

FSDG case 4 – Fatal - Hampshire

Identified vulnerabilities – Needs of care and support; smoking; alcohol / substance use; poor physical health; history of non-engagement; self-neglect; poor mental health; evidence of previous fires; candles risks; multiple ignition sources; non-functioning detection.
FSDG review identified male was known to Adult Services; Mental Health Services; Police; Local Authority Housing and HFRS.

FSDG case 5 – Injury - Hampshire

Identified vulnerabilities – candles risks.
FSDG review identified family was known to Police; Childrens Services and HFRS.

Cases involved in 2019 - 2021 thematic review

FSDG case 6 – Injury - Hampshire

Identified vulnerabilities – needs of care and support; hoarding; smoking; alcohol / substance use; physical impairment; self-neglect; poor mental health; poor cooking practices; evidence of previous fires; older person (over 65 years of age).
FSDG review identified female was known to Adult Services; SCAS; Mental Health Services; Substance Misuse Team and HFRS.

FSDG case 7 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; smoking; dementia; poor physical health; physical impairment; self-neglect; older person (over 65 years of age).
FSDG review identified male was known to Adult Services; a Care Agency; Occupational Therapy and HFRS

FSDG case 8 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; smoking; alcohol/substance use; history of non-engagement; poor mental health; poor fire safety practices; no smoke detection.
FSDG review identified male was known to Adult Services and Mental Health Services.

FSDG case 9

This was a case involving the death of a female with significant hoarding behavior, which was reviewed by the FSDG but not included in the thematic review as there was no fire incident.

FSDG case 10 – Fatal - Portsmouth

Identified vulnerabilities – needs of care and support; smoking; alcohol / substance use; dementia; physical impairment; history of non-engagement; poor fire safety practices; Poor cooking practices; evidence of previous fires; multiple ignition sources; older person (over 65 years of age).
FSDG review identified male was known to Adult Services. Care Agency. Local Authority Housing and HFRS

Cases involved in 2019 - 2021 thematic review

FSDG case 11 – Fatal – Hampshire.

Identified vulnerabilities – smoking; physical impairment; poor mental health; poor fire safety practices.
FSDG review identified male was not known to any services

FSDG case 12 – Injury - Hampshire

Identified vulnerabilities – hoarding; alcohol / substance use; self-neglect; no smoke detection.
FSDG review identified male was not known to any services

FSDG case 13 – Injury – Portsmouth

Identified vulnerabilities – alcohol/substance use; history of fire setting; poor mental health; evidence of previous fires.
FSDG review identified male was known to Adult Services; Mental Health Services; Police and SCAS.

FSDG case 14 – Injury - Hampshire

Identified vulnerabilities – needs of care and support; smoking; older person (over 65 years of age).
FSDG review identified male was known to a Care Agency; SCAS; Adult Services and HFRS.

FSDG case 15 – Injury - Hampshire

Identified vulnerabilities – needs of care and support; smoking; poor mental health.
FSDG review identified male was known to Police;. Mental Health Services; Adult Services; SCAS and HFRS

Cases involved in 2019 - 2021 thematic review

FSDG case 16 – Injury - Hampshire

Identified vulnerabilities – needs of care and support; smoking; poor mental health.
FSDG review identified female was known to Adult Services; Mental Health Services; Vivid Housing; Hospital and Police.

FSDG case 17 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; hoarding; alcohol / substance use; history of non-engagement; self-neglect; poor mental health; poor fire safety practices; multiple ignition sources.
FSDG review identified female was known to Police; Mental Health Services; Adult Services and SCAS.

FSDG case 18 – Fatal - IOW

Identified vulnerabilities – needs of care and support; smoking alcohol / substance use; cognitive impairment; poor physical health; history of non-engagement; self-neglect; poor fire safety practices.
FSDG review identified female was known to Adult Services; Sovereign Housing and IOWFRS.

FSDG case 19 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; hoarding; smoking; alcohol / substance use; cognitive impairment; poor physical health; self-neglect; poor fire safety practices.
FSDG review identified female was known to Adult Services; a care agency; Sovereign Housing; Mental Health Services and HFRS.

FSDG case 20 – Injury - Southampton

Identified vulnerabilities – needs of care and support; alcohol / substance use; history of non-engagement; poor mental health.
FSDG review identified female was known to Homelessness Team; Mental Health Services;. Police and Hospital.

Cases involved in 2019 - 2021 thematic review

FSDG case 21 – Injury (x3) - IOW

Identified vulnerabilities – smoking; alcohol / substance use; self-neglect; poor fire safety practices; candle risks; no smoke detection.
FSDG review identified family was known to Police; IOW Childrens Services and IOWFRS.

FSDG case 22 – Injury - Hampshire

Identified vulnerabilities – smoking; alcohol / substance use; poor physical health; history of non-engagement; self-neglect; poor mental health.
FSDG review identified male was known to Vivid Housing; SECAMB; Police and Substance Misuse Service.

FSDG case 23 – Fatal - Portsmouth

Identified vulnerabilities – needs of care and support; history of non-engagement; self-neglect; poor mental health.
FSDG review identified female was known to Mental Health Services; Local Authority Housing; SCAS and Police.

FSDG case 24 – Injury - Southampton

Identified vulnerabilities – Needs of care and support; smoking; poor mental health; poor fire safety practices; candles risks.
FSDG review identified female was known to Mental Health Services; Sovereign Housing; Police and Adult Services.

FSDG case 25 – Injury - Hampshire

Identified vulnerabilities – needs of care and support; smoking; alcohol / substance use; poor physical health; physical impairment; unable to self-evacuate; self-neglect; poor fire safety practices; evidence of previous fires; older person (over 65 years of age).
FSDG review identified female was known to a Care Agency; Adult Services; SCAS; Police; Abri Housing and HFRS

Cases involved in 2019 - 2021 thematic review

FSDG case 26 – Fatal – Southampton

Identified vulnerabilities – needs of care and support; smoking; poor physical health; physical impairment; emollient creams; unable to self-evacuate; poor fire safety practices; evidence of previous fires.

FSDG review identified female was known to Adult Services; a Care Agency; Local Authority Housing; District Nursing and HFRS

FSDG case 27 – Fatal - Southampton

Identified vulnerabilities – smoking; alcohol / substance use; poor physical health; self-neglect; poor Fire safety practices; electrical risks.
FSDG review identified male was known to Homelessness Service.

FSDG case 28 – Fatal – Portsmouth

Identified vulnerabilities – needs of care and support; poor physical health; physical impairment; poor cooking practices; no smoke detection; older person (over 65 years of age).
FSDG review identified female was known to a Care Agency and Adult Services.

FSDG case 29 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; smoking; alcohol / substance use; poor physical health; older person (over 65 years of age).
FSDG review identified male was not known to Services.

FSDG case 30 – Fatal - Southampton

Identified vulnerabilities – poor mental health; flammable liquids.
Due to ongoing investigations FSDG members were notified of this incident but a review of involved agencies did not occur.

Cases involved in 2019 - 2021 thematic review

FSDG case 31 – Fatal - Southampton

Identified vulnerabilities – needs of care and support; poor physical health; physical impairment; history of non-engagement; self-neglect; poor mental health; flammable liquids; non-functioning detection.
FSDG review identified female was known to Mental Health Services; Adult Services and Police.

FSDG case 32 – Fatal - Southampton

Identified vulnerabilities – needs of care and support; smoking; alcohol / substance use; sensory impairment; poor physical health; physical impairment; history of non-engagement; unable to self-evacuate; poor mental health; poor fire safety practices; evidence of previous fires; older person (over 65 years of age).
FSDG review identified female was known to Adult Services; Local Authority Housing; a Care Agency; Mental Health Services and HIWFRS

FSDG case 33 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; hoarding; smoking; sensory impairment; cognitive impairment; poor physical health; physical impairment; history of non-engagement; self-neglect; poor fire safety practices; no smoke detection; older person (over 65 years of age).
FSDG review identified male was known to Police; Adult Services; GP and SCAS

FSDG case 34 – Injury - Portsmouth

Identified vulnerabilities – needs of care and support; smoking; alcohol / substance use; poor physical health; poor mental health;
FSDG review identified male was known to Police; Two Saints; Homelessness Team; Substance Misuse Service; Adult Services and Mental Health Services.

FSDG case 35 – Injury - Portsmouth

Identified vulnerabilities – needs of care and support; smoking; poor physical health; physical impairment; self-neglect; poor mental health; older person (over 65 years of age).
FSDG review identified male was known to Local Authority Housing; Adult Services; Mental Health Services; SCAS; Police; a Care Agency; Hospital and HIWFRS

Cases involved in 2019 - 2021 thematic review

FSDG case 36 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; physical impairment; no smoke detection; older person (over 65 years of age).
FSDG review identified female was known to Adult Services; Occupational Therapy and HIWFRS

FSDG case 37 – Fatal - Hampshire

Identified vulnerabilities – needs of care and support; cognitive impairment; poor mental health; older person (over 65 years of age).
FSDG review identified male was not known to Services.

FSDG case 38 – Injury x2 - Portsmouth

Identified vulnerabilities – needs of care and support; cognitive impairment; self-neglect; older person (over 65 years of age).
FSDG review identified female was known to Adult Services; Mental Health Services; a Care Agency and HIWFRS

FSDG case 39 – Injury - Southampton

Identified vulnerabilities – needs of care and support; smoking; physical impairment; emollient creams; unable to self-evacuate; evidence of previous fires; older person (over 65 years of age).
FSDG review identified male was known to Adult Services; a Care Agency; Hospital and HIWFRS

FSDG case 40 – Fatal - Southampton

Identified vulnerabilities – needs of care and support; smoking; physical impairment; history of non-engagement; self-neglect; poor mental health; poor fire safety practices; evidence of previous fires.
FSDG review identified female was known to Adult Services; Hospital; Police and SCAS.

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