FIRE BRIGADES UNION

OLDHAM STREET INCIDENT JULY 2013

THE DEATH OF STEPHEN HUNT

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INTRODUCTION

Matt Wrack,
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There is no more serious matter for the Fire Brigades Union than the death of a member in the line of duty. Our service deals with hazardous situations every single day but our members and their families have the right to expect that firefighters will return home safely from work. That is why, over many decades, such effort has been put in to learning the lessons from earlier incidents, especially from those where lives have been lost. In many ways the story of progress in our profession has been precisely that of applying lessons learned from such tragedies. It has been a central aspect of the work of our union for almost a century.

Society expects firefighters to tackle fires and other dangerous incidents. In return, firefighters have the right to expect the best possible preparation and planning for the various incidents they may be expected to attend and the various risks they may face. This means taking account of the latest understanding and technical knowledge in developing equipment, training and procedures. It should also mean ensuring adequate resources are available to enable firefighters to tackle incidents effectively, efficiently and safely.

This document arises from one particular tragedy; the death of Brother Stephen Hunt. Stephen was a member of the FBU in Greater Manchester and was killed attending the fire in Oldham Street, Manchester, on 13 July 2013. The FBU is proud to have counted Stephen as a member and took extremely seriously the role of ensuring that the concerns around his death were raised at the inquest that took place in May and June 2016.

The FBU represented Stephen's family as well other FBU members who had attended the incident. This representation applied at all stages of the investigation from the immediate interviews and throughout the inquest. As part of the inquest, the FBU submitted a report to the senior coroner – *FBU report for Mr Meadows regarding the death of firefighter Stephen Hunt* – which analysed recommendations from previous inquests into firefighter fatalities and other fatalities in fires and assessed whether they remain current and relevant in relation to this one.

Following the inquest, the senior coroner produced a report to the home secretary and the chief fire and rescue adviser, *Regulation 28: report to prevent future deaths*. This report raised 10 areas of concern that he felt would need to be acted on to mitigate the risk of any future deaths.

A systematic pattern of failures

As an acknowledged interested party, the FBU was presented with an opportunity to try and engage further with the home secretary in relation to these recommendations. The resulting document, FBU response to the coroner's regulation 28 report regarding the death of Stephen Hunt, was submitted in July 2016 and is in three main sections.

It gives a brief background to the incident and the circumstances of Stephen's death. It then addresses each of the coroner's recommendations and relates them to previous incidents where similar factors or problems were identified. This analysis reveals a repeated and

systematic pattern of failures which were highlighted in earlier fatality reports. It is this element of our submission which is of the most significant concern.

After such tragedies we have often heard talk of the need to 'learn the lessons'. However, our submission to the home secretary demonstrates that many of the lessons identified in relation to this terrible incident are not new but have been identified and highlighted in previous reports by the FBU, by fire and rescue services and by other agencies. This suggests a significant failure to adequately monitor progress on implementing the lessons of previous incidents. We are clear that this cannot be allowed to continue.

The FBU submission identifies four key priorities which we feel must be addressed:

- risk assessments
- incident command
- a professional approach to training, and
- a mechanism for ensuring and monitoring improvements.

Discussions with the Home Office

On 1 September 2016 the FBU met with the chief fire and rescue adviser, Peter Holland, to discuss the coroner's report and a possible way forward. During this meeting Mr Holland indicated that the majority of the coroner's concerns would be addressed through guidance under the remit of the National Occupational Guidance group.

During this meeting we raised serious concerns about this guidance-only approach and suggested several other factors that need to be implemented to ensure that lessons are learned and acted upon.

Upon receipt of the guidance – *Regulation 28: report on action to prevent future deaths – Stephen Alan Hunt* – on 3 October 2016 we wrote a further letter to the Home Office reiterating our concerns and disappointment with this guidance-only approach and highlighted where it was inadequate.

All the relevant documents up to this point, plus a conclusion, are contained in this full report. Please take the time to read it.

We are fully committed to improving the safety of firefighters and will be campaigning to ensure that this is achieved.

We are already taking steps to:

- ensure that this issue is on the agenda for joint health and safety committees
- ensure that that our relevant officials are fully briefed
- encourage every member of the FBU to take an active part this campaign by organising meetings and lobbies demanding that firefighter safety is given the priority it deserves.

In publishing this report and embarking on this campaign, the union is demonstrating a commitment to ensuring that the lessons from Stephen Hunt's death, which in several areas tragically reflect similar lessons from earlier such incidents, are acted upon.

This campaign is a key priority for the union and will be raised at all levels both politically and as part of the ongoing role of the union in each brigade. It is something you can play a part in. Firefighter safety is an issue that affects us all and I urge all FBU members to get involved and to play a part in ensuring the steps we set out are adopted at national and local level.

SECTION 1

In May 2016, whilst the inquest was ongoing, the FBU submitted a report to the senior coroner, Mr Meadows. It is the view of the FBU that previous recommendations relating to incidents where firefighter fatalities had occurred could be linked to the Oldham Street incident itself, where Stephen Hunt died. The purpose of this submission was to outline our concerns that these lessons had not been learned.

This section contains the full FBU report that was sent to Mr Meadows.

FBU REPORT FOR MR MEADOWS REGARDING THE DEATH OF FIREFIGHTER STEPHEN HUNT

1 EXECUTIVE SUMMARY

1.1 The Fire Brigades Union in compiling this report for HM Senior Coroner Mr N Meadows, into the death of our member, FF Stephen Hunt, have analysed recommendations from previous coroner inquests into firefighter fatalities or fatalities in fire and assessed whether they remain current and relevant in relation to this inquest.

1.2 The FBU is deeply concerned that lessons from previous inquests may not have been learned by fire and rescue authorities or Government. To undertake such an analysis the FBU has compared those previous recommendations made by either the Fire Brigades Union, London Fire Brigade, Scottish Fire and Rescue Service or the Coroner to those the FBU make in relation to this incident.

1.3 The FBU in assessing previous recommendations that have primarily been made in relation to firefighter fatalities in operational incidents and balancing whether they remain relevant into the circumstances leading to Stephen's death make the following recommendations, these recommendations can also be found in the body of the report.

FIRE SAFETY MANAGEMENT

1.4 **FBU Recommendation 1**
That Greater Manchester Fire and Rescue Service (GMF&RS) should provide additional resources to enable their fire safety department to immediately carry out a comprehensive risk based inspection programme within Greater Manchester focusing on, but not exclusively to, the Northern Quarter. This strategy is to include an agreed and comprehensive programme of 7(2)d visits undertaken by operational crews.[1]

1.5 **FBU Recommendation 2**
That GMF&RS should, as a matter of urgency, establish a formal structure that would allow operational crews to liaise regularly with the GMF&RS fire safety managers, so that both can be fully briefed upon any new or existing buildings in which there are facilities provided for the assistance and safety of firefighters. Where necessary any Site Specific Risk Information (SSRI) about a building that may be of assistance to firefighters should be made available to all crews via North West Fire Control and the Mobile Data Terminals.[2]

1.6 **FBU Recommendation 3**
That GMF&RS seeks to actively enforce article 38 of the Regulatory Reform (Fire Safety) Order 2005 to ensure that the passive and active fire safety measures incorporated into the building for the protection of fire fighters are present and effectively maintained.[3]

1.7 **FBU Recommendation 4**
That GMF&RS undertake a thorough training needs analysis to identify gaps in firefighter operational knowledge and skills. Furthermore GMF&RS should ensure that all firefighters receive regular training in all aspects of active fire safety measures including those which are in line with the Fire Service Manual Volume 3 Fire Safety 'Fire Protection of Buildings' to make certain that all firefighters are aware of the impact the various active fire safety measures may have on their operational procedures.[4]

RADIO COMMUNICATIONS

1.8 **FBU Recommendation 5**
That a full and comprehensive review of all radio communication equipment is undertaken as a matter of urgency resulting in such equipment being operationally reliable as far as is reasonably practicable. If communication issues at operational incidents cannot be resolved to a level that is as safe as is reasonably practicable then control measures are adopted as a result of a risk assessment process and promulgated to all operational crew who have a BA wearing role.[5]

TRAINING IN BREATHING APPARATUS AND THERMAL IMAGE CAMERA

1.9 **FBU Recommendation 6**
That GMF&RS undertake a thorough training needs analysis in relation to the use of

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1 Page 14.
2 Page 14.
3 Page 14.
4 Page 15.
5 Page 16.

Breathing Apparatus, ancillary equipment and procedures, in particular the use of the Thermal Image Camera.[6]

BA PROCEDURES

1.10 **FBU Recommendation 7**
GMF&RS should immediately review and revise all its Breathing Apparatus procedures and bring them into line with the Operational Guidance for Breathing Apparatus promulgated by the Chief Fire and Rescue Advisor on behalf of Government. This review to ensure adherence to this guidance done in conjunction with the representative body safety representatives via the GMF&RS Health and Safety Committee.[7]

1.11 **FBU Recommendation 8**
GMF&RS IRMP should be revised to ensure that numbers of operational firefighters is sufficient at all times to be able to implement the outcomes of FBU Recommendation 6, specifically in relation to BA Emergency Teams.[8]

HANDOVER PROCEDURES

1.12 **FBU Recommendation 9**
That GMF&RS immediately reviews handover procedures with a view to introduce staggered handovers whenever deemed appropriate, with a controlled staged handover procedure to be introduced at all necessary times.[9]

ANALYTICAL RISK ASSESSMENTS

1.13 **FBU Recommendation 10**
That GMF&RS should immediately revise its Incident Command System and ensure that it corresponds with the Fire Service Manual Volume 2 Fire Service Operations – Incident Command. This review to ensure proper and Analytical Risk Assessments be undertaken in a timely manner and with immediate effect.[10]

DYNAMIC RISK ASSESSMENT

1.14 **FBU Recommendation 11**
That GMF&RS review its Dynamic Risk Assessment training programme, ensuring that it meets the requirements of the Incident Command System and ensure that all operational personnel and supervisory officers receive regular centrally delivered practical, theoretical and refresher training as soon as reasonably practicable.[11]

INCIDENT COMMAND UNIT

1.15 **FBU Recommendation 12**
That GMF&RS review its mobilisation policy to give consideration whether the Incident

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[6] Page 16.
[7] Page 21.
[8] Page 22.
[9] Page 29.
[10] Page 29.
[11] Page 30.

Command Unit should by policy, be the Unit that assist Incident Command at incidents of protracted and resource heavy nature, such as Oldham Street.[12]

AERIAL APPLIANCES

1.16 **FBU Recommendation 13**
That GMF&RS immediately review its procedures for the use of aerial appliances at operational incidents, particularly for the use of aerial appliances as water towers at incidents where firefighting crews are present within the building. The review to be co-ordinated within the GMF&RS Health and Safety Committee.[13]

HEROIC RESCUE ATTEMPTS

1.17 The Fire Brigades Union along with Stephen's family, would like to place on record the rescue attempts made in relation to Stephen Hunt and Jeremy Jones by all firefighters which by any measure were heroic. The FBU and Stephen's family are particularly grateful to CM Lord, FF Rowlands, FF Garrott and FF Burbidge.

[12] Page 30
[13] Page 26

2 INTRODUCTION

2.1 On the 13 July 2013 at a fire at Pauls Hairworld, FF Stephen Hunt was rescued by fire crews from the incident but lost his life to injuries he sustained. Stephen's BA partner, FF Jeremy Jones was also rescued by fire crews but survived the injuries he sustained.

2.2 The Fire Brigades Union (FBU) responded to a request from DCI Marsh, Greater Manchester Police (GMP), on the 1st December 2013, to provide some initial observations the Union may have had at that stage of the investigation.

2.3 The comments proffered by the Union at that time were compiled as a consequence of our officials representing members at Police interviews, and was offered without prejudice. We confirmed that we reserved the right to present more information if, and when, able to do so.

2.4 The FBU's initial observations provided to GMP on the 6th February 2014 focused on the following:[14]

2.5 Ventilation – There was clearly some confusion regarding the opening and closing of windows on the 1st floor.

2.5.1 We can now say, with a degree of certainty, that despite a meeting held between GM Myers, WM Keogh, WM Fenwick and WM Dalpiaz, to discuss tactical ventilation at 17:32 hrs in Sector 3, a team (FF Stott and FF Cording) was instructed to enter Sector 3 up to the 1st floor to open windows, and did so, at 17:46 hrs. Confusingly, the same team were sent into the same location to close the same windows very soon after.

2.5.2 It is not known at this time whether the opening of the windows had a deleterious effect on the nature of the fire, but it does point to a degree of a lack of overall strategic command and control of sectors, and the incident.

2.5.3 The FBU was concerned that there appeared to be a degree of attitude shift at time of change-over from the day shift to the night shift. That change of operational attitude towards the incident appears to have been borne out by a manager, now known to be GM Sheridan, allegedly stating to GM Myers on changeover 'let's put the fire out now'. It is also now known that at some point leading up to the handover and as discussing amount of relief crews required SM Parkinson informed Control that

'YEAH I'LL CONFIRM IT. WE'RE JUST GOING INCREDIBLY OFFENSIVE AT THE MINUTE.'[15]

2.5.4 There is also some evidence that indicates that the brief to BA crews entering Sector 1 became confused at around the change-over of shift.

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[14] FBU Letter to DCI Marsh – 1 December 2013.

[15] X886 Transcript Radio Comms 153977 – 1540399 From Exhibit Jam 1 Part 2 of 2 (Redacted).

2.5.5 A further point the FBU commented upon was the use, and amount, of water used at the time of Stephen's entry into the premises, and whether that was a causal factor in Stephen's death.

2.6 Stephen's death at Oldham Street was another fatality in a regrettably growing list of firefighter deaths at operational incidents.

2.7 As a consequence of subsequent Coroners' Inquiries into those fatalities a number of actions were raised, pursuant to Rule 43 of the Coroners' Rules (as amended) which was in place at the time.

2.8 For the purpose of this report the FBU will concentrate on lessons learned from previous inquests and to facilitate this work the FBU has focused on Rule 43 letters from the following incidents:

2.9.1 Firefighter Fatalities at Bethnal Green
2.9.2 Firefighter Fatalities at Harrow Court
2.9.3 Firefighter Fatality at Shirley Towers
2.9.4 Fatality at Lakanal House
2.9.5 Firefighter Fatality at Marlie Farm

2.9 This document is offered without prejudice and the FBU reserve the right to present more information and/or evidence if able to do so.

2.10 For ease of reference the FBU have adopted the identification process used by West Yorkshire Fire and Rescue Service (WYF&RS) as provided in the WYF&RS report 'Firefighter Fatality Investigation August 2014'.

2.11 The FBU whilst investigating the fatalities at Harrow Court made a number of recommendations in the respective reports and are referred to below.

2.12 Whilst the incidents at Harrow Court, Shirley Towers, Bethnal Green and Lakanal House differed from that at Oldham Street, as they were residential fires at high rise blocks of flats rather than a City Centre retail outlet, those FBU recommendations made at the time, in the view of the FBU, remain relevant today.

3 FIRE SAFETY

(The Fire Brigades Union has made a number of recommendations in previous Coroner inquests into firefighter fatalities, or fatalities in fire. For these purposes the FBU have confined recommendations similar to those made in the four inquests referred to in 2.9.1 to 2.9.5 to analyse whether lessons have been learnt.)

3.1 **FBU Recommendation 6 (Harrow Court)**
'That HFRS (Hampshire Fire and Rescue Service) should ensure that all firefighters receive regular training in all aspects of active fire safety measures in line with Fire Service Manual Volume 3 Fire Safety 'Fire Protection of Buildings' to ensure that all firefighters are aware of the impact the various active fire safety measures may have on their operational procedures.'

3.2 A number of issues greatly concern the FBU in relation to Pauls Hairworld specifically issues including housekeeping, fire loading, internal construction and means of escape.

3.3 Housekeeping was a matter of concern for Greater Manchester Fire and Rescue Service dating back to 2010 where it received a complaint from Manchester City Council Building Control Surveyor, Mr Trevor Rogers, on the 3 August 2010 which in itself had been generated by a complaint he had received from a concerned member of the public.[16]

3.4 Mr Garry Pritchard, Fire Safety Officer for GMF&RS, visited the premise on the same date and agreed that stock on the floor was impeding exit routes. Mr Pritchard also examined the Fire Risk Assessment which had also identified that obstructed exit routes had been highlighted. As a result Mr Pritchard advised remedial work and revisited the premise on the 10 August 2010 and whilst he was satisfied that although exit routes were clear on the day of re-inspection, due to the layout of the storage areas and the fact that GMF&RS had received a complaint Mr Pritchard decided to bring forward the next audit to January 2011.[17]

3.5 The West Yorkshire report states that the audit was undertaken declaring that *'The Fire Safety Audit carried out by the officer classified the premises as low risk and gave it a re-inspection frequency of 84 months' this was as a result of information provided by* GMF&RS.*'*

3.6 However, the Fire Protection report conducted by Paul Whittaker of GMF&RS states that there is no evidence that any visit was carried out in January 2011[18] and considering the provider of evidence for both statements is GMF&RS this conflict is confusing.

3.7 What seems clear from the evidence provided is that, on the day of the incident, the racks throughout the rear of the premise were heavily laden with stock, meaning that the premise itself was heavily fire loaded. This was particularly the case in the vicinity of the rear fire exit (Doorway A) meaning that clear routes of egress and access were of particular importance. In relation to chemicals used in the hairdressing industry, it is unknown if a Control of Substances Hazardous to Health (COSHH) assessment was carried out by the employer.

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16 Disclosed Evidence – Mr Trevor Rogers (C(3)iii 30).
17 Jury Bundle – Page 76.
18 X494 Fire Protection Report Completed Post Incident By Paul Whittaker.

(The Fire Brigades Union has made a number of recommendations in previous Coroner inquests into firefighter fatalities, or fatalities in fire. For these purposes the FBU have confined recommendations similar to those made in the four inquests referred to in 2.9.1 to 2.9.5 to analyse whether lessons have been learnt.)

3.8 **FBU Recommendation 29 (Harrow Court)**
'That HFRS should provide additional resources to enable their fire safety department to immediately carry out a risk based inspection programme within the county of Hertfordshire, starting with high rise residential buildings.'

3.9 The fire door that was eventually opened up by firefighters with cutting gear and designated as Sector 4 (Doorway C) was blocked by racking and stock. In the report into the cause of the fire, Merseyside Fire and Rescue Service (MF&RS) describes this door as being decommissioned as a fire exit[19], it is unknown whether that decommissioning was authorised or not. West Yorkshire Fire and Rescue Service describe the door as being blocked off with racking and storage covering the inside and that a roller shutter between the staircase and Pauls Hairworld was in the closed position.[20]

3.10 To compound this issue, Doorway A had the overall fire exit aperture decreased by both the introduction of a cage that contained waste cardboard packaging on one side (right hand if one was exiting) along with the introduction of racking from floor to ceiling that contained large quantities of combustible stock on the other. The result of these alterations to the fire exit resulted in the aperture decreasing from 4 metres wide to 1 metre wide.[21]

3.11 Photographic evidence from GMP assesses the gap between the racks as being approximately 700 mm at the rear of the premise which is on a route of egress.[22] Government guidance regarding disabled access is:

> *'Someone who does not use a walking aid can manage to walk along a passage way less than 700 mm wide, but just using a walking stick requires greater width than this; a minimum of 750 mm. A person who uses two sticks or crutches, or a walking frame needs a minimum of 900 mm, a blind person using a long cane or with an assistance dog needs 1100 mm. A visually impaired person who is being guided needs a width of 1200 mm.'*[23]

3.12 The Fire and Rescue Service's role as the enforcing authority is to ensure the means of escape in case of fire and associated fire safety measures provided for all people who may be in a building are both adequate and reasonable, taking into account the circumstances of each particular case.

3.13 It is the obligation of the Responsible Person as defined by the Regulatory Reform (Fire Safety) Order 2005 to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be in the premises, including disabled people, such a plan should not rely upon the intervention of the Fire and Rescue Service to make it work.

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19 MF&RS Fatal Investigation Report – Page 11, Paragraph 8.9.
20 WYF&RS Report – Page 12.
21 MF&RS Fatal Investigation Report – Page 44.
22 X925 GMP Photograph.
23 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/3695/inclusive-mobility.pdf

3.14 Notwithstanding that the routes of means of escape in the event of a fire at the front of the shop would be problematic, exit out of Doorway A would be impossible unaided. Doorway C if available would at least provide egress to a protected staircase before encountering stairs.

3.15 Furthermore, the waste cardboard packaging in the cage at Doorway A was at a level at the top of the cage, estimated to be a level of four feet.[24] The MF&RS Investigation Report identifies that cardboard is a substance which once ignited will burn freely.[25]

3.16 It seems to the FBU a matter of common sense, that storing combustible material at a fire exit route, in the vicinity of an area which staff and public are known to smoke, presents at the very least a reasonably foreseeable risk of fire, the blocking off of the fire door at Doorway C seems from a fire safety perspective to be a challenging decision. It is not clear from the evidence to date, who made that decision.

3.17 The Regulatory Reform (Fire Safety) Order 2005 places certain obligations on the Responsible Person (defined in the legislation as the employer). Part 2, Regulation 14 of the Regulatory Reform Order states that:

'(1) Where necessary in order to safeguard the safety of relevant persons, the responsible person must ensure that routes to emergency exits from premises and the exits themselves are kept clear at all times.

(2) The following requirements must be complied with in respect of premises where necessary (whether due to the features of the premises, the activity carried on there, any hazard present or any other relevant circumstances) in order to safeguard the safety of relevant persons

(a) *Emergency routes and exits must lead as directly as possible to a place of safety;*
(b) In the event of danger, it must be possible for persons to evacuate the premises as quickly and as safely as possible;
(c) The number, distribution and dimensions of emergency routes and exits must be adequate having regard to the use, equipment and dimensions of the premises and the maximum number of persons who may be present there at any one time;
(d) Emergency doors must open in the direction of escape;
(e) Sliding or revolving doors must not be used for exits specifically intended as emergency exits;
(f) Emergency doors must not be so locked or fastened that they cannot be easily and immediately opened by any person who may require to use them in an emergency;
(g) Emergency routes and exits must be indicated by signs; and
(h) Emergency routes and exits requiring illumination must be provided with emergency lighting of adequate intensity in the case of failure of their normal lighting.'[26]

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[24] MF&RS Fatal Investigation Report – Page 48.
[25] MF&RS Fatal Investigation Report – Page 48.
[26] http://www.legislation.gov.uk/uksi/2005/1541/contents/made

3.18 The FBU are unsure whether Pauls Hairworld was subject to a visit from operational crews who would undertake a familiarisation visit, described in 7(2)(d) of the Fire and Rescue Services Act 2004; 7(2)(d) requires that in making provision under subsection (1) (making provision for the purpose of extinguishing fires and protecting life and property in the event of fires in its area) a fire and rescue authority must in particular make arrangements for obtaining information needed for the purpose mentioned in subsection (1).

3.19 7(2)d visits play an important element of connecting the legislative and operational arms of the fire and rescue service and can be a vital source of information for fire safety departments. Regrettably, due to budget pressures, fire safety departments are diminishing in line with all sections of the fire and rescue service and important work such as this may be detrimentally impacted upon.

3.20 The West Yorkshire report states that GMF&RS, in January 2011, classed Pauls Hairworld as low life risk and low operational risk, despite previous concerns, and declared that Pauls Hairworld did not require a risk information gathering visit. This information, West Yorkshire state, is gleaned from information provided by GMF&RS, the FBU have yet to view any such evidence.[27]

3.21 However, the FBU feel sure that any recent 7(2)d visit would have generated further visits from the GMF&RS fire safety department to investigate any concerns regarding fire loading, housekeeping and fire exits. This is an area of the fire and rescue service activity that must be increased and given priority.

3.22 The addition of a mezzanine level without the submission of the requisite plans is an instinctive risk for firefighters; with staff employed within offices above a heavily fire loaded area that may have escape route obstructions, presenting an issue that for firefighters stands out as an obvious hazard that may need additional control measures or removal.

(The Fire Brigades Union has made a number of recommendations in previous Coroner inquests into firefighter fatalities, or fatalities in fire. For these purposes the FBU have confined recommendations similar to those made in the four inquests referred to in 2.9.1 to 2.9.5 to analyse whether lessons have been learnt.)

3.23 **FBU Recommendation 30 (Harrow Court)**
'That HFRS should establish a formal structure that would allow operational intervention managers to liaise regularly with the HFRS fire protection managers, so that they can be fully briefed upon any new or existing buildings in which there are facilities provided for the assistance and safety of firefighters. Where necessary any information about a building that may be of assistance to firefighters should also be added to the HFRS 35 Risk card and placed on the control and command computer, so that it can be passed to any crews mobilised to any incident at such a building.'

3.24 **London Fire Brigade Recommendation 2 (Lakanal House)**
It is recommended that the Brigade review procedures for sharing information gained as a result of section 7(2)(d), familiarisation and home fire safety visits with crews both within the station in question and at other local stations.

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[27] WYF&RS Report – Page 177.

3.25 **FBU Recommendation 32 (Harrow Court)**
'That HFRS actively enforce article 38 of the Fire Safety Order (when implemented) to ensure that the passive and active fire safety measures incorporate into the building for the protection of fire fighters are present and effectively maintained.'

3.26 The purpose of article 38 is to ensure that the Responsible Person establishes a suitable system of maintenance for any measures (such as those under article 37) provided for the safety of firefighters, whether under the provisions of the Order or any other enactment. It covers, for example, firefighting water supplies, access and hard standing for fire appliances, fixed firefighting systems operated by the Fire and Rescue Authority, some fire suppression systems and firefighting stairs and lifts if they have been provided under the requirements of Building Regulations or any other enactment.

3.27 However, it is noted that many features are provided to aid firefighters in protecting persons through firefighting or rescue. Any failure to maintain facilities which would affect the ability of firefighters to safely fight the fire or carry out rescues which in turn places one or more relevant persons at risk of death or serious injury in the case of a fire may be an act of non-compliance of the Order.

3.28 The FBU note that a lack of regular 7(2)d visits from operational crews, for whatever reason, is a real loss of credible fire safety information and compromises the effectiveness of any real fire safety audit strategy.

3.29 The Fire Brigades Union make a number of recommendations in this report (not to be confused with recommendations made in previous inquests which are identity tagged).

FBU Recommendation 1
That GMF&RS should provide additional resources to enable their fire safety department to immediately carry out a comprehensive risk based inspection programme within Greater Manchester focusing on, but not exclusively to, the Northern Quarter. This strategy is to include an agreed and comprehensive programme of 7(2)d visits undertaken by operational crews.

FBU Recommendation 2
That GMF&RS should, as a matter of urgency, establish a formal structure that would allow operational crews to liaise regularly with the GMF&RS fire safety managers, so that both can be fully briefed upon any new or existing buildings in which there are facilities provided for the assistance and safety of firefighters. Where necessary any Site Specific Risk Information (SSRI) about a building that may be of assistance to firefighters should be made available to all crews via North West Fire Control and the Mobile Data Terminals.

FBU Recommendation 3
That GMF&RS seeks to actively enforce article 38 of the Regulatory Reform (Fire Safety) Order 2005 to ensure that the passive and active fire safety measures incorporated into the building for the protection of fire fighters are present and effectively maintained.

4 TRAINING

4.1 The FBU have identified a number of issues that indicate a potential training needs. Those areas involve the use of the Thermal Image Camera (TIC) and compartment firefighting/ventilation/BA procedures. Those issues are covered further in this report.

4.2 **London Fire Brigade Recommendation 2 (Bethnal Green)**
A video training package to raise awareness amongst operational staff of the key risk critical findings of this incident.

4.3 **London Fire Brigade Recommendation 3 (Bethnal Green)**
An evaluation of compartment fire tactics.

4.4 **London Fire Brigade Recommendation 5 (Bethnal Green)**
Review and Revision of the programme of prescribed station/watch based training for all operational personnel to maintain competence including specific team work and briefing/ debriefing skills.

4.5 **Rule 43 Recommendation 2 (Shirley Towers)**
It is recommended that a review is undertaken to ensure that the teaching and training of those firefighting techniques used to contain and cool compartment fires, on the one hand, fully complement techniques designed to attack and extinguish fires, on the other.

4.6 **Rule 43 Recommendation 3 (Shirley Towers)**
It is recommended that a review is undertaken to ensure the adequacy of teaching and training of tactical ventilation procedures in compartment fires to highlight the effect ad-hoc ventilation can have on fire development and to confirm the associated dangers.

(The Fire Brigades Union has made a number of recommendations in previous Coroner inquests into firefighter fatalities, or fatalities in fire. For these purposes the FBU have confined recommendations similar to those made in the four inquests referred to in 2.9.1 to 2.9.5 to analyse whether lessons have been learnt.)

FBU Recommendation 4
That GMF&RS undertake a thorough training needs analysis to identify gaps in firefighter knowledge and skills and to ensure that all firefighters receive regular training in all aspects of active fire safety measures including those which are in line with the Fire Service Manual Volume 3 Fire Safety 'Fire Protection of Buildings' to ensure that all firefighters are aware of the impact the various active fire safety measures may have on their operational procedures.

5 EQUIPMENT

5.1 The two main issues the FBU have identified regarding the Oldham Street fire involving equipment involve both radio communications and the use of the Thermal Image Camera.

5.2 It is evident that the radio communications equipment failed crews on a regular basis.

5.3 As part of the pre-entry checks the Entry Control Board operator, FF Thomson-Ruddy conducted a radio communications check with FF Hunt who believed that Channel 3 was the standard channel to use.

5.4 FF Jeremy Jones gave evidence that at the time when he and FF Hunt began to realise they could not find their way back out to their Entry Control Point that FF Hunt radioed *'5 or 6 times which suggests there was no response, so at this point we were annoyed that there was no response…'* It is without doubt that if radio communications had operated correctly then a far earlier 'BA Emergency' could have been declared and earlier rescue attempts conducted.

(The Fire Brigades Union has made a number of recommendations in previous Coroner inquests into firefighter fatalities, or fatalities in fire. For these purposes the FBU have confined recommendations similar to those made in the four inquests referred to in 2.9.1 to 2.9.5 to analyse whether lessons have been learnt.)

FBU Recommendation 5
That a full and comprehensive review of all radio communication equipment is undertaken as a matter of urgency and that such equipment is operationally reliable as far as is reasonably practicable. If communication issues cannot be resolved to a level that is as safe as is reasonably practicable then control measures are adopted as a result of a risk assessment process and promulgated to all operational crew who have a BA wearing role.

5.5 The use of the Thermal Image Cameras in this incident has been universally identified as being a safety critical issue. Many witnesses including FF Jones stated that they were using the TIC's to measure ambient temperature when that is not the purpose of the TIC.

5.6 The TIC is used to identify heat sources rather than gauging ambient temperatures and that incorrect use of the TIC may have given BA crews a false sense of security as lower temperatures were read as ambient temperatures.

5.7 FF Jones states that his reading of the TIC identified a 50 degree centigrade reading which clearly was not the ambient temperature of the inside of Pauls Hairworld and whilst FF Jones does identify that the TIC does not measure ambient temperature but that of the temperature of the surface the TIC is pointing to, the reading does seem to have been taken as ambient temperature by FF Jones and a considerable number of other firefighters. (See recommendation 6.)

FBU Recommendation 6
That GMF&RS undertake a thorough training needs analysis in relation to the use of Breathing Apparatus, ancillary equipment and procedures, in particular the use of the Thermal Image Camera.

6 BREATHING APPARATUS PROCEDURES

6.1 The FBU have identified what the Union believes to be a number of significant breaches of the relevant national procedures along with local procedures adopted by GMF&RS in relation to BA procedures.

6.2 The FBU in the Harrow Court fatality made the following recommendations:

6.3 **FBU Recommendation 54 (Harrow Court)**
That HFRS should immediately revise its Breathing Apparatus procedures and bring them back into line with TB 1/97. This review will need to take into account of any recommendations that may arise from both the Bethnal Green fatal fire and this particular Harrow Court investigation, together with any recommendations that may arise from the following documents.

- *The revised TB 1/97*
- *Any future revisions to the national 'Guides to Operational Risk Assessment'.*

And,

6.4 **FBU Recommendation 56 (Harrow Court)**
The HFRS IRMP (Integrated Risk Management Plan) should be revised to ensure that the services intervention capability is sufficiently robust to ensure the weight and speed of response delivers sufficient firefighters and operational equipment on the initial attendance to enable their Breathing Apparatus procedures to be implemented in full from the very start of every incident.

London Fire Brigade Recommendation 1 (Bethnal Green)
Improved detailed guidance to Command Officers and firefighters about briefing/ debriefing of breathing apparatus (BA) crews.

6.5 Technical Bulletin 1/97 has now been superseded by the Operational Guidance for Breathing Apparatus (OGBA) from 2014, however TB 1/97 contained the extant procedures at the time of the incident.

6.6 TB 1/97 was augmented by local procedures implemented by GMF&RS.

6.7 Investigation has uncovered a number of breaches of both national and local procedures, amongst these are; the use of the Acme Thunderer whistle for selective withdrawal of crews, the 'splitting up' of BA crews leading resulting on several occasions to a BA wearer being left on their own inside a fire in an area of extreme risk.[28]

6.8 Some of the more significant breaches which may have had a direct impact of the issues encountered by FF Hunt and FF Jones involve:

6.9 **Lack of Emergency Teams**.

6.10 To reinforce how Government expects fire and rescue services to approach TB 1/97 and to what extent it expects services to adhere to the Bulletin it states at 'Introduction – Int2 General Aims and Objectives, Paragraph 1'

[28] (DCOL 5/94).

'BA is used in atmospheres that would be hazardous to health. Often the work undertaken in BA will be complex, physically and psychologically demanding and in circumstances where the normal sensory perceptions are denied. The wearer may face risks from hazards in addition to the irrespirable atmosphere, such as from fire, explosion or collapse. To reduce these risks to the lowest practicable level, command and control procedures are required. The procedures set out in this Guidance must be adopted by all firefighters in all brigades at all incidents.'

6.11 It is unclear at what point in the incident that the Incident Commander decided to implement Stage II BA procedures but clearly the incident quickly merited Stage II. For avoidance of doubt Stage II must be used when

(a) the scale of operations is likely to be protracted or demand greater control and supervision than is provided by Stage I procedure;
(b) more than two ECPs are necessary;
(c) more than ten BA wearers are committed into the risk area at one time; or
(d) branch guide lines are used.[29]

6.12 This incident satisfied 3 of the 4 requirements above and therefore Stage II must be implemented in any event.

6.13 In the event that it has not been possible or necessary for the OiC to appoint an officer to manage operational requirements at the ECP, the ECO should be a minimum rank of crew manager.[30]

6.14 The GMF&RS procedures state that whilst Technical Bulletin 1/97 states that the minimum required rank to be in overall command of a BA ECB at Stage Two is 'Crew Commander' GMFRS Policy is that where possible, a 'Watch Commander, should be in overall command of the BA ECB. It is permissible for any qualified BA wearer to assist. All personnel associated with running a BA ECB must don a yellow and black checked tabard'.

6.15 Up until FF Hunt and FF Jones were committed it was the general practice for firefighters to be placed in charge of the ECB.

6.16 Emergency Teams are fundamental to the safest operation of BA Wearing at incidents and are required at all times at all ECB's at Stage II. TB 1/97 refers to emergency teams being required and equipped at least to the standard that of BA wearers committed to the incident. Emergency teams should be at least the number of the largest BA team committed (ref) and they must be established at all incidents where Stage II BA entry control procedures have been implemented.

6.17 The GMFRS procedures reflect this guidance in that an emergency team must always be available at every entry control point when Stage II is in place. GMF&RS procedures also require emergency teams to have with them at the ECP, an Emergency Air Supply Equipment (EASE) pack.[31]

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29 TB 1/97.
30 TB 1/97.
31 BA010 Emergency Procedures.

6.18 It is not known why the Incident Commander decided to vary this requirement and what risk assessment this was based on but the procedures are very clear in that issue of emergency teams is not a variable but a requirement to ensure safest standards of work.

6.19 Evidence indicates that some ECO's were determined to keep their emergency teams until they were instructed away from the ECB to undertake non-emergency BA operations. CM Thompson-Ruddy stated that when a manager came over attempting to take his one emergency team away he refused on the grounds that he had a BA team committed within the building.[32] That team was not available at the time FF Hunt and FF Jones were in difficulty within the building.

6.20 In relation to the Main Control board TB 1/97 is silent in relation to the minimum level of manager to be appointed as BA Main Control Officer (MCO) but does state that as a minimum the MCO should have the appropriate command and management skills and have shown proficiency in the responsibility required.

6.21 The GMF&RS procedures require that the minimum rank of a BA Main Control Officer to be Watch Manager.[33] Importantly then training would be provided those at a role (rank) designated to undertake the role. CM Gaunt was not a Watch Manager but a Crew Manager.

6.22 The BA Main Control procedures are as clear in this regard. TB 1/97 requires the BA Main Control Officer after liaison with the OiC and ECO's to decide upon the number of emergency BA teams and the number to be in each team.

6.23 For reasons unknown to the FBU, the Incident Commander, GM O'Brien decided that the BA Main Control should have in charge a Crew Manager, rather than the required Watch Manager.[34] CM Lee Gaunt was placed in charge of the BA Main Control and stated in his evidence that he initially he was shocked as he had never run a BA Main Control before and as it was a specialist function should have been run by a Watch Commander (Manager). CM Gaunt had never operated a BA Main Control before and had in fact had only observed one Main Control Board used in his 16 years of service.[35]

6.24 CM Gaunt was relieved to notice the Incident Command Unit attend the incident as this would free the staff from the Operational Support Unit to assist him running the Main Control Board, however the Incident Command Unit was released from the incident without being utilised.

6.25 Tragically, since the incident CM Lee Gaunt has taken his life.

6.26 What is clear from the evidence is that at the time of the BA emergency, there was no emergency team either at Sector 1 nor Sector 4 and whilst the BA emergency was initiated in Sector 4 confusion would have occurred due to FF Hunt and FF Jones entering via Sector 1 ECB.

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[32] Statement 66 – CM Thompson-Ruddy.
[33] BA Command and Control Procedure – Ref BA016.
[34] Statement 64 – GM O'Brien, Page 16.
[35] Statement 57 – CM Gaunt, Page 2/3.

6.27 It was recognised by the Sector Commander at Sector 1, WM Keogh that conditions inside the building were arduous and hazardous and consequently he introduced a secondary control measure of limiting BA wears to a maximum of 20 minutes.[36] This was well known and referred to in the evidence of CM McDonald and FF Brookes (ECO). FF Hunt and FF Jones should therefore have either been relieved by FF Garrott and FF Burbidge at 20:19 hours or they should have been withdrawn, failure to withdraw should have resulted in emergency teams being committed to retrieve them.

6.28 Notwithstanding that point, there were some concern in relation to the safety of FF Hunt and FF Jones that would have alerted BA Emergency Teams to be prepared for urgent commitment.

6.29 FF Hall became concerned that the team he was delivering water to was not using that water and made his concerns known to the ECO who was now CM Flynn. FF Hall also informed CM Dodson, who was by now Sector Commander for Sector 1, that the crew was not using water, CM Dodson instructed CM Flynn to commit two BA wearers to relieve FF Hunt and FF Jones.[37]

6.30 The BA Emergency was declared soon after but rather than specific Emergency Teams committed for the task of rescue, one team that had withdrawn from Sector 1 to get a TIC had to be utilised at Sector 4 whilst other teams had to make their way to the Sector. The lack of an Emergency Team necessarily meant a delay in the rescue operations and meant that a significant time difference of 6 minutes occurred between the rescue of FF Jones and that of FF Hunt.

6.31 The Confined Space Regulations 1997 also require that:

'Emergency arrangements

5.(1) Without prejudice to regulation 4 of these Regulations, no person at work shall enter or carry out work in a confined space unless there have been prepared in respect of that confined space suitable and sufficient arrangements for the rescue of persons in the event of an emergency, whether or not arising out of a specified risk.

(2) Without prejudice to the generality of paragraph (1) above, the arrangements referred to in that paragraph shall not be suitable and sufficient unless –

(a) they reduce, so far as is reasonably practicable, the risks to the health and safety of any person required to put the arrangements for rescue into operation; and

(b) they require, where the need for resuscitation of any person is a likely consequence of a relevant specified risk, the provision and maintenance of such equipment as is necessary to enable resuscitation procedures to be carried out.

(3) Whenever there arises any circumstance to which the arrangements referred to in paragraph (1) above relate, those arrangements, or the relevant part or parts of those arrangements, shall immediately be put into operation.'[38]

6.32 The confined space regulations are the subject of a Health and Safety Executive (HSE) Operational Circular 334/5 promulgated in March 2003. The Operational Circular states;

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36 Statement 60 – WM Keogh, Page 9.

37 Statement 42 – FF Hall.

38 http://www.legislation.gov.uk/uksi/1997/1713/contents/made.

'1 The Confined Spaces Regulations 1997 came into force on 28 January 1998. There are no exemptions for the emergency services and therefore fire brigades are required to comply with the Regulations and associated ACoP. The Regulations came into force just over a year after HSE prosecuted Tayside Fire Board for an incident where a firefighter was killed trying to rescue two men trapped inside a silo containing soda ash.

2 It is frequently a feature of confined space incidents that the rescuers underestimate the risks and may themselves require rescuing. Following the Tayside fatality the Home Office reissued guidance in a slightly revised form (Dear Chief Officer Letter DCOL 1/1997 – now replaced) to the fire service on safe entry into agricultural and industrial silos.'[39]

6.33 Again the requirement for emergency teams in relation to this element of legislation seems not to have been considered.

6.34 The FBU are of the opinion that with the presence of an Emergency Team at each ECB then those Teams would have been committed to both Sector 1 and Sector 4 ECB's meaning that there is a reasonable assumption that a speedier rescue could have taken place. The FBU do not assert that FF Hunt would have survived his injuries but that FF Hunt would have been rescued more speedily.

6.35 **Entry Control Operator Procedures**

6.36 BA Entry Control Operators (ECO's) are restricted to those activities that are directly related to the monitoring of breathing apparatus wearers. There is evidence that some ECO's had dual roles such as appointed as an ECO, along with being a driver and a pump operator.

6.37 FF Brookes, Sector 1 ECO states in his evidence that *'At no time did I ever monitor the rear of my pump although it was supplying water to the teams in Sector 1 and at some point it nearly ran out of fuel and was replaced, crews were withdrawn whilst the pump was changed over. I recall FF Greenhalgh being the ECO in Sector 4, he was also the driver of an appliance and he too had more than one role, his pump was supplying water into Sector 4.'*[40]

6.38 This multi-roling led to the Salford appliance running short of fuel leading to the appliance having to be swapped over with another appliance with sufficient fuel. That meant the water being pumped onto the fire having to be stopped for a period of around 7 minutes leading to a further build-up of the fire.

FBU Recommendation 7
GMF&RS should immediately review and revise all its Breathing Apparatus procedures and bring them into line with the Operational Guidance for Breathing Apparatus promulgated by the Chief Fire and Rescue Advisor on behalf of Government. This review to ensure adherence to the guidance and done in conjunction with the representative body safety representatives via the GMF&RS Health and Safety Committee.

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[39] HSE Operational Circular – 334/5.
[40] Statement 8 – FF Brookes.

Each Fire and Rescue Authority is required, by Section 1.3 of the Fire and Rescue National Framework for England, to produce an Integrated Risk Management Plan (IRMP). The Secretary of State is required to prepare the Fire and Rescue National Framework by virtue of Section 21 of the Fire and Rescue Services Act 2004.

FBU Recommendation 8
GMF&RS IRMP should be revised to ensure that numbers of operational firefighters is sufficient at all times to be able to implement the outcomes of FBU Recommendation 6 at all times.

7 INCIDENT COMMAND

(The Fire Brigades Union has made a number of recommendations in previous Coroner inquests into firefighter fatalities, or fatalities in fire. For these purposes the FBU have confined recommendations similar to those made in the four inquests referred to in 2.9.1 to 2.9.5 to analyse whether lessons have been learnt.)

7.1 **FBU Recommendation 57 (Harrow Court)**
'That HFRS should immediately revise its Incident Command System and ensure that it corresponds with the Fire Service Manual Volume 2 Fire Service Operations – Incident Command. This review will also need to take account of any recommendations that may have arisen from both the Bethnal Green fatal fires, and Petershill Court, Glasgow fire and this particular Harrow Court investigation.'

And,

7.2 **FBU Recommendation 59 (Harrow Court)**
'That HFRS would also have to prepare a new Dynamic Risk Assessment training programme, ensuring that it meets the requirements of the Revised Incident Command System and ensure that all operational personnel and supervisory officers receive regular centrally delivered practical, theoretical and refresher training as soon as reasonably practicable.'

And,

7.3 **Coroner Recommendation (Lakanal House)**
'It is recommended that the Brigade Review its policy and procedures concerning incident command, having regard to whether it is effective for the choice of IC to be tied closely to the number of type of appliances attending an incident and the effectiveness of a policy which may result in rapid and frequent changes of IC. It is also recommended that consideration be given to training of IC's and potential IC's to enhance their performance in relation to the following

- *Use of the Dynamic Risk Management model and other management tools to enable ICs to analyse a situation, and to recognise and ract quickly to changing circumstances*
- *To recognise when to escalate attendance by more experienced ICs*
- *To anticipate that a fire might behave in a manner inconsistent with the compartmentation principle*
- *To be aware of the risks to those above and adjacent to the fire flat*
- *Handover from one IC to the next and effective deployment of outgoing ICs*
- *The collection of information from all possible sources*
- *Use of methodical search patterns'.*

And,

7.4 **FBU Recommendation 61 (Harrow Court)**
'The HFRS IRMP should be revised to ensure that the services intervention capability is sufficiently robust to ensure that the weight and speed of response delivers sufficient firefighters and operational equipment on the initial attendance to enable their Incident Command System procedures to be implemented in full from the very start of every incident.'

7.5 It is poignant and regrettable that the FBU today recommend the very same actions in relation to potential learning outcomes from FF Hunt's death.

7.6 It is without doubt that Incident Command is the most important element of successfully resolving an emergency incident as safely as is possible. Those with Incident Command responsibilities must be trained and competent to do so.

7.7 Much is made in the Fire Service Manual Volume 2 Fire Service Operations Incident Command 3rd Edition 2008 regarding lines of command and spans of control. To assist the Incident Commander (IC) in these processes the IC may decide to delegate responsibility and devolve authority for some of the operations. It is vital that those delegated with responsibility do so diligently and report back to the IC on all relevant occasions.

7.8 **Roles and Responsibilities**

7.9 At this incident there were a number of personnel who had functional roles delegated to them such as Operations Commander, Sector Commanders, Safety Officers, Command Support Officers, Operations Support Officer, Logistics Officer, ECO's, BA Main Control Officer and Welfare Officer. This was a protracted and difficult incident with many functional officers assisting the IC. GMF&RS adopt a further role of Operations Assurance Officers.

7.10 GMF&RS train their officers in how to discharge their delegated authority yet the evidence indicates that this was not properly carried out at all times.

7.11 **Logistics Officer**

7.12 The GMF&RS procedures provide for the Logistics Officer to, amongst other duties take responsibility for personnel numbers and equipment, but also for Breathing Apparatus and would supervise the BA Officer. BA Main Control will communicate with the Logistics Officer.

7.13 SM Parkinson was the Logistics Officer but thought that WM Jordan was the BA Main Control Officer, he was wrong in that regard.[41] That error resulted in a Crew Manager who had never managed BA Main Control before having to undertake a role he was clearly uncomfortable with. The Logistics Officer should have ensured GMF&RS procedures were adhered to and that along with the BA Main Control Officers input ensure that BA Emergency Teams were available at all ECB's at all times.

7.14 WM Jordan confirms that GM O'Brien appointed him as the Welfare Officer.[42]

7.15 **Operational Assurance Officers**

7.16 GMF&RS adopt the practice of using Operational Assurance Officers (OAO) to ensure that procedures are adhered to and all work practices are as safe as is possible.

7.17 SM Duckworth was the first OAO to attend but made certain errors that the FBU believe to be safety critical.

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41 Statement 30 – SM Parkinson.

42 Statement 64 – GM O'Brien.

7.18 SM Duckworth stated that the temperature readings recorded by the TIC were monitored both outside and inside to monitor conditions. SM Duckworth refers to TIC readings being only 50 degrees centigrade in Sector 1 when clearly that was not the case.[43] As aforementioned it is accepted by all parties that the use of the TIC was not as prescribed in the guidance, it concerns the FBU when the OAO, who are essentially the operational quality control element of GMF&RS, replicate the error.

7.19 SM Duckworth also believed that there were sufficient BA Emergency Teams available for use as and when required when that evidently was not the case. Again, an important opportunity to rectify such a safety critical error was missed indicating a possible cultural malaise exiting in relation to such matters. It is accepted that issues such as this are resource intensive but safety cannot be arbitrary and the safety of crews can be the only determinant factor.

7.20 SM Duckworth is confused regarding the incident Sector numbers and refers to a Sector that was never operational (Sector 2), it is unknown at this stage whether that had any effect on operational issues but it would be expected that those in operational assurance positions would be aware of Sectors within the operational ambit.

7.21 It is interesting to note that SM Duckworth was of the opinion that no BA crews were committed deep into the building and so was puzzled as to the BA Emergency call.

7.22 SM O'Connor made similar mistakes in relation to both being confused about the Sector numbering and the identity of the BA Main Control Officer. SM O'Connor was of the opinion that Sector 1 was at the front of the building on Oldham Street and that the BA MCO was WM Jordan. This and other errors are not what caused the death of FF Hunt but indicate a general lack of incident command awareness and skills that seemed to seep throughout Incident Command.[44]

7.23 This was further indicated in the lead up to the handover processes and the apparent change of tactical direction in that a more aggressive approach to the firefighting activity seemed to be adopted without a suitable and sufficient assessment of risk.

7.24 The use of the aerial appliance as a water tower in Sector 3 is of particular concern. It is clear from the evidence that all involved in the application of water from the aerial appliance in Sector 3 were not aware of any BA crews within the building at any sector and have confirmed they would not have introduced water onto the fire if they knew. Suck application of water into a fire within a compartment would without doubt have changed conditions for the worse. Sector commanders in Sectors 1 and 4 were similarly unaware of water being introduced into the compartment.

7.25 FF Hood when he was made aware of the aerial appliance being used to introduce water into the first floor of Plaintree House refused to enter the building on safety grounds, grounds which were accepted by the Sector command team.

7.26 It is equally concerning that whilst giving evidence operational managers have confirmed that they did not believe that such use of aerial appliances as water towers were of concern and would conceivably repeat their actions.

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[43] Statement 24 – SM Duckworth.

[44] Statement 40 – SM O'Connor.

FBU Recommendation 13
That GMF&RS immediately review its procedures for the use of aerial appliances at operational incidents, particularly for the use of aerial appliances as water towers at incidents where firefighting crews are present within the building. The review to be co-ordinated within the GMF&RS Health and Safety Committee.

8 RISK ASSESSMENT

8.1 The evidence suggests that a strategic decision was taken to move from a tactical direction of not allowing firefighters to commit into the building at any Sector, to an apparent more aggressive approach of committing firefighters deeper into the building.

8.2 At any time of a change of tactical direction, it is assumed that the Incident Commander would undertake an appropriate risk assessment. The FBU can find no evidence of any analytical risk assessment being undertaken throughout the incident until the BA Emergency, as required by the Fire and Rescue Service Manual Vol 2, Fire Service Operations, Incident Command, 3rd Edition 2008. The risk assessment process involves a number of key functions involving generic risk assessment (GRA), dynamic risk assessment (DRA) and analytical risk assessment (ARA).

8.3 Analytical risk assessment is a more detailed assessment of risk than the dynamic risk assessment and must be recorded. The ARA should be kept under constant review, whenever the risk to firefighters change (or at 20 minute intervals, whichever is the sooner) the Tactical Mode should be reviewed and the risk assessment confirmed or changed as required.[45]

8.4 The Department for Communities and Local Government produced a health, safety and welfare framework for the operational environment in June 2013. The framework states;

> *'Many incidents attended by a Fire and Rescue Authority are dealt with using limited resources. In many cases, especially where the incidents are quickly brought under control and concluded, electronic recording may be sufficient on its own. However, sometimes more control is required which may involve extensive resourcing by a Fire and Rescue Authority, including fire appliances, equipment and personnel. These incidents often require the support of partner services and agencies. In turn, this may require a more detailed and written record of the significant findings of risk assessment.*
>
> *These can relate to activities at several locations throughout an incident ground but may relate to elaborate measures at smaller incidents as well. The generic Fire and Rescue Authority term for this written record is an analytical risk assessment on which detailed guidance is provided in the* Incident Command Manual.'[46]

8.5 There appears an over reliance on the DRA at this incident with no recorded ARA up to the time of the death of FF Hunt. Evidence indicates that a Policy and Decisions Log was commenced at 22:10 hrs which was after FF Hunt lost his life.

8.6 What is evident is that SM Parkinson reports to control sometime prior to change of shift and whilst discussing numbers of relieving crews with control that *'We're just going incredibly offensive at the moment'.*[47]

8.7 At 19:18 hrs GM O'Brien sent a message that all BA were withdrawn from inside the building due to worsening conditions and that the fire had broken through to the first floor. GM O'Brien confirmed that jets and an Aerial Appliance were being directed into the first floor windows. That resulted in considerable water being introduced into the premise undoubtedly causing a considerable rise in steam.

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45 Incident Command Manual 3rd Edition – Section 4.10.

46 Fire and Rescue Authorities Health, Safety and Welfare Framework for the Operational Environment.

47 X886 Transcript Radio Comms 153977 – 1540399 From Exhibit Jam 1 Part 2 of 2 (Redacted).

8.8 At 19:30 hrs GM O'Brien was seen in discussion with a number of managers, and was observed pointing at Sector 1.[48] GM O'Brien then appeared to instruct GM Myers to change the operational plan and GM Myers made his way to the Entry Control Point (ECP) and relayed this information to CM McDonald who in turn relayed the information to the BA crews, FF's Markham and Hood. FF's Markham and Hood did as instructed and CM McDonald informed the ECO CM Thompson-Ruddy who amended the BA board as a consequence. The photograph of the BA Board indicates that the brief was amended to record that the task was 'first floor stairwell'.[49]

8.9 It is not known at this point why the plan changed and crews instructed to go further into the building whilst significant water was being introduced at Sector 3 via jets and an Aerial Appliance, but what is known is that there is no evidence of an ARA to support this change of tactic.

8.10 This is concerning, as prior to this decision, and mindful of the requirement to have to withdraw firefighters due to deteriorating conditions, water was lost at Sector one at around 18:42 hrs for approximately 7 minutes due to an appliance being switched due to low fuel. This led to a dramatic increase in smoke as well as an increase in temperature inside the building.

8.11 At Sector 4, at 19:44 hrs, water was also lost to the Ground Monitor for a period of 8 minutes with again the obvious resultant increase in temperature inside the building.[50]

8.12 Further, at 18:58 hrs, tactical ventilation took place at Sector 3 requiring crews at Sector 1 being withdrawn. The effect of such a tactic would be to introduce fresh air into the building with a view to ventilating smoke and reducing the risk of flashover.

8.13 Evidence also indicates that the Aerial Platform that was delivering water into the first floor was lowered and delivered water into the ground floor at Sector 3. This introduced significant amounts of water into the incident at the ground floor level.

8.14 No ARA seems to have taken place on any of these occasions.

8.15 FF Jones states that he and FF Hunt received briefs from CM Thompson-Ruddy who was the ECO at that time and CM McDonald. FF Jones says he asked the manager to run through the brief again which was to find a set of stairs on the left hand side leading to a mezzanine level, from there their role was to search out hot spots using the TIC and search out any seats of fire.[51]

8.16 What is clear from FF Jones's statement is that they did not stay at the top of the stairs but made their way into the building. FF Hall states that they took 10 metres of hose into the building.

8.17 FF Jones states that they made their way left and adopted search tactics. This was evidenced by FF Hunt utilising what firefighters know to be a 'door procedure' which is adopted when opening a door with fire suspected to be behind it, the firefighter kneels and protects his/herself whilst opening the door in a controlled manner. This would not have occurred if the brief was understood to be to stay at the top of the stairs.

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48 WYF&RS Sequence of Events.
49 X482 Photograph dsc 0001
50 WYF&RS Sequence of Events.
51 GMP Interview Transcript – FF Jeremy Jones, Part 1, Page 16.

8.18 FF Hunt and FF Jones then made their way to the mezzanine stairs with FF Hunt taking the decision to go to the top of the stairs to the mezzanine level. FF Hunt was the only firefighter to go to the top of the mezzanine stairs in the entire incident to that point.

8.19 It may well be that there was some confusion with the use of the term 'mezzanine' but the additional control measures in place at the time ensured no firefighter went past the top of the stairs. Both CM Thompson-Ruddy and CM McDonald state they are sure that the brief they gave was the same brief as they gave all day with, CM McDonald stating that *'My instructions to them remained the same but in a little more detail, due to night crew being new to the incident. I told them to go to the top of the stairs, turn left, then look right and fight the fire from there, to use the TIC and if it gets too hot then pull yourself out. I reinforced that the conditions inside were compact and that I didn't want any heroics.'*

8.20 CM Thompson-Ruddy stated that *'The brief was to relieve a team already in, I told them to go through a double set of doors up a short step of stairs to a mezzanine and squirt water from there don't move, nothing more than that. My role was to was to relay what's been set down before and I am confident my brief reflected this; I would never tell them to do something different.'*

8.21 It is also interesting to note that CM Thompson-Ruddy remembers SM Crawley stating over the radio to crews to make sure the changeover is smooth as because *'this could go Pete Tong'*.

8.22 Whilst FF Hunt and FF Jones were committed into the building through Sector 1, an incident wide hand over seems to be taking place at the same time. In Sector 1, both the ECO and the Sector Commander handed over, or were handing over to their relieving teams but CM McDonald's role was not replicated. The entire incident command team was handing over to their reliefs.

8.23 There appears to be no thought of a staged handover, over a number of hours and in fact GM O'Brien states that he wanted to reward the crews on the incident ground with overtime that would become available by changing over with the night crew.

8.24 With the handovers taking place at the same time, a scaling down of the safety regime (the loss of CM McDonald's role) and the BA team of FF Hunt and FF Jones receiving briefs from two people, along with a significant amount of water being applied to the ground floor via the Aerial Appliance at Sector 3, a jet delivered through the window via the raised platform at Sector 1 and a ground monitor at Sector 4, all of this cumulatively presented a set of circumstances that placed FF Hunt and FF Jones at a significant risk.

FBU Recommendation 9
That GMF&RS immediately reviews handover procedures with a view to introduce staggered handovers, with a controlled staged handover procedure to be introduced at all necessary times.

FBU Recommendation 10
That GMF&RS should immediately revise its Incident Command System and ensure that it corresponds with the Fire Service Manual Volume 2 Fire Service Operations – Incident Command. This review to ensure proper and Analytical Risk Assessments be undertaken in a timely manner.

FBU Recommendation 11
That GMF&RS review its Dynamic Risk Assessment training programme, ensuring that it meets the requirements of the Incident Command System and ensure that all operational personnel and supervisory officers receive regular centrally delivered practical, theoretical and refresher training as soon as reasonably practicable.

FBU Recommendation 12
That GMF&RS review its mobilisation policy to give consider whether the Incident Command Unit should by policy be the unit that assist Incident Command at incidents such as Oldham Street.

POSTSCRIPT

Recently the joint report into the death of FF Ewan Williamson was published. The report was compiled by the Fire Brigades Union and the Scottish Fire and Rescue Service and has been accepted in its entirety by the Scottish Fire and Rescue Service Board on behalf of the Scottish Government.

The report seeks to identify lessons that must be learnt from Ewan's death via a number of recommendations which have a striking similarity to the recommendations the FBU make in relation to identifying lessons to be learnt from Stephen's death.

In March 2015, the Scottish Fire and Rescue Service (SF&RS) pleaded guilty to a contravention of sections 2(1), 2(2) and 33(1) (a) of the Health and Safety at Work etc. Act 1974 in that their statutory predecessors, Lothian and Borders Fire and Rescue Board had failed to ensure, so far as reasonably practicable, the health safety and welfare at work of their employees engaged as firefighters, including firefighter Williamson, in four separate respects. These were:

- *(firstly)* failing, between 13 July 2008 and 12 July 2009, to adequately monitor and ensure attendance by fire fighters at training courses and failing to maintain adequate training records for them;
- *(secondly)* failing, between 13 July 2008 and 12 July 2009, to adequately train firefighters to ensure close personal contact was maintained during firefighting and search and rescue activities;
- *(thirdly)* failing on 12 July 2009 at the fireground at the Balmoral Bar, 178 Dalry Road, Edinburgh to have in place an effective system of radio communication; and
- *(fourthly)* failing on 12 July 2009 at the fireground at the Balmoral Bar to have in place an effective system of implementation of procedures for firefighters using breathing apparatus.

A summary of the lessons and recommendations including a benefit assessment (right hand column) resulting from Ewan's death is provided below:

Lessons and recommendations summary

Lesson 1: The incident has highlighted the urgency for the SFRS to implement a robust breathing apparatus policy and procedure.	
Recommendation 1: The SFRS to develop an overarching BA policy that includes detail on the requirements for BA training and welfare arrangements.	**Critical**
Recommendation 2: The SFRS to develop and publish a standard operating procedure (SOP) on the use of breathing apparatus.	**Critical**
Lesson 2: Training operational staff in the developed SFRS breathing apparatus procedure, and ensuring they are competent, will reduce the risk to firefighters.	
Recommendation 3: The SFRS to develop publish and implement a training standards framework that includes the use of breathing apparatus.	**Critical**

Lesson 3: Early consideration needs to be given to the development of a SFRS policy for the tactical ventilation of buildings.	
Recommendation 4: The SFRS to develop and implement a consistent policy and procedure for tactical ventilation across the Service.	**Critical**
Lesson 4: The training of operational staff in tactical ventilation techniques to ensure competency in line with SFRS policy will reduce the risk to our Firefighters.	
Recommendation 5: All operational staff from firefighter to watch manager are required to be competent in line with the SFRS tactical ventilation policy and procedure.	**Essential**
Recommendation 6: All flexi duty managers are required to have an understanding of the application of tactical ventilation techniques so that they are competent to develop a tactical plan.	**Essential**
Recommendation 7: In addition to an ongoing maintenance of skills programme, refresher training is required in line with the training standards framework.	**Essential**
Lesson 5: There is a need to renew the emphasis on the resourcing of an appropriate command, control and communications infrastructure at complex incidents.	
Recommendation 8: An operational maintenance of skills syllabus and training programme is developed to ensure competence in incident command and functional roles is established and maintained.	**Essential**
Recommendation 9: The SFRS to develop incident command and functional officer memory aid to provide support to those undertaking functional roles.	**Advantageous**
Recommendation 10: The SFRS operational assurance process is required to support the ongoing development of incident commanders by sharing lessons identified.	**Essential**
Recommendation 11: The SFRS to ensure that the communications infrastructure on the incident ground is fit for purpose.	**Essential**
Lesson 6: The level of training for operational staff in risk management is insufficient to ensure a balanced approach between meeting operational needs and the health and safety of staff on the incident ground.	
Recommendation 12: The SFRS is required to develop a risk management policy and guidance for use at operational incidents.	**Essential**
Recommendation 13: A greater focus is required to embed ARA into decision making when developing an operational or tactical plan. Therefore it should become a key component of incident training.	**Essential**
Recommendation 14: Operational personnel at all levels require training in risk management to improve the use of DRA and ARA in order to improve firefighter safety.	**Essential**
Recommendation 15: Consideration should be given to supporting the undertaking of a UK wide project into behavioural safety at operational incidents.	**Essential**

Lesson 7: Any future enquiries are required to ensure that the timely, effective and proportionate organisational support to staff in such stressful situations is made available.	
Recommendation 16: The SFRS is required to test its capability and capacity to deal with the occupational health requirements for an incident on the scale of the reasonable worst case scenario	**Essential**
Recommendation 17. The SFRS should review their Death in Service Policy taking due consideration of the Chief Fire Officers Association Death in the Workplace guidance.	**Advantageous**
Lesson 8: The resources required to provide expert advice to a police force outside Scotland in support of an investigation on this scale should not be underestimated.	
Recommendation 18: Clarity on the role, responsibilities and financial arrangements prior to the drawing up of a protocol between the SFRS and a police force requires to be established.	**Advantageous**
Lesson 9: The full set of professional competencies required to undertake an investigation of this nature is unlikely to be available within any fire and rescue service.	
Recommendation 19: The SFRS should develop a database of professional advisors to support complex investigations and project delivery in areas that are outwith the scope of internal staff competencies.	**Advantageous**

The FBU in compiling this report endorses the lessons and recommendations from the joint report into Ewan's death and notes that they reflect the recommendations resulting from Stephen's death, independently made prior to viewing this report.

It seems clear that lessons are not being learnt from previous tragedies and it is hoped that the recommendations made within this report are accepted by HM Senior Coroner, Mr N Meadows to assist the process in which firefighters can be as safe as is reasonably practicable undertaking the job we are trained to undertake on behalf of the communities we serve.

Monday 2 May 2016

SECTION 2

Following the conclusion of the inquest the senior coroner, Mr Meadows, published a Regulation 28 report in relation to the Oldham Street incident. This report was primarily addressed to the home secretary and the chief fire and rescue adviser but was copied to other interested parties including the Fire Brigades Union.

The report outlined:

- **The findings of the jury on a range of issues**
- **The circumstances that resulted in the death of Stephen Hunt**
- **Several concerns and a number of recommendations that would need to be actioned to avoided further firefighter fatalities.**

(N.B the section outlying the circumstances resulting in the death of Stephen Hunt has been redacted to protect the identity of the juveniles involved.)

This section contains the Regulation 28 report from Mr Meadows in full.

STEPHEN ALAN HUNT (DECEASED)

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- The Rt Hon. Theresa May MP, the Home Secretary
- Mr Peter Holland CBE, Chief Fire and Rescue Adviser

Copies for interest to:

- The Chief Fire Officer of Greater Manchester Fire and Rescue Service
- The Chief Fire Officer of Merseyside Fire and Rescue Service
- The Chief Fire Officer of West Yorkshire Fire and Rescue Service
- The family of the Deceased
- The President of the IFE
- The other Interested Persons in the Inquest

1 CORONER

I am Nigel Meadows, H.M. Senior Coroner for the area of Manchester City.

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INQUEST

In summary terms the jury found that the deceased had been unlawfully killed (by unlawful act manslaughter by arson) by a joint enterprise involving two juveniles and answered a number of other specific factual issues.

Narrative conclusion comprising the answers to the following questions:

Question 1: Are you satisfied so that you are sure that the deceased was unlawfully killed by the acts of a single person?

Answer: No

Question 2: Are you satisfied so that you are sure that the deceased was unlawfully killed by the acts of a joint enterprise?

Answer: Yes

Question 3: Do you find that the fire was probably deliberately started by the acts of one person?

Answer: No

Question 4: Do you find that the fire was probably deliberately started by the acts of a joint enterprise?

Answer: Yes

Question 5: Was the caged cardboard storage area and the racking up the stairs from the emergency exit doors probably installed in or about the summer of 2009?

Answer: Yes

Question 6: Was the caged cardboard storage area and the racking up the stairs from the emergency exit doors probably installed and in place on 2 August 2012 when a fire risk assessment was carried out and was it in place on 13 July 2013?

Answer: Yes

Question 7: Did the presence of the caged cardboard storage area and the racking up the stairs from the emergency exit doors contribute to the fire developing?

Answer: Yes

Question 8: This question asks you about the probable control measures that were in place during the afternoon shift on 13 July 2013:-

(a) Was the period of wear for BA crews entering through the doorway in sector 1 probably limited to a period of time during the day shift?

Answer: Yes

(b) If the answer to the previous question is "yes", what was the time limit?

Answer: Maximum 20 minutes

(c) Were most BA crews entering through the doorway in sector 1 probably told to remain at the top of the stairs just inside the doorway and fight the fire from there only?

Answer: Yes

(d) Were there any other probable safety control measures instigated in sector 1 doorway for BA crews entering the building during the afternoon of 13 July 2013?

Answer: Yes, there was a second safety officer to keep an eye on BA crews entering the doorway and to keep visual and/or verbal contact to check that they are okay.

Question 9: Were the safety control measures that you have identified in response to question 8 probably communicated to:-

(a) The entry control officer who sent the deceased and Jeremy Jones into the building?

Answer: No

(b) The new sector commender for sector 1 at the changeover of shifts at about 2000 hours on 13 July 2013?

Answer: Yes

(c) The new entry control officer for sector 1 at the changeover of shifts at about 2000 hours on 13 July 2013?

Answer: No

Question 10: Were the same safety measures that you have identified in response to question 8 probably in place when the Deceased and his colleague entered the building and if not should they have been?

Answer: Measures were in place although not implemented. These measures should have been carried through over handovers.

Question 11: Did the new sector commander and/or entry control officer for sector 1 probably fail to understand or comprehend and then implement the safety measures they were advised about?

Answer: The new sector commander misinterpreted the brief and the entry control officer was not fully informed and, therefore, couldn't implement the safety measures.

Question 12: On or about the time the deceased and his colleague entered the building was either of the new Entry Control Officer, the Sector Commender, the Sector Safety Officer, probably aware of the following:-

(a) that the previous BA teams had been limited to a 20 minute wear? If so, please specify who (by reference to their role and not their name – for example, Sector Commander; Entry Control Officer; Sector Safety Officer etc) knew what?

Answer: Ops commander, Sector 1 commander, Second safety officer, Ops support, Ops assurance and Sector safety officer.

(b) that they had been directed to go to the top of the stairs and fight the fire at that point but go no further? If so, please specify who (by reference to their role and not their name – for example, Sector Commander, Entry Control Officer; Sector Safety Officer; etc) knew what?

Answer: Sector 1 commander, BA entry control officer, second safety officer, incident commander, operations commander, operational support, operations assurance, sector safety officer, logistics officer, and sector 4 commander.

(c) that a safety officer had been dedicated to watch over them and keep in communication? If so, please specify who (by reference to their role and not their name – for example, Sector Commander; Entry Control Officer; Sector Safety Officer; etc) knew what?

Answer: Second safety officer, sector 1 commander, operations commander, operational support, sector safety officer, and sector 4 commander.

Question 13: (a) What brief was probably given to the deceased and his colleague before entering the building at 20:04 hours; and (b) had this brief changed from earlier briefs and, if so, in what respect/s?

Answer: The deceased and his colleague were two briefs. The entry control officer gave: "Go to the top of the stairs, take over, sit there and squirt water, top of the mezzanine, you know what the crack is". The second safety officer gave this quote "Go to the top of the stairs, turn left, turn right, use the thermal imaging camera, and spray water from there." The brief changed from earlier briefs due to the wording – sorry, the brief changed from earlier briefs due to the wording with the inclusion of the word "mezzanine" and no direct instructions.

Question 14: Did the deceased and his colleague probably follow their brief?

Answer: Yes, they followed their brief as they understood it. The confusion was due to the use of the term "mezzanine" and "seek out hot spots" may have led them to misunderstanding the brief.

Question 15: What factors probably contributed significantly to the death? They need not be the sole or even the principal cause of death, but they must be more than merely minimal.

Answer:

1. Lack of communication/information at handover
2. Lack of communication, information at briefing and debriefing
3. Misinterpretation of instructions
4. Incorrect decision making
5. Competency within roles given
6. Paul's Hair World storeroom layout, internal conditions (stock, debris, smoke detectors)
7. Breakdown of telemetry radio communications
8. Inadequate fire risk assessments
9. Inadequate fire safety measures within Paul's Hair World (Fire drills)
10. Act of vandalism/criminal damage.

4 CIRCUMSTANCES OF THE DEATH

The events concern a business known as Paul's Hair and Beauty World ("PHW") operating from the ground floor of 21 to 33 Oldham Street in the city centre of Manchester. The business is run by Mr Paul Barnett and he took up occupation of this premises in approximately 2003 as a sub-tenant. He then became the main tenant in 2006. Over the years his business has been quite successful and he has other outlets. The nature of the business is the sale in particular of human and synthetic hair extensions as well as associated hair and beauty products. He also had an on-line business.

Prior to PHW's occupation, the premises was used as a nightclub requiring a public entertainment licence. It has a main front entrance as well as a rear emergency exit comprising of two doors which open outwards, but also another emergency exit which led onto a protected staircase also towards the rear of the premises. It seems the protected staircase emergency exit was not used and indeed was padlocked when PHW took over the premises. The evidence indicated that it had never been used. The front of the premises was designed as a shop in which customers could simply walk through aisles of products and it also had display cabinets. There was a main counter system. The rear of the premises was used for storage and office space and this was at a premium. It seems that over the years in order to boost the level of stock that could be kept a system of wooden racking from floor to near ceiling had been fitted out. It seems that by 13 July 2013 the disused emergency exit doors had been covered with racking for some years.

In or about 2004 Mr Aspinall, who had previously been a Greater Manchester Fire and Rescue Service ("GMFRS") firefighter for 23 years, started an unincorporated business known as Firefighter UK. Originally, he simply serviced fire extinguishers at PHW but, as his business developed, he subsequently held himself out as being a competent fire risk assessor. In 2009, he completed a formal fire risk assessment document for PHW. He returned in 2010 and 2011 to service the business's fire extinguishers. However, in July 2012 PHW had a health and safety assessment carried out by Mr Melia of a business known as Spectra Business Solutions and it was noted that the businesses fire risk assessment was out of date. Mr Aspinall was contacted and arranged to attend again, and conducted what he told the court was a fresh or initial fire risk assessment.

In about the summer of 2009, a Mr Smith, of RA Smith Joinery was asked by PHW to construct a mezzanine floor level within the storage area at the rear of the demised premises and in addition to create some additional racking to store products which run up from the emergency exit doors at the rear of the premises on the right-hand side as you look at them from outside. He also created a caged cardboard storage area which was situated behind the left hand door as you look at them from the outside.

Consequently, when Mr Aspinall carried out his first fire risk assessment in 2009, the evidence suggested that the mezzanine together with the additional racking by the emergency exit doors and the cardboard storage area had been created and was in existence and in use. That would be the same position in 2010 and 2011 and indeed again in 2012.

The emergency services were called at 14:59 hours and initially three fire appliances (or pumps) attended with other supporting colleagues travelling by other vehicles. However, very quickly it became clear that additional resources would be required to fight a fire and eventually some twelve pumps attended, in addition to initially one and then a second aerial platform. The fire was deep-seated and extremely difficult to tackle.

On 13 July 2013 [redacted] and [redacted] had travelled by train into Manchester from Bolton in order to visit the city centre. [redacted] had her 15th birthday only a few days before and she had been given some money by her father. The weather on that day was particularly warm with temperatures reaching 27°C. Both girls were intending to visit a business known as Affleck's Palace which is adjacent to PHW's premises.

One entrance into Affleck's Palace is situated near to the rear of PHW's premises on what is known as Tib Street. Significant parts but not all of the events of relevance that happened thereafter were captured on CCTV cameras. The evidence indicates that [redacted] and [redacted] went to sit outside the rear emergency exit doors of PHW at about 14:38:32 hours. Both girls wanted to smoke and it seems that they sat down and lit and smoked a cigarette each. [redacted] had a handbag which contained both the cigarettes and lighters which were in their possession. There was a significant dispute as to fact between [redacted] and [redacted] about what transpired. It was contended by [redacted] that for some time she had difficulty in practical terms in actually using a lighter and she got her friends to do so and in particular [redacted].

[redacted] told the court that she was still unable to light a cigarette using a lighter on 13 July 2013. She said that [redacted] lit her cigarette for her on this occasion and passed her the lit cigarette. However, [redacted] maintained that whilst [redacted] had been unable to light her own cigarettes using a lighter for some time, she was able to do so by 13 July 2013 and did in fact light her own cigarette on this occasion. It would be fair to say that there were inconsistencies and contradictions in both their accounts but this was a matter of fact for the jury to determine.

The girls sat down and smoked the cigarettes slowly and chatted for a few minutes. The CCTV shows their leaving the vicinity of the rear emergency exit doors 14:45:36 hours. However, it is suggested that on close observation of the CCTV images the first signs of smoke from the fire are seen at about 14:46:33 hours. This was before the girls leave the doorway. At about 14:47:06 smoke was clearly visible. In other words about one and a half minutes after the girls moved away from the doors. Ms Purcell, the shop manager, ran around the back and is seen on camera at 14:47:11 hours and she thought that it had taken about 2 minutes being alerted to the fire to arriving at the back doors. The fire itself was discovered by an employee of the business known as Mr Bardsley. Allowing a margin of error for back circulation it was estimated that he had actually discovered the fire at about 14:45:35 hours. This means that the fire was first noticed when [redacted] and [redacted] would still have been at the doors. When it was first discovered the fire was described as being in the cage cardboard storage area with flames about 4 or 5 feet high. As a matter of common sense it would have taken some time to get to that stage after ignition, albeit quite rapidly as the expert evidence indicated.

The court heard from a total of four expert witnesses in relation to the cause of the fire. Merseyside Fire and Rescue Service have been appointed to investigate the fire and the fire investigator involved was Mr Michael Kirby. He was an extremely experienced fire officer with over 10 years experience as a fire investigator and had investigated in excess of 1000 fires. He visited the scene of the fire following the fatality and took a number of photographs. Subsequently a number of tests were conducted in a simulation of the location. In his opinion, the fire had been caused by naked flame passed underneath the left-hand door as you look at them from the outside coming into contact with cardboard in the store.

In simple terms on the accounts given by both juveniles, neither of them could have been responsible for starting the fire. There was no evidence of any other third party involved.

Even if there had been a discarded cigarette involved originating from either of them they both told the court that they smoke their cigarettes virtually down to the filter and had stubbed their cigarettes out very shortly before leaving. Irrespective of the consideration of there being insufficient fuel in the sense of tobacco to burn in the cigarette, the experiment that Mr Henderson conducted would suggest that even in unique circumstances it would have taken another three and a half minutes for the fire to have started and it was quite clear that the fire had started when the girls were at the back door.

Mr Kirby's opinions were supported by Mr Julyan Isaac who is a forensic scientist and has been investigating fires since about 2002. He had been involved in advising the police and the CPS in connection with the original prosecution of [redacted]. He agreed that the seat of the fire was the caged cardboard store. He too had attended the scene of the fire and assisted in the initial excavation. In his opinion the most likely explanation was fire started as a result of a naked flame rather than a smouldering cause, such as a lit cigarette. He agreed with Mr Kirby that a lit leaflet could ignite cardboard within seconds or almost instantly. Whilst he acknowledged that in very particular circumstances it may be possible to start a fire using a lit cigarette, having read the transcripts of the evidence given by both juveniles it was apparent that neither of them was saying that any cigarette butt that they had been smoking had rolled under the left-hand door or could have rolled under the left-hand door.

In any event both girls were saying that their cigarettes were completely extinguished and had been smoked virtually down to the filter. Mr Isaac's opinion that the cause of the fire was due to a naked flame was supported because of the timing of the events and that the girls were at the doors when the first signs of smoke can be seen. All of this points towards a naked flame ignition rather than a smouldering source.

Mr Alan Henderson, another forensic scientist who had been investigating fires longer than Mr Isaac, was essentially of the same view, particularly with regard to the timings of the development of the fire. He had been instructed by the solicitors then acting from [redacted] in respect of the criminal charges but had not been provided with copies of the girls' police interview records to understand precisely what they were alleging had happened. He had been asked to consider whether or not the fire could have been potentially caused by a discarded lit cigarette igniting combustible materials. He was advised that [redacted]'s cigarette was dropped on the floor and it either was rolled or was kicked under the rear door. However, he agreed when giving evidence that if the explanation about a lit cigarette rolling under the door is ruled out then that would leave only one other potential source of ignition. Namely, the use of a naked flame in the form of a lit leaflet pushed under the door.

He did not attend the scene and carried out a paper review but then also carried out his own experiments. He purchased a number of cigarettes including those which were apparently being smoked by the girls at the time. He lit seven whole cigarettes and placed them on top of cardboard but on no occasion did they ignite a fire. For the eighth cigarette he created what he described as a cardboard sandwich with some paper wedged between them. He then inserted a lit cigarette horizontally into the package and blew on it several times. After about three and a half minutes there was an ignition and a flaming fire started. Unfortunately he did not record how many times he blew on the cigarette or for what length of time nor with what strength. Having completed this experiment, he thought as he demonstrated it was possible in some circumstances for a fire to be started and therefore did not do any further experiments including control experiments or putting a lit cigarette in contact with cardboard and/or paper at a different

angle. Nor did he use cigarettes that have been smoked virtually down to the filter as was described in this case. This is important because the experiment that he video recorded when a fire was ignited indicated that at least half of the cigarette had to be burnt before a fire could start. A virtually completely smoked cigarette would have very little fuel in the sense of tobacco to burn and would self extinguish within a much shorter space of time. Apparently, the CPS decided to discontinue the prosecution and offer no evidence based on the contents of his report.

The court instructed another independent expert called Mr Neil Gibbins. He was a very senior ex-Assistant and Acting Chief Fire Officer. He started investigating fires in 1984 and became a specialist fire investigation officer in 1993. He was the lead instructor for fire investigation for Derbyshire Fire and Rescue Service, as well as teaching police officers and scenes of crime officers about the process of fire investigation. He passed a number of examinations relevant in the fire service and was a member of the Institute of Fire Engineers. He investigated a large number of both fatal and non-fatal fires. He felt that the only credible way that the fire started was by the application of naked flame. He too took into account the timing of the events and pointed out that even if a discarded lit cigarette from the girls had managed to find its way under the door it would have taken much longer for any fire to have started than the evidence clearly shows in this case.

The expert evidence clearly indicates that the only credible explanation for the start of the fire is the introduction of a naked flame under the door into the cardboard storage area.

The fire itself took hold quite rapidly despite attempts by the owner and indeed others to try and extinguish the initial flames in the cardboard storage area. They had spread to the ceiling and across to the racking on the other side and ignited materials there which in turn had spread. There was a significant amount of combustible material. The premises were evacuated of all persons and on arrival one pump went to the back of PHW and the other to the front. The rear emergency doors where the fire started was designated as sector 1 in fire service terminology and the front of the building as sector 2. Initially crews wearing breathing apparatus (BA) were sent in to sector 1 in order to try and fight the fire but also carry out a reconnaissance mission. They reported back that the conditions were very cramped and there was an enormous amount of smoke being generated by the fire.

The span of command at a fire like this has an overall incident commander. Depending upon the nature and size of the fire they may have an operations commander as well as a logistics commander. The various designated sectors will each have sector commanders. The incident commander will set the overall strategy for fighting the fire which is then actioned by the operations commander. The individual sector commanders have responsibility for fighting the fire in their area and for the health and safety of the firefighters involved as well as members of the public. Where BA crews are used there will also be what is known as an Entry Control Officer who also operates the Entry Control Board. This can be written on with a black chinagraph pencil but also has telemetry connections with the BA crews' equipment. In this case, considerable amounts of pressurised smoke poured out of the building from both the front and the rear. Jets of water were applied to the front of the premises from early on but there was no ingress into the building by BA wearers.

As the afternoon progressed the sector commander in sector 1 appointed an overall sector safety officer but also appointed a second safety officer with a particular role. He had formulated a plan that BA wearers could enter via the emergency exit doors in sector 1, go up a short flight of about six steps and fight the fire from the top of that area but go no further. They were to be within visible sight or to be contacted audibly at

all times. They could then direct jets of water to particular hotspots. Crews were given radios and thermal imaging cameras to assist. In addition because of extremely hot conditions both outside but particularly inside he set a maximum wear of 20 minutes. Over the afternoon there were some 40 entrances and exits by BA crew teams. In addition there was a specific entry control officer who had the responsibility of operating what is known as the entry control board. This role was carried out in the afternoon by a firefighter. He kept an eye on the 20 minute time limit and notified the second safety officer when crews needed to be withdrawn. Overall, during the afternoon crews had self withdrawn on several occasions due to the deteriorating conditions. In addition they had been withdrawn by the second safety officer who could observe the conditions himself but from the outside. The entry control board itself has what is known as telemetry with the BA wearers equipment. On occasions this can be lost or can be intermittent but this would not automatically trigger any emergency response.

Over several hours, the conditions periodically changed in that there would be periods when less smoke came out of the building but other periods when significant amounts of pressurised smoke emanated from the building. In sector 1 they had managed to take down boarding across a disused window at the back of the building and make an entry into that compartment so that firefighters could be positioned on a platform immediately outside the building spraying a jet of water inside. They also managed to gain access to a protected staircase on the other side of the building in what became sector 4 and cut a hole in roller shutter doors covering the other set of disused emergency exit doors that had apparently been covered up with racking in the PHW premises. From there they deployed a fixed ground monitor. This is a static jet of water that is not controlled by firefighters themselves.

It was recognised this was a fire that was going to burn for some considerable time. The day shift would change at about 19:00 hours and new crews would be attending in order to take over from their colleagues who had been fighting the fire all afternoon. At the front of the premises had been positioned what is known as an aerial platform. This is able to deliver significant quantities of water onto a fire usually from a height. Depending upon the availability of water this equipment can fire a jet which is many times more in the terms of quantity than an ordinary 45mm hose. The building itself had on one side a coffee shop and on the other a hotel. There was concern to stop the fire spreading. At one point it was noticed that fire had apparently spread to the first floor and at about 19:18 hours there was a direction that all BA crews be withdrawn from the premises whilst the aerial platform directed water into the first floor.

This appeared to be successful and at about 19:30 hours the incident commander and his other senior officers met and decided that BA crews could be redeployed into the premises in sector 1 because there was no noticeable effect at the rear from the deployment of the aerial platform at the front of the building. Consequently, at 19:35 hours two firefighters wearing BA equipment were deployed into the building and they left at 19:52 hours. The BA crew team leader did not recall being told about the 20 minute maximum wear but in any event heard a shout for them to leave and they did so and took with them their hose. Usually they would have a debrief with either the entry control officer or the sector commander but this did not take place. It would seem that sometime after about 19:30 hours the sector commander of sector 1 handed over to his replacement and maintained that he gave a thorough brief explaining in particular the role of the second safety officer outside the sector 1 entrance keeping an eye on the firefighters at the top of the stairs. The second safety officer himself told the court that he briefed three colleagues on his role because originally he thought one of them was going

to take over his particular tasks. Likewise the entry control officer says that he handed over what he had been doing that afternoon.

The incoming sector commander, entry control officer and sector safety officer give evidence and did not seem to have either heard or understood about the particular safety measures for BA crews entering via sector 1. It is a matter of fact for the jury to decide but on the evidence that they have heard they could come to the conclusion that whatever brief was given to the deceased and Firefighter Jones was not the same as the earlier briefs. There was no second safety officer appointed. The jury were played CCTV recordings of the exit of the firefighters at 19:52 hours and then the deceased and Firefighter Jones preparing to go in at 20:04 hours.

The sector 3 commander decided to redirect the aerial platform jet into the front ground floor main entrance of the premises but indicated that he would not have done so had he realised that there were BA crews entering via sector 1. It seems that he decided to do this without any specific instruction from the operations commander who told the court that he gave no such authority or instruction. Both the operations commander and the incident commander told the court that in fact they would have had no concern about this because they knew something of the structure of the internal part of the premises in that there was a dividing wall between the front of the shop in the rear storage area. Ideally sector commanders should communicate with one another about their activities in case they may affect the firefighting operations in another sector.

The deceased and his colleague Firefighter Jones had arrived as a member of the new evening shift and formed the BA team. They were directed to go to sector 1 and went under air at 19:59 hours and then went into the building at 20:04 hours. If they had been subject to a 20 minute maximum wear then they should have been exiting the building at 20:19 hours. In the event relief crew was sent in at 20:26 hours and they believed that it took them a couple of minutes to find the deceased and Firefighter Jones. They had gone to the top of the stairs, turned left and had been found in the area outside what was described as the post room and at the base of a flight of stairs up to a mezzanine level. Visibility inside was virtually zero. The relieving crew had followed in the hose. The deceased was the leader of the BA crew and apparently walked towards the leader of the relieving crew and thrust the hose in his chest and said words to the effect that they were getting out of there.

It was thought that this was about 10 metres inside the building. It was only a few feet away from the top of the stairs and the exit. Firefighter Jones had no recollection of this at all and in particular seeing and being relieved by the new BA crew. However, he did remember the post room and the fact that the deceased had gone virtually to the top of the stairs leading to the mezzanine when Firefighter Jones explained that he was feeling extremely hot and he thought that they should leave the premises. His recollection was that the deceased came down the stairs and they tried to follow their hose out but could not do so. They were crawling on their hands and knees and he recognised that he was suffering the cognitive effects of extreme heat. At one point he recognised the need to press the emergency button on his ASDU equipment but simply could not manage to do so even though he knew fully how to operate it. It seems that he suffered a very painful burn to his left hand and removed his glove.

The BA crew which had gone in to relieve the deceased and Firefighter Jones very quickly came to the conclusion that the circumstances inside were not as described to them when they were briefed and they decided to withdraw from the building and were seen

doing to at 20:32 hours. When they exited they were mistaken for being the deceased and Firefighter Jones. On leaving the building they thought they heard cries for help.

The BA equipment also known as ASDU has a telemetry system to make contact with the entry control board. This will show the rate of consumption of their air. It also has a movement sensor system so that if the operator does not physically move for a period of 36 seconds it will set an alarm off. The equipment can also set off what is known as a low pressure alarm when only a limited amount of air is still in the BA cylinder. In this case, the deceased's low pressure alarm was sounded at 20:30 hours and then motion alarm itself 20:35 hours. This coincided with the time that the deceased actually ran out of air completely.

Firefighter Jones' low pressure alarm sounded at 20:32 hours. A BA emergency was called at 20:34 hours. A BA crew that had been sent to reposition the ground monitor at sector 4 heard what they thought was the sound of colleagues within the compartment. By crawling on his hands and knees he came across Firefighter Jones began to rescue him with the assistance of his colleagues. This coincided with the initiation of the BA emergency and it is thought Firefighter Jones was rescued at 20:35 hours. Other colleagues came to assist but it was not until 20:41 hours that the deceased was found a short distance away and removed from the fire compartment outside. He was still wearing his facemask but not his helmet. He had also lost a glove and a boot. Attempts were made to resuscitate him at the scene but with no success. He was taken to the Manchester Royal Infirmary where further efforts at resuscitation also proved unsuccessful and he was pronounced dead at 21:21 hours.

After his death was reported to me, I authorised a forensic post-mortem examination carried out by a very experienced forensic pathologist. I also authorised a second post-mortem examination carried out by another forensic pathologist. It was apparent the deceased had suffered no significant traumatic injuries and examination of his heart and other organs demonstrated no abnormality. The first Forensic Pathologist, Dr Carter, gave evidence and in summary terms expressed the opinion that the cause of death should be described as 1(a) Heat exhaustion and hypoxia.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

(1) It is suggested that all Fire and Rescue Services (FRS's) should consider the implementation of measures to reduce the risks associated with the physiological effects of working in a hot environment. In particular consideration should be given to:

- Duration of wears under breathing apparatus;
- Having regard to all relevant factors including, for example the weather, previous exertions of BA teams and individual circumstances;
- Training and guidance for all operational personnel to recognise the effects of heat both on themselves and on their colleagues and the appropriate steps to take upon such recognition, including withdrawal and self withdrawal;
- Training and guidance for all operational personnel to have the ability and confidence to ensure the withdrawal of others who may be adversely affected by heat whether by calling a BA emergency or otherwise appropriately;

- Training and guidance for all operational personnel to have the ability and confidence to withdraw themselves by whatever means appropriate including activating the ADSU.

(2) It is suggested that all FRS's should consider the implementation of measures to reduce the risks associated with the loss of communications at operational incidents. For example, to include safety control measures to ensure BA teams can be withdrawn from the risk area if needed.

(3) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training of the handing over and taking over of roles at incidents to ensure all the key areas of information, including safety control measures, are captured and shared.

(4) It is suggested that all FRSs should ensure that significant hazards and any safety control measures are the responsibility of the incident commander and should be recorded within each sector, to ensure visibility to all on the fireground, and passed/copied for use by the incident commander/command team to assist on the analytical risk assessment.

(5) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training in the appropriate use of thermal imaging cameras to include the limited extent to which they cam be relied upon to measure ambient temperature.

(6) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training in the deployment of aerial monitors to ensure the safety of any personnel within the risk area is not compromised.

(7) It is suggested that all FRSs should undertake a review to consider the circumstances in which inspections should be carried out under section 7(2)(d) of the Fire and Rescue Services Act 2004.

(8) It is suggested the above mentioned steps be undertaken jointly by Fire and Rescue Services and the FBU or other Health and Safety Representatives on the Health and Safety Committees.

(9) It is suggested that the Secretary of State for the Home Department considers measures to ensure that:
- fire risk assessors are adequately trained and qualified so as to be competent in the role, and
- the responsible person has the means to verify the competence of any person holding themselves out to be a fire risk assessor.

(10) It is understood that there are some 45 Fire and Rescue Services and the findings of the inquest need to be disseminated down to them all. The pressure is upon them to find their own solutions to problems against the backdrop of financial pressures. The Home Office now leads on fire issues and there has been ever increasing decentralisation. Whilst this is not without merit there appears to be difficulties in ensuring that services are meeting expectations and a means of disseminating national learning.

It is suggested that consideration is given to being able to mobilise a national and consistent approach to sharing the learning and testing so that it can be shown to be received, understood, actioned and embedded.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 12 August 2016. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Interested Persons. I have also sent it to organisations who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 8 June 2016

Nigel Meadows
HM Senior Coroner
Manchester City Area

SECTION 3

After the publication of the coroner's Regulation 28 report, the FBU made a submission to the then home secretary.

The submission briefly covers the events that took place at Oldham Street on 13 July 2013. However its primary focus is the 10 recommendations made by Mr Meadows in his report to the home secretary.

Each recommendation from Mr Meadows is analysed separately. For each recommendation the FBU provides at least one example of similar recommendations that have previously been made in relation to another firefighter fatality.

In concluding, the union proposes a way forward to ensure that all of the concerns are addressed to avoid future deaths.

This section contains the whole submission to the home secretary made by the Fire Brigades Union.

FBU RESPONSE TO THE CORONER'S REGULATION 28 REPORT REGARDING THE DEATH OF STEPHEN HUNT

21 July 2016

This is the Fire Brigades Union (FBU) response to the Regulation 28 report by senior coroner Nigel Meadows with respect to the death of firefighter Stephen Hunt. The FBU is the authoritative, professional voice of firefighters across the UK. The union represents the vast majority of firefighters in England, Scotland, Wales and Northern Ireland, including wholetime (full-time) and retained (part-time, on-call) operational firefighters and control staff.

The FBU was proud to count Stephen Hunt as one of its members and the whole union still feels the loss of our brother. The FBU has supported Stephen's family since the incident and as an 'interested party' took an active part at the coroner's inquest. The union has accumulated considerable experience in recent years regarding firefighter fatalities, injuries and near-misses. We are writing to you in response to the coroner's report because we want to assist in every way possible to ensure the lessons from Stephen's death are learned and that the mistakes made are never repeated.

The FBU would like to put on record our thanks to senior coroner Nigel Meadows for his report. The FBU believes Mr Meadows has outlined the circumstances of Stephen's death and provided a very robust set of concerns. He has produced the most comprehensive Regulation 28 (previously Rule 43) letter on firefighter fatalities in living memory. Firefighters will be grateful for his attention to detail and identification of key issues arising in our industry. The FBU believes he has produced an agenda to drive safety in the fire and rescue service for the foreseeable future. We are keen to work with you to ensure that this opportunity is not missed.

BACKGROUND

This year is an appropriate one to assess firefighter fatalities. It is 20 years since the death of Fleur Lombard, to date the only woman operational firefighter killed in the line of duty in the post war period. It is also 20 years since the deaths of firefighters Steven Griffin and Kevin Lane in Blaina, Gwent. In the five years after those deaths, following some improvements in firefighter safety, there were no operational firefighter deaths anywhere across the UK.

However the onset of New Labour's so-called modernisation programme, signalled by the Bain review in 2002 and consummated through the Fire and Rescue Services Act 2004, saw a dreadful surge in firefighter fatalities. Between 2003 and 2007 some 13 firefighters were killed at fires, the worst five year period in more than 30 years. This included deaths of firefighters Joe McCloskey in Northern Ireland (2003), Richard Jenkins in South Wales (2004), Billy Faust and Adam Meere in London (2004), Michael Miller and Jeff Wornham in Hertfordshire (2005), Brian Wembridge and Geoff Wicker in East Sussex (2006), Paul Mallaghan in Hertfordshire (2007) and John Averis, Ian Reid, Ashley Stephens and Darren Yates-Badley, firefighters in Warwickshire (2007). The subsequent deaths of Ewan Williamson in Scotland (2009), Alan Bannon and Jim Shears in Hampshire (2010) and Stephen Hunt in Greater Manchester (2013) indicated that lessons had not been learned and firefighters were at increased risk.

The FBU raised the alarm about these risks. Our officials produced comprehensive reports after these deaths and contributed to investigations carried out by the police, the Health and Safety Executive (HSE) and individual fire and rescue services. The union represented members and their families through inquests and court cases. In 2008, the union published *In the Line of Duty*, assessing firefighter deaths since 1978. In 2014 we published *Voices from the Fireground*, a report by Professor Andrew Watterson on firefighter fatalities up to 2013. These reports were shared with ministers, MPs and other stakeholders in the service. We have also published reports on the majority of these deaths.[1]

The FBU believes that firefighter safety was seriously undermined following the transfer of responsibility in England from the Home Office after the 2001 general election. Fire and rescue in England was placed first under DTLR, then the ODPM and finally DCLG. It was devolved in Scotland, Wales and Northern Ireland. The government of the day abolished the fire inspectorate in England. It also abolished the Central Fire Brigades Advisory Council (CFBAC), the statutory advisory body that had contributed enormously to improvements in the service for the public and for firefighters.

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[1] FBU, Fatal accident investigation report: Ewan Williamson (Scotland 12 July 2009); FBU, Fatal accident investigation report: John Averis, Ian Reid, Ashley Stephens and Darren Yates-Badley (Warwickshire 2 November 2007); FBU, Health and Safety Investigation – Harrow Court (Hertfordshire 2 February 2005); FBU, Findings of the FBU Health and Safety Investigation into the Fatal Fire which occurred at Bethnal Green Rd [London] on 20 July 2004

After the FBU published *In the Line of Duty*, the fire minister Sadiq Khan wrote to the union (22 December 2008) with promises to progress our concerns through the Practitioners' Forum, the ad hoc body set up to engage with stakeholders. However this body ceased to meet during the coalition government and the concerns we had raised remain unaddressed.

The FBU believes there has been a systematic failure to manage firefighter safety over the past decade. The root of these failures was the legislation enacted in 2004-05 and the institutional arrangements put in place after the old system was torn up. The union has concluded that DCLG and its predecessors failed to adequately oversee essential fire and rescue matters, affecting both the public and firefighters.

The FBU believes the Home Office has a unique opportunity to put this right. We remain and reiterate that we are willing to work with ministers, civil servants and other representative bodies from the fire and rescue service to establish robust and resilient safe systems of work. This response is intended to contribute to the work of the Home Office and assist with the actions necessary to remedy these concerns. In particular we add to the coroner's account of Stephen Hunt's death (section 4), the areas of concern (section 5) and the actions to be taken (section 6).

CIRCUMSTANCES OF STEPHEN HUNT'S DEATH

The FBU believes that the coroner's report into the circumstances of Stephen Hunt's death on 13 July 2013 captures the main events of that tragic day. In particular it establishes the circumstances that led to the fire and summarises forensic assessments to establish the precise cause of ignition.

The FBU does not dispute the detail of the coroner's description of developments on the fireground during the afternoon and evening. We agree with the list of 10 factors contributing to the death. We would however like to make some additional specific observations, which may help to clarify important issues for action *within* the fire and rescue service as a result of this fatality.

First, Greater Manchester Fire and Rescue Service procedures require a BA main control officer (BAMCO) to be watch manager, so that training would be provided to those at a role (rank) designated to undertake the role. However the incident commander, decided to place crew manager Lee Gaunt in charge of the BA main control. Lee stated in his evidence that he was initially shocked as he had never performed BA main control duties before and as it was a specialist function should have been run by a watch manager. Lee had never operated a BA main control before and had in fact had only observed one main control board used in his 16 years of service. Tragically, since the incident Lee Gaunt has taken his life.[2] The FBU is of the opinion that this terrible event at Oldham Street resulted in the loss of the lives of two firefighters.

[2] The minister should be aware that this is not the first occasion such a further loss of life has occurred. The Coroner's Rule 43 letter for the Bethnal Green fatalities in 2004 noted that "sadly, the court was notified after the conclusion of the inquest that one of the firefighters involved in the incident had apparently died as a result of a deliberate act of self harm". Andrew Scott Reid, Inquest into the deaths of firefighters Billy Faust and Adam Meere, Coroner's Rule 43 Letter – Bethnal Green, 24 May 2007

Second, the wider context of this fatality needs to be drawn out. One of the lessons from the Blaina fire in 1996 was the need to have the right speed and weight of response, to ensure when firefighters are committed into a building, whether it is a domestic dwelling or business premises, that sufficient numbers are available to support, assist and when necessary extract them.

At the incident when Stephen Hunt was killed, there were noticeably more firefighters in attendance before the change of shift at 19.00. The FBU believe that this had a bearing on the turn of events. Stephen and Jeremy Jones were part of the night shift mobilised to the incident and were sent into the building at just after 20.00, five hours after the call was received and during a period where the attendance was noticeably less than on the day shift.

Over recent years Greater Manchester Fire and Rescue Service drastically reduced the numbers of firefighters it employed, according to official figures:[3]

Year	Wholetime	Retained	Fire control	Total firefighters
2004	2,100	22	65	2,187
2013	1,587	27	49	1,663

Over the decade, Greater Manchester Fire and Rescue Service reduced the number of firefighters by a fifth, or to put it differently, went from 500 on duty at any one time to 400 on duty, responsible for a population of 2.7 million people across Greater Manchester. Last year, the number of wholetime firefighters had further reduced to 1,419 and calls are now handled from the North West fire control centre. Greater Manchester Fire and Rescue Service announced around 250 further job losses in June 2016. The FBU feel that this is bound to put the public and firefighters at greater risk.

CORONER'S CONCERNS

In this section we establish the repeated and systematic nature of failures, by referring to previous coroner's reports, official safety reports and brigade investigations. We believe this evidence adds weight to Mr Meadows' concerns arising from Stephen Hunt's death, highlighting lost opportunities in the past to improve safety. (The coroner's comments are in ***bold and italics***, FBU comments in ordinary text.)

The FBU draws your attention to the following sources:

- Andrew Scott Reid, Inquest into the deaths of firefighters Billy Faust and Adam Meere, Coroner's Rule 43 Letter – Bethnal Green, 24 May 2007
- Edward Thomas, Harrow Court Fire, Coroner's Rule 43 Letter, Harrow Court, Hertfordshire, 8 March 2007
- HSE, The Management of Health and Safety in the GB Fire and Rescue Service: consolidated report based on the 8 inspections completed by HSE in 2009/10, October 2010
- Lady Justice Hallett, Coroner's Inquests into the London bombings of 7 July 2005: Report under Rule 43, 6 May 2011

[3] ODPM, Operational Statistics Bulletin for England and Wales, 2003/04; DCLG, Operational Statistics Bulletin for England, 2012-13 (full time equivalent, as at 31 March of each year).

- Frances Kirkham, Lakanal House fire 3 July 2009, Coroner's Rule 43 Letters to Eric Pickles, the London Fire Brigade and Southwark Council, 28 March 2013
- Keith Wiseman, Inquest into the deaths of Alan Bannon and James Shears, Coroner's Rule 43 Letter – Shirley Towers, Hampshire, 24 February 2013
- Warwickshire Fire and Rescue Service, Report on the fire at Atherstone-on-Stour, 2 November 2007. Warwickshire 2014
- Scottish FRS, Lessons identified report from the Balmoral Bar Incident Dalry Road, Edinburgh, 12 July 2009. Edinburgh 2015

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

Ministers should note these areas of concern highlighted by the coroner mirror those made by HSE after eight inspections of fire and rescue services during 2009 and 2010. HSE examined four operational topics:

- Breathing apparatus (BA) and compartment fire behaviour (CFB) training
- Core skills training
- Incident command training
- Provision of risk critical information.[4]

The FBU draws attention to this report because it is clear from Stephen Hunt's death that these operational matters did not receive sufficient attention in the years after the inspections were carried out.

(1) It is suggested that all Fire and Rescue Services (FRSs) should consider the implementation of measures to reduce the risks associated with the physiological effects of working in a hot environment.

For a number of years, the guidance for breathing apparatus (BA) use was governed by Technical Bulletin TB 1/97, issued by the Home Office in the aftermath of firefighter fatalities the previous year. TB 1/97 has now been superseded by the Operational Guidance for Breathing Apparatus from 2014. However TB 1/97 was the extant guidance at the time of Stephen Hunt's death.

The introduction to TB 1/97 stated the issues clearly:

> BA is used in atmospheres that would be hazardous to health. Often the work undertaken in BA will be complex, physically and psychologically demanding and in circumstances where the normal sensory perceptions are denied. The wearer may face risks from hazards in addition to the irrespirable atmosphere, such as from fire, explosion or collapse. To reduce these risks to the lowest practicable level, command and control procedures are required. The procedures set out in this Guidance must be adopted by all firefighters in all brigades at all incidents.

[4] HSE, The Management of Health and Safety in the GB Fire and Rescue Service: consolidated report based on the 8 inspections completed by HSE in 2009/10, October 2010

The FBU makes two initial points in relation to this concern. First, the physiological effects of working in a hot environment have not been re-examined during the period of increased firefighter fatalities. The last significant research report, *Physiological Assessment of Firefighting, Search and Rescue in the Built Environment*, was commissioned by the ODPM and published more than a decade ago.[5] Despite the research showing the extreme impacts on firefighters' health of working in hot environments, it was not followed up systematically. This is in contrast to the United States, where federal bodies such as the National Institute of Standards and Technology continue to carry out vital research with stakeholders.[6]

Second, while guidance has been produced and formally adopted, FBU representatives report problems of implementation and inconsistencies across different fire and rescue services. In the absence of an inspectorate, these concerns have not been drawn to the attention of ministers, nor is there a significant stakeholder body to discuss concerns and seek improvements. The FBU also believes that after the cuts to fire and rescue budgets in recent years, there are often too few firefighters available at critical times during incidents, which puts firefighter and public safety at risk when emergency intervention is necessary.

In particular consideration should be given to: (i) Duration of wears under breathing apparatus;

The duration of BA wears was an important factor in Stephen Hunt's death and for the injuries sustained by Jeremy Jones. However this was also a factor in previous firefighter deaths. At Bethnal Green, London in 2004, crews were worked to the point of exhaustion and there were insufficient crews to provide BA teams.[7]

In Scotland in 2009, there was concern over the high turnover of BA wearers and firefighters were instructed to wear BA up to five times at this incident. The Scottish fire and rescue service's own lessons learned report, published in 2015, was candid enough to admit that firefighters were "still participating in multiple BA wears similar to those undertaken by firefighter Williamson on the morning he died".[8]

DCLG guidance published in 2008 makes the following recommendation:

> For firefighting, search and rescue activities conducted under conditions of live fire and continued to the operation of the low cylinder pressure warning whistle, the average firefighter should have at least 50 minutes of recovery, ideally, but not necessarily in a cool environment, with their PPE removed, and to consume a minimum of 1000 ml cold water. This recovery duration should be extended to at least 65 min to protect 95% of firefighters engaged in more typical 20 min deployments and redeployments.[9]

The FBU believes that this guidance is not being implemented in every fire and rescue service across the UK.

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5 Optimal Performance Limited, Physiological Assessment of Firefighting, Search and Rescue in the Built Environment. ODPM. December 2004

6 National Institute of Standards and Technology, Report on High-Rise Fireground Field Experiments, Technical Note 1797, April 2013

7 London Fire Brigade Fire investigation Group, Adam Meere Billy Faust. 2005 p.25; FBU, Findings of the FBU Health and Safety Investigation into the Fatal Fire which occurred at Bethnal Green Rd on 20 July 2014, n.d. p.8

8 Scottish FRS, Lessons identified report from the Balmoral Bar Incident Dalry Road, Edinburgh, (12 July 2009), 2015 p.19, p.28-29

9 Communities and Local Government (CLG) Core Temperature, Recovery and Re-deployment during a Firefighting, Search and Rescue Scenario, Fire Research Technical Report 18/2008 p.6

(ii) Having regard to all relevant factors including, for example the weather, previous exertions of BA teams and individual circumstances;

There were a number of additional factors, as the coroner points out, which played a part in Stephen Hunt's death. It was a particularly hot day and this would have added to the physiological strain on BA wearers, especially when carrying out multiple wears. The issue of hydration and rehydration in such conditions is vital, as is the duration discussed above.

Wider circumstances are also important. The pattern of public and firefighter deaths in tower block fires underlines the need for fire and rescue services to plan and prepare for the worst scenarios, when firefighters have to use BA. These issues have been raised previously by coroners. In 2010, two firefighters were killed at a high rise incident at Shirley Towers in Hampshire. The coroner's Rule 43 letter made three recommendations, which the FBU believes are crucial to firefighter safety:

1: It is recommended that a review is undertaken to ensure that the teaching and training of those firefighting techniques used to contain and cool compartment fires, on the one hand, fully complement techniques designed to attack and extinguish fires, on the other.
2: It is recommended that a review is undertaken to ensure the adequacy of teaching and training of tactical ventilation procedures in compartment fires to highlight the effect ad-hoc ventilation can have on fire development and to confirm the associated dangers.
3: It is recommended that all FRSs should consider the implementation of measures to reduce the risks associated with fallen cables. In particular consideration should be given to:
   a) Providing insulated wire cutters, or other means of severing cables, to all breathing apparatus teams;
   b) Modifying breathing apparatus sets to reduce the risk of cables becoming caught between the wearer's back and the cylinder (as introduced by Hampshire Fire and Rescue Service – please contact HFRS for more details);
   c) Training all breathing apparatus wearers in the risks presented by fallen cables and how to reduce those risks.[10]

(iii) Training and guidance for all operational personnel to recognise the effects of heat both on themselves and on their colleagues and the appropriate steps to take upon such recognition, including withdrawal and self withdrawal.

Training for the use of breathing apparatus has been a very longstanding concern for firefighters and for the service. A Home Office Fire Service Circular from 1970 laid down "a syllabus for a course of 70 hours (minimum)" for the basic training for wholetime firefighters "in the wearing of breathing apparatus". It further stated that the secretary of state "recommended that all breathing apparatus wearers should attend a 2-3 day refresher course at 2-yearly intervals".[11]

Training and guidance for BA wear has been highlighted in several firefighter fatalities. The Rule 43 letter following the Bethnal Green fatalities stated that "4. Continuation training including review and revision, as necessary, of real fire training provision for experienced firefighters and incident commanders…"[12] The Scottish FRS, Lessons identified report also made a similar recommendation: "3: The SFRS to develop publish and implement a training standards framework that includes the use of breathing apparatus."[13]

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[10] Keith Wiseman, Inquest into the deaths of Alan Bannon and James Shears, Coroner's Rule 43 Letter – Shirley Towers, Hampshire, 24 February 2013

[11] Home Office, 'Breathing Apparatus – Basic Training of Wholetime Men', Fire Service Circular No 17/1970, 24 April 1970

[12] Andrew Scott Reid, 24 May 2007 p.7

[13] Scottish FRS, Lessons identified report 2015 p.45

Perhaps most damning was the findings of HSE's inspections in 2009/10. Key concerns were:

3.1.1 All services had procedures for training and assessment in BA and CFB training although each had a different approach.

3.1.5 All services had some form of BA and CFB refresher training although not all conformed to FSC 18/2009 'Fire-fighter safety at operational incidents' - in respect of the timing and duration of that refresher training. Some services had more structured and developed refresher training programmes to maintain competence in these topics than others.

3.1.9 Deficiencies in the recording of training were common although in most cases the services had already identified this as a problem and had planned improvements.

HSE made a series of important recommendations to ensure that relevant, effective BA & CFB initial and refresher training. The FBU draws particular attention to recommendation 3.1.12: "The production of *national guidance on common minimum standards* and sharing of good practice on how the training may best be delivered is recommended. This would improve interoperability as well as enable all services to ensure sufficient commonality of firefighter safety and competence for operational work" (our emphasis).[14]

(iv) Training and guidance of all operational personnel to have the ability and confidence to ensure the withdrawal of others who may be adversely affected by heat whether by calling a BA emergency or otherwise appropriately.

At Oldham St, a decision was taken to impose a maximum wear time of 20 minutes, but this was not implemented consistently. These issues have been raised at earlier firefighter fatalities, as indicated above. In the case of the Warwickshire fire in 2007, when four firefighters were killed, the brigade's report noted the following:

> When the BA emergency was called there were two teams within the lift lobby area. Fire and rescue service national guidance states that "When a distress signal is heard the team leaders of BA teams who have sufficient reserves of air are to direct their teams to investigate the source of the sound. Rendering assistance to a wearer in distress is to take precedence over the work in hand but regard must be had to keeping escape routes open and for rescues already being carried out. Once sufficient help is available any hose lines temporarily abandoned must be reinstated." [TB 1/97] However no ADSU was sounding at the time of the 'BA Emergency' message being sent back, meaning that initial emergency crews did not have an audible target to locate.
>
> National guidance under the heading of 'Lost in Smoke' also gives guidance that emergency crews could use to locate a BA team "The branchman can always be found by following the appropriate hose line." However in this incident this would have taken emergency crews in the wrong direction and into potential danger (accelerating fire conditions and hanging cables)…

Warwickshire's own investigation recommended that: "Brigades should consider whether their BA refresher addresses training for BA emergencies in realistic scenarios covering unknown casualty locations, unconscious casualty handling and entrapped procedures."[15]

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14 HSE, October 2010 p.10-11

15 Warwickshire Fire and Rescue Service, Report on the fire at Atherstone-on-Stour, 2 November 2007. Warwickshire 2014 p.68-69

(v) Training and guidance for all operational personnel to have the ability and confidence to withdraw themselves by whatever means appropriate including activating the ADSU [automatic distress signal unit].

The activation of firefighters' automatic distress signal unit (ADSU) has also been highlighted repeatedly in previous firefighter fatality reports. The coroner's Rule 43 letter following the deaths of two firefighters at Harrow Court, Stevenage in Hertfordshire in 2005 stated that "there were concerns, particularly relating to ADSU units that the batteries recommended by manufacturers could not be relied upon at temperatures above 55^0C." At Bethnal Green the previous year, the ADSU of one of the firefighters killed did sound, but to no avail.[16]

The Scottish lessons learned report found that "the teams hear the sector 1 commander asking FF Williamson to activate his DSU but no BA wearers within the bar area can hear the DSU sounding at this time".[17]

(2) It is suggested that all FRSs should consider the implementation of measures to reduce the risks associated with the loss of communications at operational incidents. For example, to include safety control measures to ensure BA teams can be withdrawn from the risk area if needed.

Communications failures have been a recurring theme at firefighter fatalities over the last decade. The coroner's report into the two firefighters killed at Bethnal Green, London in 2004 found that Billy Faust and Adam Meere's deaths raised issues of communication. The coroner explained that "the court was surprised to hear evidence that, at the time of this incident, it was standard practice for there to be only one set of breathing apparatus communication equipment per crew of two firefighters". The Rule 43 letter stated: "9. Review and revise allocation of breathing apparatus, radio interface equipment (BARIE) and radios on pumping appliances so that every BA crew has radio communication."[18]

The coroner in the 7 July 2005 bombings raised the issue of communications, particularly in relation to rendezvous points, although she stated that the introduction of Airwave "will greatly assist the emergency services in liaising with each other when attending a major incident".[19]

In the Rule 43 letter on the Lakanal House fire sent to the London Fire Brigade, the coroner recommended that the brigade consider "whether it would be beneficial to use additional breathing apparatus radio communications channels and personal radio channels at major incidents to reduce the amount of traffic on each channel."[20]

The Scottish FRS lessons learned report noted that "the Balmoral Bar incident experienced delays in the allocation of separate incident command and BA radio channels. This, along with radio blocking, restricted communications and information flows. The allocation of radio channels to specific roles, the development of a communications timeline and radio discipline all play their part in maintaining suitable and sufficient command and control of an incident". Its recommendation 11 stated: "The SFRS to ensure that the communications infrastructure on the incident ground is fit for purpose."[21]

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16 London Fire Brigade Fire investigation Group, Adam Meere Billy Faust. 2005: 24

17 Scottish FRS, Lessons identified report 2015 p.14

18 Andrew Scott Reid, 24 May 2007 p.2, p.4

19 Lady Justice Hallett, Coroner's Inquests into the London bombings of 7 July 2005: Report under Rule 43, 6 May 2011 p.45

20 Frances Kirkham, Lakanal House fire 3 July 2009, Coroner's Rule 43 Letter to London Fire Brigade, 28 March 2013 p.3

21 Scottish FRS, Lessons identified report 2015 p.33, p.46

(3) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training of handing over and taking over roles at incidents to ensure all the key areas of information, including safety control measures, are captured and shared.

Handovers and briefings are a crucial part of incident command in a fluid situation and have been the subject of previous firefighter fatality reports. The coroner's Rule 43 letter for the Bethnal Green fatalities recommended: "1. Improved detailed guidance to command officers and firefighters about briefing/debriefing of breathing apparatus (BA) crews."[22]

The coroner's Rule 43 letter after the Lakanal House inquest recommended to the London Fire Brigade that "consideration be given to training of incident commanders and potential incident commanders to enhance their performance in relation to… handover from one IC to the next and effective deployment of outgoing incident commanders."[23]

Similarly, the Warwickshire report stated:

> Briefing and de-briefing of BA crews
> There was a lack of consistency in approach between commanders and BA crews to facilitate the exchange of important and relevant information. This was particularly evident at Entry Control Points although there were ad hoc briefing/debriefings taking place. The learning point is that a standard methodology should be adopted to ensure a standardised approach.
>
> Handovers between Incident Commanders
> There was a failure to document and time record the handover between ICs in the early phases up to the point when the Command Support function was fully established. There was also a lack of clear methodology in the handover. The learning point is that there should be a standardised methodology for handover between ICs.[24]

22 Andrew Scott Reid, 24 May 2007 p.7
23 Frances Kirkham, Lakanal House fire 3 July 2009, Coroner's Rule 43 Letter to London Fire Brigade, 28 March 2013 p.3
24 Warwickshire Fire and Rescue Service, 2014 p.65

(4) It is suggested that all FRSs should ensure that significant hazards and any safety control measures are the responsibility of the incident commander and should be recorded within each sector, to ensure visibility to all on the fireground, and passed/ copied for use by the incident commander/command team to assist the analytical risk assessment.

During the incident at Oldham Street, incident commanders made critical decisions around committing BA teams and firefighting methods. An obvious change in incident command is demonstrated by the removal of the second safety officer who was tasked with watching over and communicating with BA wearers.

When any change to tactical direction is made, it is assumed that the incident commander would undertake an appropriate risk assessment. There does not appear to be evidence of any analytical risk assessment being undertaken throughout the incident until the BA Emergency, as is required by the Fire and Rescue Service Manual Vol 2, Fire Service Operations, Incident Command, 3rd Edition 2008. The risk assessment process involves a number of key functions involving generic risk assessment (GRA), dynamic risk assessment (DRA) and analytical risk assessment (ARA).

Analytical risk assessment is a more detailed assessment of risk than the dynamic risk assessment and must be recorded. The ARA should be kept under constant review, whenever the risk to firefighters change (or at 20 minute intervals, whichever is the sooner) the tactical mode should be reviewed and the risk assessment confirmed or changed as required.[25]

The Department for Communities and Local Government produced a health, safety and welfare framework for the operational environment in June 2013. The framework states:

> Many incidents attended by a Fire and Rescue Authority are dealt with using limited resources. In many cases, especially where the incidents are quickly brought under control and concluded, electronic recording may be sufficient on its own. However, sometimes more control is required which may involve extensive resourcing by a Fire and Rescue Authority, including fire appliances, equipment and personnel. These incidents often require the support of partner services and agencies. In turn, this may require a more detailed and written record of the significant findings of risk assessment.

These can relate to activities at several locations throughout an incident ground but may relate to elaborate measures at smaller incidents as well. The generic fire and rescue authority term for this written record is an analytical risk assessment on which detailed guidance is provided in the incident command manual.[26]

Failings in incident command feature very prominently in every fire fatality reports in recent years before Stephen Hunt was killed.

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[25] Incident Command Manual 3rd Edition – Section 4.10

[26] DCLG, Fire and Rescue Authorities Health, Safety and Welfare Framework for the Operational Environment, June 2013

The coroner's Rule 43 letter on Bethnal Green recommended:

1 Improved detailed guidance to command officers and firefighters about briefing/debriefing of breathing apparatus (BA) crews.
4 Continuation training including review and revision, as necessary, of real fire training provision for experienced firefighters and incident commanders…
7 Development and implement comprehensive monitoring and feedback for incident command training.[27]

The Warwickshire report stated: "The Incident Commander (IC) has the ultimate responsibility for the health and safety of crews at the scene of an incident. The role involves constantly taking in information from a range of sources, prioritising that information and making decisions based on it. These decisions are dependent on the quality, accuracy and availability of information."[28]

The coroner's Rule 43 letter on Lakanal House stated:

> It is recommended that the [London Fire] Brigade Review its policy and procedures concerning incident command, having regard to whether it is effective for the choice of IC to be tied closely to the number of type of appliances attending an incident and the effectiveness of a policy which may result in rapid and frequent changes of IC. It is also recommended that consideration be given to training of IC's and potential IC's to enhance their performance in relation to the following:
> - Use of the Dynamic Risk Management model and other management tools to enable ICs to analyse a situation, and to recognise and react quickly to changing circumstances
> - To recognise when to escalate attendance by more experienced ICs
> - To anticipate that a fire might behave in a manner inconsistent with the compartmentation principle
> - To be aware of the risks to those above and adjacent to the fire flat
> - Handover from one IC to the next and effective deployment of outgoing ICs
> - The collection of information from all possible sources
> - Use of methodical search patterns.[29]

The Scottish FRS lessons learned report recommended:

8 An operational maintenance of skills syllabus and training programme is developed to ensure competence in incident command and functional roles is established and maintained.
9 The SFRS to develop incident command and functional officer memory aid to provide support to those undertaking functional roles.
10 The SFRS operational assurance process is required to support the ongoing development of incident commanders by sharing lessons identified.
12 The SFRS is required to develop a risk management policy and guidance for use at operational incidents.
13 A greater focus is required to embed ARA into decision making when developing an operational or tactical plan. Therefore it should become a key component of incident training.
14 Operational personnel at all levels require training in risk management to improve the use of DRA and ARA in order to improve firefighter safety.[30]

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27 Andrew Scott Reid, 24 May 2007 p.7
28 Warwickshire Fire and Rescue Service, 2014 p.64
29 Frances Kirkham, Lakanal House fire 3 July 2009, Coroner's Rule 43 Letter to London Fire Brigade, 28 March 2013 p.3
30 Scottish FRS, Lessons identified report 2015 p.46

The coroner's Rule 43 over the fatalities in Hampshire recommended:

> Guidance and clarification is required with regard to search procedures as set out in Technical Bulletin 1/97 (Breathing Apparatus Command and Control Procedures), to ensure that…
> f) Fire-fighters understand the importance of fully extinguishing fires before proceeding past or above the fire scene
> g) Methodical search patterns are undertaken e.g. area by area, room by room or floor by floor.
> h) Search patterns are standardised across every FRS in the UK so that there is common understanding and procedure when fire-fighters from different FRSs are engaged in joint working.[31]

Finally, the HSE inspectors report in 2010 also recommended changes in incident command:

> 3.3.2 Different approaches to the acquisition and maintenance of command competence skills were evident between services. Generally it appeared that incident commanders received their initial training on a formal course, either at a training centre or at the Fire Services Colleges in England or Scotland. Whilst there may be a need for variation due to local factors, a lack of consistency between services may affect interoperability between services at multi agency and cross border incidents.
> 3.3.5 There were differences between policies for training and assessing firefighters who either 'step up' to incident command or who are on temporary promotion. Some services did not allow staff to carry out the role of Incident Commander unless they had been formally assessed as competent in the role – many using the computer simulation training systems as part of that assessment. In other services attendance at a formal training course and assessment of competence were required. In some services procedures were less well defined and not as embedded as was expected.
> 3.3.7 The extent to which Incident Commanders received support from more senior officers during operations varied as did the extent to which their command competence was monitored and whether and how feedback was given following incidents.
>
> Recommendations
> 3.3.8 Services should ensure that they deliver effective training (acquisition and development) and assessment for all those who carry out incident command including those on temporary promotion or 'acting'.
> 3.3.9 National guidance should be provided on good practice in incident command training.[32]

The FBU believes these recommendations underline and reiterate the systematic failure to train and prepare incident commanders for taking life changing and life-saving decisions in difficult circumstances.

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31 Keith Wiseman, 24 February 2013: 2

32 HSE, 2010 p.12-13

(5) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training in the appropriate use of thermal imaging cameras to include the limited extent to which they can be relied upon to measure ambient temperature.

The coroner is right to highlight concerns about thermal imaging cameras, which have been made in previous firefighter fatality reports. The report on the Warwickshire fatalities stated:

> Thermal imaging cameras (TICs) are a key control measure for the fire and rescue service. Their ability to assist in both identifying casualties and locating a fire has been extremely beneficial.
> When operational crews at Atherstone-on-Stour used TICs in thick smoke they showed a screen display with no contrast. The cameras were tested and were working prior to entry to the risk area. This occurred before and after the BA emergency.
> During BRE's work for WFRS they identified a possible explanation; when heavy smoke has a high concentration of carbon, a uniform heat layer can be observed through the TIC due to the ability of carbon to absorb and emit heat readily.
> WFRS has contacted their current suppliers of TICs who have considered the issue. They believed that BRE's explanation is plausible but also identified some other possible causes, which include the impact on the cameras of high humidity (possible side effect of gas cooling). Unfortunately, they are unable to give an explanation unless they can recreate the effect under controlled circumstances.
> WFRS have made crews aware of the potential phenomenon. The lesson to be learnt is that more investigation into recognising the limitations of TIC's is required and national guidance should be produced.[33]

The Scottish FRS lessons learned report noted that "a thermal imaging camera (TIC) was deployed in the Dalry Rd incident in Scotland, but no concerns were raised."[34] The coroner's Rule 43 letter on the Hampshire fatalities recommended: "Guidance and clarification is required with regard to search procedures as set out in Technical Bulletin 1/97 (Breathing Apparatus Command and Control Procedures), to ensure that… e) Thermal imaging cameras (TIC) are used to search for fire in smoky conditions."[35]

[33] Warwickshire Fire and Rescue Service, 2014 p.67-68
[34] Scottish FRS, Lessons identified report 2015 p.8
[35] Keith Wiseman, 24 February 2013 p.2

(6) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training in the deployment of aerial monitors to ensure the safety of any personnel within the risk area is not compromised.

The FBU believes that the way that the aerial appliance was used as a water tower played a part in creating the situation that led to the death of Stephen Hunt. Those firefighters who applied water from the aerial appliance were not aware of any BA crews within the building at any sector and have confirmed they would not have introduced water onto the fire if they had been aware. The application of water into a fire within a compartment would without doubt have changed conditions for the worse. While this is a recommendation relating to aerial appliances it outlines that the risk assessment, communication procedures and incident command and control procedures associated with using this appliance were not adequate.

The role of aerial appliances in previous firefighter fatalities has varied. In the Bethnal Green deaths, the role of aerial appliances was not raised. In the Harrow Court deaths, an aerial appliance was not deployed. At Marlie Farm (East Sussex), aerial ladder platforms were deployed (and one damaged in the explosion), but were not considered a material factor in the deaths of the two firefighters.

In the Warwickshire deaths, aerial appliances were not deployed. At Shirley Towers (Hampshire), an aerial appliance was deployed as part of the pre-determined attendance.

The FBU's principal concern is whether sufficient numbers of firefighters are available at the right time – what is known as the speed and weight of response. Clearly the way firefighters, resources and equipment are deployed matters. However incident commanders have fewer options when they have fewer firefighters available. Technologies are no substitute for the right number of boots on the ground.

(7) It is suggested that all FRSs should undertake a review to consider the circumstances in which inspections should be carried out under section 7(2)(d) of the Fire and Rescue Services Act 2004.

The role of fire inspections was altered by the Fire and Rescue Services Act 2004 and the Regulatory Reform (Fire Safety) Order 2005. The latter gave employers and landlords greater responsibility for carrying out fire risk assessments.

These regulatory arrangements have been criticised on the grounds of public and firefighter safety. In the Rule 43 letter on the Lakanal House fire to Eric Pickles, the coroner recommended that DCLG review generic risk assessment guidance on high rise firefighting, particularly on familiarisation and home fire safety visits with crews within the station in question and at other local stations. The coroner also recommended that the brigade consider how to improve the dissemination of fire safety information to achieve effective communication with residents of high rise buildings.[36]

In the Warwickshire deaths, the brigade's report identified premises risk information gathering and processing as an issue. It stated that "opportunities were missed prior to the incident (previous operational calls, planning lists and fire safety inspections) for WFRS to obtain risk information on the building. Up-to-date plans should have been available for crews attending the fire."

There was confusion at the incident over the layout and design of the building. Warwickshire fire and rescue service pleaded guilty to a health and safety offence that the lack a premises risk information card or familiarisation visits may have contributed to the deaths of the four firefighters, although the crown court judge found that, if that was a factor it was a "minor one" amongst "a whole host of causes".

Since the fatalities, Warwickshire fire and rescue service have introduced new policy combining Regulatory Reform (Fire Safety) Order 2005 (RRO) inspections with inspections under section 7.2(d) of the Fire and Rescue Services Act 2004. They say "this promotes better understanding of risks within station areas and is supported by a new database and improved information exchange between fire safety, operational support and water departments."[37]

At the Shirley Towers fatalities in Hampshire, risk assessment, premises information, pre-planning and familiarisation were highlighted. Hampshire's own report recommended the service:

> 32 Produce an improved description of how operational risks are assessed, particularly for fighting fires. This should include;
> - How the Risk Assessment Record fits in with the production of Service Orders
> - How further measures (e.g. new technology, systems developed by other FRS, measures identified as needed due to other incidents) are identified and assessed
> - How operational risk assessments adequately cover all the topics that the GRAs do when a Service Order is not produced.
>
> Clarify the links between SSRI records, generic pre-planning, and familiarisation visits.[38]

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36 Frances Kirkham, Lakanal House fire 3 July 2009, Coroner's Rule 43 Letter to DCLG, 28 March 2013 p.2

37 Warwickshire Fire and Rescue Service, 2014 p.70

38 Hampshire fire and rescue service, Fatal fire investigation, 8 April 2013 p.162

The HSE inspectors examined whether services had systems in place to ensure that risk critical information was obtained and disseminated to front line crews. They found that some "did not seem to have adequate systems", while others "were less adept at capturing new risks within their areas". Inspectors recommended that:

3.4.6 All services should ensure that:

- they provide adequate training for staff gathering and assessing risk critical information;
- there is a system in place to actively collect relevant risk critical information;
- they monitor the effectiveness of these arrangements;
- risk critical information is kept up to date and is in a suitable format; and
- incident commanders are able to access the information to inform their command decisions.

3.4.7 The production of national guidance on the classification of risk premises and the collection and dissemination of risk information is recommended.[39]

The FBU is aware that DCLG published national guidance on premises risk information, including the content and frequency of familiarisation, early in 2012. In light of further fatalities, injuries and near misses, the issue for today is whether this guidance needs further revision, whether guidance in place has been implemented and what can be done to better monitor these issues.

[39] HSE, 2010 p.13-14

(8) It is suggested the above mentioned steps be undertaken jointly by Fire and Rescue Services and the FBU or other Health and Safety Representatives on the Health and Safety Committees.

The FBU welcomes this recommendation and recognises its responsibility in raising concerns at these committees. The FBU has been widely praised and widely cited in the context of firefighter fatalities. The FBU is the co-signatory of the Scottish FRS, *Lessons identified* report for the Dalry Road, Edinburgh, fatality in 12 July 2009. Coroners in earlier inquests have specifically thanked the FBU for input over Harrow Court, Hampshire and Hertfordshire deaths in their Rule 43 letters.

For example, the coroner in the Hampshire deaths also referred to his colleague's Rule 43 letter on the Hertfordshire firefighter fatalities in 2005. This also involved a fire in a high-rise building and fallen cables were also cited as a contributory factor in the deaths. Both coroner's referred to an FBU recommendation to remove all surface-mounted plastic trunking, cable clips and ties.[40]

The FBU has represented our deceased members and their families in all the legal cases, inquests and hearings arising from these fatalities, including Stephen Hunt's case and the Marlie Farm (East Sussex) deaths that took eight years to resolve.

The FBU is the only representative body to consistently lobby government about these issues. After producing the *In the Line of Duty* report, the union held a rally at Westminster Central Hall involving over one thousand firefighters on the issue of firefighter deaths. Our subsequently commissioned research by Professor Andrew Watterson, *Voices from the Fireground*, was also sent to ministers and MPs for consideration.

The FBU is in the process of producing reports for Hampshire and Greater Manchester deaths. The union has produced our own reports of investigation into firefighter fatalities during the period under consideration:

- FBU, Fatal accident investigation report: Ewan Williamson (Scotland 12 July 2009)
- FBU, Fatal accident investigation report: John Averis, Ian Reid, Ashley Stephens and Darren Yates-Badley (Warwickshire 2 November 2007)
- FBU, Health and Safety Investigation – Harrow Court (Hertfordshire 2 February 2005)
- FBU, Findings of the FBU Health and Safety Investigation into the Fatal Fire which occurred at Bethnal Green Rd [London] on 20 July 2004.

Every FBU fatality report to date has made recommendations on:

- Breathing apparatus procedures and training
- Communications
- Incident command.

The FBU has a national network of safety representatives, including representatives in every brigade and region across the UK. FBU officials receive health and safety training and work constructively in health and safety committees to monitor and improve activity on the fireground.

The union therefore believes we are the best representatives of firefighters from within the sector to assist ministers and civil servants with learning and applying lessons from these tragedies.

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[40] Edward Thomas, Harrow Court Fire, Coroner's Rule 43 Letter, Harrow Court, Hertfordshire, 8 March 2007 p.2

(9) It is suggested that the Secretary of State for the Home Department considers measures to ensure that:

(i) Fire risk assessors are adequately trained and qualified so as to be competent in the role, and
(ii) The responsible person has the means to verify the competence of any person holding themselves out to be a fire risk assessor.

The coroner has rightly referred to inadequate fire and other risk assessments as contributing to the death of Stephen Hunt. The training, qualifications and competence of fire risk assessors has long been a concern for the FBU.

There was no fire risk assessment in place at Lakanal House, despite almost three years between the reform of fire safety legislation and the fire that killed six people. The coroner's Rule 43 letter asked Southwark Council to consider "the skills and experience needed to undertake an assessment of higher risk residential buildings" and "the training required for members of staff considered to be competent to carry out assessments".[41]

Following the Lakanal House fire the Competency Council was created in order to produce a competency standard for fire risk assessors. The intention was that third party accreditation schemes should use the Competency Council standard as a basis for their membership. The UK Accreditation Service (UKAS) should use the Competency Council standard to assess the suitability of third party accreditation schemes.

A fire risk assessor who is a member of a UKAS accredited third party fire risk assessment scheme does provide a 'gold standard' for fire risk assessors. However there are still many challenges. In the case of simple buildings, the 'duty holder' may have sufficient knowledge to carry out a fire risk assessment. However if the task is more complicated, a specialist should be appointed.

Fire and rescue services sell fire risk assessment training (either directly or via "arm's length companies") but do not direct trainees to third party accredited schemes. It is therefore both difficult and financially unrewarding for them to them encourage the use of fire risk assessors who are members of such schemes.

Fire and rescue services deliver fire risk assessments themselves (either directly or via "arm's length companies") but do not insist on their staff joining third party accredited schemes. Again, this makes it difficult for them to them encourage the use of fire risk assessors who are members of such schemes.

Fire and rescue service fire safety training is highly localised and inspecting officers are not members of third party accredited schemes themselves. This means that there is no common standard and inspecting officers may not be able to tell a 'gold standard' fire risk assessment from a poor one.

In recent years, fire and rescue services carried out fire risk assessments and maintained this link between prevention and intervention. All those who carried out the fire risk assessments had been trained to a level accepted by the fire and rescue service and were competent and qualified to do so. This recommendation places much more onus on the responsible person not just to ensure the building complies with the relevant legislation but that the fire risk assessor is competent and qualified to perform this role. It may prove difficult for the responsible person to be 100% sure that their particular fire risk assessor has the necessary skills for this role.

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[41] Francis Kirkham, Lakanal House fire 3 July 2009 – Coroner's Rule 43 Letter to Southwark Council, 28 March 2013

(10) It is understood that there are some 45 Fire and Rescue Services and the findings of the inquest need to be disseminated down to them all. The pressure is upon them to find their own solutions to problems against a backdrop of financial pressures. The Home Office now leads on fire issues and there has been ever increasing decentralisation. Whilst this is not without merit there appear to be difficulties in ensuring that services are meeting expectations and a means of disseminating national learning.

The FBU has been critical of the regulatory and institutional framework established in 2004-05. This effectively broke up much of the post-war architecture of the fire and rescue service, as it had been governed by the Home Office, without putting alternatives systems in place. The FBU believes that the fire and rescue service became successively more fragmented after 2004, when the rhetoric of "modernisation" masked a hands off, laissez faire approach to our vital service.

This was evident even in some official reports. Thus HSE inspectors stated after their inspections in 2009-10:

> 2.1.3 The most common policy theme was the dispersed and sometimes complex, basis on which different FRS organised their core framework policies for safety-critical activity. This is not a bureaucratic fixation but is based on inspectors' observations of the difficulty that operational staff had putting their hands on a relevant piece of guidance or instruction. In some cases important records that inspectors would have expected to find did not exist.[42]

We believe this fragmentation has continued since 2010 and that DCLG has not been effective in overseeing the service. This was illustrated by Eric Pickles' reply to the Lakanal House Rule 43 letter (May 2013), just three months before Stephen Hunt's death, which revealed alarming levels of complacency within DCLG.[43] Essentially the message was to proclaim that the department and local fire and rescue services have the matters of contention in hand, that they will take care of past failings and that the public and firefighters have little to worry about. This is not the experience of FBU members on the fireground. There have been too many deaths and major injuries, too many near misses, too much "winging it" by some principal managers happy to please their political masters but unwilling to adequately protect their workforce.

The union welcomed the National Audit Office (NAO) report, *Financial sustainability of fire and rescue services*, and related reports,[44] which the FBU believes contains a wide range of valuable insights into the current state of the fire and rescue service in England.

The FBU agrees with the NAO that DCLG has taken "an outcomes-based rather than a risk-based approach to its oversight of the sector". The NAO's impact report is right to argue that there is a lack of detailed evidence on the relative contributions behind improvements in outcomes in recent years.[45]

The NAO is quite right to point out the paucity of the last "Section 25" report and how far these reports have withered, given the original motivation for them. When the Fire and Rescue Services Act was introduced, ministers assured parliament that the biennial report would provide sufficient evidence to scrutinise the service.

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42 HSE, October 2010 p.5

43 Eric Pickles, Reply to Frances Kirkham: Coroner's Rule 43 Letter – Lakanal House, 20 May 2013

44 NAO, Impact of funding reductions on fire and rescue services , November 2015; NAO, Methodology, November 2015; NAO, Technical Paper – Variation in spending by fire and rescue authorities, November 2015

45 NAO, Impacts 2.11 2015 p.27; 3.15, 2015 p.40

The most recent written statement was mostly premised on Ken Knight's review, which the NAO report shows to be largely misconceived.[46] The accompanying report by the Secretary of State on fire and rescue authorities' progress with the Fire and Rescue National Framework for England consisted of scarcely a page of writing.[47] The FBU believes that this lacklustre approach indicates that delivery is not being planned on the basis of risk. National resilience has to be assessed from the top-down; it cannot simply be a bottom-up exercise.

The second part of the NAO's financial sustainability report contains valuable contributions to recent debates within the fire and rescue service. Probably the most significant clarification concerns the Knight review, which claimed that there were "inexplicable differences in the expenditure of different fire and rescue authorities".[48] The NAO's own model can explain at least half (48%) of the variation between fire authority spending with reference to local factors outside of their control, including the presence of particular social groups or industrial facilities. This is set out in more depth in NAO's additional technical report.[49]

Although the NAO claims that its analysis does not invalidate the Knight Review's conclusion that there is scope for the sector as a whole to improve efficiency, its reports certainly do draw Knight's assessment into question. If it is possible to explain much of the variation in spending, then the scale of "efficiencies" suggested by Knight appear to be exaggerated. If there is less scope for efficiencies than Knight anticipated, then government cannot continue to cut central funding to fire and rescue services using his report as justification. As we explain below, a significant element of Knight's proposed efficiencies – the substitution of retained for wholetime firefighters – does not stand up to scrutiny.

46 NAO, Impacts 3.25-26, 2015 p.39; Hansard HC, 15 July 2014: col 48-49WS

47 DCLG, Report by the Secretary of State on fire and rescue authorities' progress with the Fire and Rescue National Framework for England, July 2014

48 Ken Knight, Facing the Future, 2013 p.7, p.16

49 NAO, Impacts 2.4, 2015 p.25; NAO, Technical Paper 2015

It is suggested that consideration be given to being able to mobilise a national and consistent approach to sharing the learning and testing so that it can be shown to be received, understood, actioned and embedded.

The coroner in the Bethnal Green fatalities stated that in the course of their investigation, they had shared their experience with coroners dealing with deaths in Hertfordshire (2005) and East Sussex (2006). There is coherence between the Rule 43 letters as a result. However the mechanism for disseminating these recommendations within the fire and rescue service itself has not been robust enough. DCLG has not been sufficiently proactive, nor had stakeholders had the opportunity to come together with governments to pool their own experiences and formulate a consistent plan for action.

The coroner refers to "all FRSs" in his areas of concern. The FBU agrees that these matters are relevant to every fire and rescue service across the UK. We also believe bluntly that it implies national professional standards on a whole range of issues where they no longer exist. We again refer to the HSE inspectors report from 2010, which recommended "the production of *national guidance on common minimum standards* and sharing of good practice", which they argued would "improve interoperability as well as enable all services to ensure sufficient commonality of firefighter safety and competence for operational work" (our emphasis).[50]

The first clause of the Home Office's Fire Services Act 1947 gave the secretary of state the power to enact standards for equipment, training, calls, inspection, fire prevention and providing advice. The fire and rescue service during the post war period operated with national standards of fire cover, ensuring firefighters attended incidents in sufficient numbers more rapidly than they do today.

Developing common minimum standards for the modern fire and rescue service does not mean merely reproducing the past. It would start from the wider range of risks that firefighters currently manage and adapt to the changing social, environmental, technological and industrial challenges facing today's fire and rescue service. Such an approach would provide a first class, twenty-first century professional service to all our communities, implemented by motivated and skilled firefighters.

[50] HSE, October 2010 p.10-11

ACTIONS TO BE TAKEN

The coroner's Regulation 28 letter is addressed to the home secretary and rightly regards central government as the agency with most power to prevent future deaths. But the fire and rescue service is a locally delivered and governed service. Ministers and civil servants cannot police activity on the fireground – everyone who works in the fire and rescue service has to take ownership of safety improvements.

The FBU's key priorities for action we believe accord with some of the home secretary's concerns as expressed in recent speeches and statements to the House of Commons. We also believe they follow from the analysis provided throughout this document. These action points are deliberately broad enough to encompass all the recommendations raised by the coroner and allow further dialogue on specific elements to take place.

1. Risk assessment

Risk assessment covers several areas that need to be looked at. There is a logical argument that fire crews should undertake more regular inspections of their risks. The same logic recognises that firefighters should be the primary premise inspectors. This has two immediate benefits in that all concerned (responsible persons, fire and rescue services and inspectorates) can be confident that the assessors are competent and adequately qualified and that any premises deemed at additional or specific risk can be brought to the attention of the crews. This in turn will assist them in their familiarisation and preparation for emergency incidents and to ensure that any risk assessment has an accurate overview of risks likely to be encountered. Additional action on risk assessment would need to look at how the issue of ongoing and 'during event' risks are assessed.

2. Incident command review

A large number of recommendations relating to this incident relate either directly or indirectly to incident command. Responding to breakdown in communications, risk assessment, duration of wears, hand over procedures, recognition of the environment all relate to the responsibility of one or more incident commander. The fire and rescue service has developed training packages and qualifications for all roles. The first point of call is to review these and ensure that they are robust and deliver the outcomes, i.e. a competent incident commander. The second action is to ensure that this robust methodology is applied consistently across the fire and rescue service, to ensure that a common and safe approach to this key function is maintained.

3. Professional approach to training

The majority of the recommendations from the Stephen Hunt inquest relate to training. These range from recognising the effects of heat and stress to handing over procedures. This is another reoccurring recommendation in other recent firefighter fatality reports. It may be that the fire and rescue service has already developed training packages and qualifications for all roles and scenarios. The initial review would ensure that they are robust and deliver the outcomes, i.e. a competent and safe firefighter able to safely deal with the incidents they attend.

4. A task and finish group – a mechanism for guaranteeing improvements

The FBU welcomes proposals to create a fire inspectorate, as long as this is an independent body with wide-ranging responsibility for operational matters, rather than simply finance. But such a body requires both common standards to assess performance and an advisory body to turn lessons learned into practical guidance to be implemented in all fire and rescue services and on all incident grounds. The FBU sees this as a key to ensuring that the previous three aims are delivered and maintained.

The FBU proposes that the home secretary initially establish a task and finish group to tackle the challenges raised by the coroner in Stephen Hunt's inquest. This task and finish group provides the right forum to plan how to implement the coroner's recommendations, such as ensuring all the standard operating procedures are adequate. This forum could provide advice on two levels in a similar way that the scheme advisory pension boards which will eventually provide advice to the secretary of state and to local pension boards. In this case however the task and finish group could provide assistance to the inspectorate and also assist the joint health and safety committees that have been identified as the forum for undertaking the steps outlined in the coroner's report.

This group will have the expertise to provide advice on a range of issues, including for example:

- assessing the protocols for BA wearers and their ability to recognise signs and symptoms of heat exhaustion
- focusing on incident command, to ensure consistency and disseminate best practice
- examining communications, to ensure robust systems are in place for the wide range of incidents, from flooding to terrorist attacks, which firefighters tackle.

A compact and manageable task and finish approach has proven successful in recent times for dealing with areas of concern. A good example is the joint working party on firefighter fitness, which included employers, unions and government representatives. This working group provided an agreed approach to firefighter fitness, even though an industrial dispute was still ongoing. This was followed by a joint approach to an initiative from the FBU to provide consistent training to encourage a high level of fitness instruction support to be available to firefighters using recognised apprenticeships at no cost to the employer.

The FBU believes these proposals would be a fitting way to learn and apply lessons from the recent firefighter fatalities and ensure that those who were killed in the line of duty did not do so in vain. It will help make the fire and rescue service more accountable, more effective and more professional than ever before. It will benefit not just the public, but firefighters too. The FBU is willing to work to deliver these goals and would welcome an opportunity to meet with you or your representatives to discuss this in more detail.

SECTION 4

The government officially responded to Mr Meadows with reference to the recommendations in his Regulation 28 report. The government's response was compiled by their chief fire and rescue adviser, Peter Holland.

It is the view of the government that the majority of the recommendations can be addressed by reviewing and amending existing guidance via the National Operational Guidance programme.

This section contains the complete response to the Regulation 28 recommendations from Peter Holland with an accompanying letter from Brandon Lewis, the minister of state for policing and the fire service.

Dear Nigel,

Regulation 28: Report on Action to Prevent Future Deaths – Stephen Alan Hunt

I write further to your email of 8 June 2016 and in response to the above report.

May I take the opportunity to thank you for your report and the detail that you have provided and to confirm that I share your desire to prevent future deaths of firefighters.

The death of Firefighter Stephen Hunt was a tragic event, indeed any firefighter's death has a profound effect on the fire and rescue service nationally.

The enclosed information has been compiled by the Chief Fire and Rescue Adviser and is intended to provide you with assurance that the ten concerns that you raise have been considered and have either been dealt with or are in the process of being dealt with.

I trust this demonstrates our commitment to addressing the concerns raised in your report.

Brandon Lewis
Minister of State for Policing and the Fire Service

REGULATION 28: REPORT ON ACTION TO PREVENT FUTURE DEATHS – STEPHEN ALAN HUNT

Author – Chief Fire and Rescue Adviser Peter Holland CBE QFSM FIFireE (Life)

INTRODUCTION

As Chief Fire and Rescue Adviser (CFRA) I have reviewed your report and discussed it with colleagues in the Chief Fire Officers Association (CFOA) and have written formally to Roy Wilsher, Chief Fire Officer of Hertfordshire Fire and Rescue Service who chairs the CFOA National Operations Committee and National Operational Guidance Strategy Board (OGSB). In his capacity as chair of the two boards Roy has circulated the report to all Chief Fire Officers in England, Wales, Scotland and Northern Ireland to ensure that every Fire and Rescue Service is aware of your report and concerns and takes action to address those concerns within their individual services and can review their policies and procedures.

Nine of the ten concerns (with the exception of number nine) that you raise are operational matters and will be dealt with by the two aforementioned committees in conjunction with the sector. I have written separately to the National Operational Guidance (NOG) Programme director to bring the regulation 28 report to his attention and asked him to review operational guidance in light of the report and make the necessary amendments and updates following that review.

The National Operational Guidance Programme is a collaborative venture involving and funded by the Chief Fire Officers' Association, the Local Government Association, the Home Office and London Fire Brigade. The programme is informed by a stakeholder forum which has a broad and senior membership representing the views of the fire and rescue service and the wider fire sector including representative bodies. This group reviews and scrutinises all of the products and projects of the programme and makes recommendations to it.

You may be aware that the Prime Minister in her tenure as Home Secretary initiated a programme of Fire Reform which was introduced in a speech in May 2016. This reform agenda includes two key components which have a direct impact on addressing your concerns. The Home Secretary in her speech brought forward plans to establish a rigorous and independent inspection regime for fire and rescue services in England and this is intended to be underpinned by statute in the Policing and Crime Bill, which is currently under consideration by Parliament. If passed this will ensure the government has the power to commission inspections of particular issues or fire and rescue services. Furthermore the Home Secretary welcomed the CFOA's efforts to produce a coherent and comprehensive set of professional standards to drive excellence within the sector and this work will complement the work of the NOG programme.

Another recent improvement which has a direct bearing on your concerns is the development of a national research and development hub which will be a centre of excellence for fire and rescue service equipment development and testing.

Please note that his letter has been sent to the devolved administrations of Northern Ireland, Wales and Scotland in addition to the 45 Fire and Rescue Services in England.

The remainder of this response is intended to address your ten concerns in more detail.

RESPONSE TO SPECIFIC CONCERNS

(1) It is suggested that all Fire and Rescue Services (FRSs) should consider the implementation of measures to reduce the risks associated with the physiological effects of working in a hot environment. In particular consideration should be given to:

(i) Duration of wears under breathing apparatus; Having regard to all relevant factors including, for example the weather, previous exertions of BA teams and individual circumstances;

(ii) Training and guidance for all operational personnel to recognise the effects of heat both on themselves and on their colleagues and the appropriate steps to take upon such recognition, including withdrawal and self withdrawal.

(iii) Training and guidance of all operational personnel to have the ability and confidence to ensure the withdrawal of others who may be adversely affected by heat whether by calling a BA emergency or otherwise appropriately.

(iv) Training and guidance for all operational personnel to have the ability and confidence to withdraw themselves by whatever means appropriate including activating the ADSU [automatic distress signal unit].

In January 2014 (6 months after the incident) the Technical Bulletin 1/97 (TB 1/97), the extant national Breathing Apparatus guidance at the time of the incident, was replaced with new guidance, 'Fire and Rescue Authority Operational Guidance – Breathing Apparatus' (OGBA). This guidance was produced by the Chief Fire and Rescue Advisers team, at the time in the Department for Local Government and Communities, and contributions were made by Chief Fire Officers, front-line personnel, central government, representative bodies, the HSE, and others, and was based on the best sources of information available at the time.

An initial assessment of the current OGBA document suggests that all of the concerns you have raised are addressed within the new guidance and in the following additional guidance:

a. Operational Training Guidance – Breathing Apparatus
b. Fire Service Manual Vol 4 Fire Service Training – Guidance on the Management of heat stress during Training
c. Fire Service Manual Vol 4 Fire Service Training – Guidance on Compliance Framework for Compartment Behaviour Training

Notwithstanding the information above, a recommendation will be submitted to the Operational Guidance Strategy Board to review the OGBA documentation as part of their work plan in light of your report and concerns.

(2) It is suggested that all FRSs should consider the implementation of measures to reduce the risks associated with the loss of communications at operational incidents. For example, to include safety control measures to ensure BA teams can be withdrawn from the risk area if needed.

This concern is covered in 'Part B-3 – Communications' of the OGBA and is further enhanced by the use of telemetry which provides additional communication capabilities.

Once again I confirm that a recommendation will be submitted to the Operational Guidance Strategy Board to review the OGBA documentation to ensure your concerns are fully addressed and where they are not appropriate revisions will be made.

(3) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training of handing over and taking over roles at incidents to ensure all the key areas of information, including safety control measures, are captured and shared.

In 2015 The Incident Command Manual 4th edition was released and this includes significant information regarding the organisation of an incident and in particular references the importance of hand over processes and procedures and Fire and Rescue Services are required to have clear procedures for briefing and handover of information.

As detailed in the introduction all Fire and Rescue Services have received a copy of your regulation 28 report concerns in order that they may review their policies in this regard.

(4) It is suggested that all FRSs should ensure that significant hazards and any safety control measures are the responsibility of the incident commander and should be recorded within each sector, to ensure visibility to all on the fireground, and passed/ copied for use by the incident commander/command team to assist on analytical risk assessment.

The Incident Command Manual 4th edition is the most relevant National Guidance to this concern and it states:

> *"Fire and rescue services must have policies and procedures for assessing risk to personnel on the incident ground. These should outline how the risk assessment should be carried out, by whom and the method of recording significant findings.*
>
> *Fire and rescue services should have procedures for deciding and implementing tactical modes following a risk assessment."*

Once again all Fire and Rescue Services have received a copy of your concerns in order that they may review their policies in this regard and a recommendation will be submitted to the Operational Guidance Strategic Board to review the OGBA documentation to ensure your concerns are fully addressed and where they are not appropriate revisions will be made.

(5) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training in the appropriate use of thermal imaging cameras to include the limited extent to which they can be relied upon to measure ambient temperature.

The use of Thermal Imaging Camera's (TICs) is covered generally in OGBA under 'Part B-7 BA ancillary equipment and additional procedures' and recognises that providing the equipment does not make the incident safe from changes and only provides information for decision making. Individual FRS should have procedures for the use of TIC at incidents at all stages during an incident including with the use of Breathing Apparatus.

Further information on the use of TIC's is contained within 'Operational Training Guidance – Breathing Apparatus' which provides limited reference to the capabilities and limitations of the use of TIC for the Incident Commander/Incident Monitoring Officer but does not cover use by the BA wearer.

As stated within the introduction I have ensured that all Fire and Rescue Services have received a copy of your concerns in order that they may review their policies in this regard.

(6) It is suggested that all FRSs should undertake a review to ensure the adequacy of standard operating procedures, guidance and training in the deployment of aerial monitors to ensure the safety of any personnel within the risk area is not compromised.

The use of aerial monitors is covered briefly in the following two national guidance documents:

Fires in the built environment 2014
Fires and firefighting 2015

Both documents refer to the need to monitor the impact of the techniques to ensure the safety of crews and to ensure the fire is brought under control and eventually extinguished. The use of aerial appliances and water towers is covered in individual fire and rescue services policies and procedures and following the dissemination of your regulation 28 report to Chief Fire Officers they will review these policies.

(7) It is suggested that all FRSs should undertake a review to consider the circumstances in which inspections should be carried out under section 7(2) (d) of the Fire and Rescue Services Act 2004.

National guidance was produced in 2012 entitled 'The Fire and Rescue Service Operational Guidance – Operational Risk Information' and this was developed to assist fire and rescue services provide a common approach to operational planning and management of risk. It includes a model known as PORIS – The Provision of Operational Risk Information System which seeks to provide a common methodology and approach to managing the identification, gathering, analysis, provision, audit and review of operational data, whilst allowing individual fire and rescue services the flexibility to integrate its processes into their own systems.

This guidance should be used by individual fire and rescue services in development and review of their service policies and again the concerns raised by you and shared with all Chief Fire Officers should result in a review of these policies.

(8) It is suggested the above mentioned steps be undertaken jointly by Fire and Rescue Services and the FBU or other Health and Safety Representatives on the Health and Safety Committees.

All new and revised National Guidance produced by the NOG Programme has a comprehensive and detailed stakeholder engagement strategy and quality assurance process which ensures that this is completed in detail and that external validation is conducted to assure the work that is carried out.

Individual fire and rescue services should also consult their representative bodies and Health and Safety Committees during the development and review of policies and procedures.

Notwithstanding this information the CFRA has arranged to meet with Matt Wrack, General Secretary of the Fire Brigades Union to discuss their concerns, establish the best approach, and ensure your concern is addressed.

(9) It is suggested that the Secretary of State for the Home Department considers measures to ensure that:

(i) Fire risk assessors are adequately trained and qualified so as to be competent in the role, and
(ii) The responsible person has the means to verify the competence of any person holding themselves out to be a fire risk assessor.

The Government makes available guidance to help 'responsible persons' comply with fire safety legislation. This guidance is clear that where a responsible person is unable to apply the guidance to their particular premises, then they should seek expert advice from a competent person.

The Government has worked with the fire sector, including CFOA, to develop a set of criteria against which the competency of those offering commercial fire risk assessment services could be assessed and independently certified.

These criteria were published in 2013 by the Fire Risk Assessment Competency Council, alongside a 'Guide to Choosing a Competent Fire Risk Assessor'. This guide (updated in 2014) includes details of organisations holding registers of companies or individuals whose competency to carry out fire risk assessments has been independently assessed by a certification and/or professional body.

The guide and the competency criteria are available on the Fire Sector Federation and the CFOA websites and fire and rescue authorities were encouraged to make this information available locally on their websites.

Earlier this year, the then Home Secretary announced her intention to publish a range of fire and rescue information to support greater public accountability of fire and rescue authorities and officials will look to include the fire sector's 'Guide to Choosing a Competent Risk Assessor' alongside other public-facing fire safety information.

Where a fire and rescue authority considers that a fire risk assessment is unsuitable or insufficient, it has powers to take action, up to and including prosecution, against the responsible person. The Order extends the responsible person's duties to include any other person for example, a risk assessor, to the extent that they have control of the premises.

(10) It is understood that there are some 45 Fire and Rescue Services and the findings of the inquest need to be disseminated down to them all. The pressure is upon them to find their own solutions to problems against a backdrop of financial pressures. The Home Office now leads on fire issues and there has been ever increasing decentralisation. Whilst this is not without merit there appear to be difficulties in ensuring that services are meeting expectations and a means of disseminating national learning.

It is suggested that consideration be given to being able to mobilise a national and consistent approach to sharing the learning and testing so that it can be shown to be received, understood, actioned and embedded.

The NOG Programme is undertaking a new project known as the National Operational Learning (NOL) project. The purpose of this project is to provide a best practice framework for operational learning across the fire and rescue sector. The framework will include elements that determine how the learning is collected, analysed, and subsequently used to drive decision making that secures continual improvements in firefighter and public safety, reduces loss and damage to property and protects the environment. Information from operational incidents, training and exercising and from emerging issues from the wider fire sector will be considered and processed to inform changes in the guidance. This valuable pool of information will also be available to services to support operational and safety improvements.

In addition to this sector owned project, the Joint Emergency Services Interoperability Programme (JESIP) (a Government programme aimed at improving the way emergency services work together at major multi agency incidents) has launched Joint Organisational Learning (JOL) arrangements for emergency services and Local Resilience Forums (LRFs) in the UK. JOL is a unique but simple way to capture learning that may impact on multi-agency working and allow continual improvement in what we do. Learning may come from training, testing and exercising or incidents. It is intended that this will become a national repository for interoperability lessons and notable practice.

The NOG and JESIP programmes are working together to ensure that these two learning platforms supplement each other to drive improvements across the emergency services sector.

This report was compiled by Peter Holland, the Government's Chief Fire and Rescue Adviser, and is intended to address the ten 'matters of concern' raised in the Regulation 28: Report on Action to Prevent Future Deaths regarding Stephen Alan Hunt. Any queries, questions or requests for further information should be directed to peter.holland2@homeoffice.gsi.gov.uk

SECTION 5

Following the government's response to the recommendations in the Regulation 28 report, the union sent a letter to the home secretary outlining our concerns. Whilst the FBU believes guidance is important, the union does not share the government's view that guidance alone will prevent further firefighter injuries and fatalities.

The union has serious concerns about the approach suggested by the Home Office and outlines other factors that will need to be actioned to ensure that all of the concerns are addressed.

This section contains the letter sent from the Fire Brigades Union to the home secretary outlining the union's concerns.

3 October 2016

Dear Home Secretary

FBU comments on the Home Office response to the coroner's letter, Regulation 28: Report on Action to Prevent Future Deaths – Stephen Alan Hunt

On 21 July 2016, I wrote to you in relation to the coroner's Regulation 28 report into the death of firefighter Stephen Hunt. Thank you for your reply of 8 September 2016, enclosing the Home Office response to the coroner's letter, *Regulation 28: Report on Action to Prevent Future Deaths – Stephen Alan Hunt*.

In my correspondence, I included a detailed response from the FBU, which highlighted several key concerns in relation to this incident and firefighter safety in general. This response also outlined the potential opportunities we now have to work together to ensure that both the coroner's and our concerns are addressed.

On 1 September 2016, representatives from the FBU met with the Chief Fire and Rescue Adviser (CFRA), Peter Holland, and his team to discuss the matters of concern contained in the coroner's report and a possible way forward. During this meeting, the CFRA indicated that the majority of the items could be addressed by reviewing and amending guidance as part of the ongoing work of the National Operational Guidance Programme (NOG). This approach is detailed in the Home Office response, *Regulation 28: Report on Action to Prevent Future Deaths – Stephen Alan Hunt.*

The FBU is represented on the NOG stakeholder forum (the Operational Guidance Group, OGG), so we have the opportunity to contribute to the review and amendment of guidance. We are fully committed to engaging in this process. However, we are aware that the scope of

the work undertaken by NOG is limited. The approach currently suggested by Peter Holland does not allow the sector, including the FBU, to address the full range of concerns that arise from the incident and the subsequent inquest.

The inappropriate status of national guidance

Although we recognise that guidance is extremely important, a primary concern is that its observance and implementation is not mandatory. The most appropriate example is breathing apparatus guidance. In common with many other occurrences where firefighters have died on the incident ground, Stephen Hunt was a member of a breathing apparatus (BA) crew undertaking firefighting operations. Until January 2014 the principal document for BA was Technical Bulletin 1/1997 Breathing Apparatus - Command and Control Procedures (TB1/97). The procedures laid out within that document were mandatory. The document made this clear in underlined narrative which read: *"The procedures set out in this Guidance must be adopted by all firefighters in all brigades at all incidents"*.

TB 1/97 was replaced on 14 January 2014 by *Operational Guidance: Breathing Apparatus*, which watered down the status of the guidance. Instead of being mandatory the document stated: *"It is a matter for each individual Fire and Rescue Service whether to adopt and follow this operational guidance"*.

The FBU raised concerns with both the content and the status of the revised guidance in our letter to the DCLG minister with responsibility for Fire on 3 February 2014. We wrote to the responsible minister in Wales, Scotland, and Northern Ireland, the Chair of the OGG, the Fire lead at the HSE, the President of CFOA and the NJC National Joint Secretary. In view of the composition of the National Operational Guidance Strategy Board (OGSB), we wrote to the President of CFOA, the responsible lead at the LGA and the responsible lead at the London Fire Brigade. Similarly, we wrote to every Chief Fire Officer in the UK.

The DCLG minister replied to our letter on 26 February 2014. He advised that the matters would be addressed by the Chief Fire and Rescue Adviser. As a consequence we wrote to the CFRA on 11 March 2014 to explain our concerns in extensive detail.

The outcome of these discussions was to refer the matter to NOG. The decision at NOG was that Operational Guidance: Breathing Apparatus would be considered as legacy guidance and would be reviewed in due course. That review is long overdue. The voluntary or optional status of guidance produced through NOG remains a continued concern.

We are happy to provide you with copies of the correspondence, should these not be available to you from DCLG and the CFRA.

Reference to the National Operational Guidance Programme is insufficient

The Home Office's response to the coroner's Regulation 28 report is deficient because guidance is only one part of a wider programme of improvement. Guidance by itself will not provide the measures and improvements identified as necessary by the coroner. Our representatives explained this during the meeting with Peter Holland but we feel it must be reiterated directly to you.

Alongside the necessity for guidance to be robust and mandatory, it is essential that the following additional factors are introduced. These factors are specifically ***not*** included in the terms of reference of NOG:

- Training packages designed to ensure the application of tactical guidance
- Monitoring the implementation of national guidance and its application into fire and rescue services' operational policies

- Monitoring the implementation of training packages
- Monitoring the quality of training delivery programmes and methods
- Monitoring the quality of assessment programmes and procedures
- Robust independent inspection of the service's risk assessment, resources and standards of services delivery; essentially the IRMP
- Provision of feedback of inspection outcomes and required improvements
- A review mechanism to oversee the implementation of improvement requirements
- An enforcement protocol in the event of unsatisfactory improvement.

Comments on the specific measures provided in the Home Office response to the coroner

The coroner raised 10 key points in his original letter. The CFRA has responded on behalf of the Home Office to each of these. What follows is the FBU's response to the CFRA's specific comments on each point:

(1) Response to concerns about the effects of working in a hot environment

The Home Office response gives an inaccurate description of the status of the current BA guidance in contrast to TB 1/97. To repeat the point made above: TB 1/97 was mandatory whereas the CFRA's *Operational Guidance: Breathing Apparatus* (OGBA) is voluntary.

The Home Office response on the review of OGBA lacks urgency. It states: *"Notwithstanding the information above, a recommendation will be submitted to the Operational Guidance Strategy Board to review the OGBA documentation as part of their workplan in light of your report and concerns"*.

The FBU believes the Home Office should instruct the Operational Guidance Strategy Board to immediately review the OGBA.

The FBU's letter to the DCLG Fire minister (3 February 2014) was explicit about the OGBA. We stated: *"To be clear we believe the guidance is not fit for purpose."*

(2) Response to concerns about the loss of communications

The Home Office response on loss of communications is insufficient. It refers to the use of telemetry boards. It is our understanding that not all fire rescue services have telemetry boards, and further, those that do have them do not use them to their full capacity. It is puzzling why the Home Office simply refers to the existence of telemetry boards when the jury highlighted: *"Breakdown in telemetry radio communications"*.

In the FBU's letter to the CFRA (11 March 2014), we recommended that the provision of radio communications sets for all BA wearers was a necessity. This was not acted upon.

There are additional matters raised by the coroner regarding measures for when an emergency arises. It is absolutely clear that an emergency crew must be in place at the time when a crew is committed for search and rescue, or to extinguish a fire. When we wrote to the CFRA (11 March 2014) we made clear that the extended use of rapid deployment – where crews were committed without a prerequisite of an emergency team – was unacceptable and dangerous. An emergency team is required by the Confined Space Regulations 1997 and reinforced by HSE's *Safe Work in Confined Spaces: Confined Spaces Regulations 1997. Approved Code of Practice, Regulations and guidance* (2014) and by the HSE field directive on fire and rescue services, *Inspection of fire service,* (OC 334/5). The FBU's concerns have not been acted upon.

(3) Response to concerns about handover and command/control

The Home Office response is accurate. However, common to all of the responses in respect of fire and rescue services the Home Office has no mechanism, method or practice to assure itself that the guidance (in this case incident command) has been implemented by fire and rescue services. Incident command is integral to resolving incidents efficiently and effectively in such a way as to provide for the safety of fire crews and the members of the public. The FBU's response (21 July 2016) to the coroner's letter pointed out that this issue had been raised in earlier inquests and inquiries arising from firefighter deaths in London (Bethnal Green) and Warwickshire.

(4) Response to concerns about on-site recording, signalling and reporting of hazards to the incident commander

The Home Office response quotes from the incident command manual. However, it is entirely reliant upon an expectation that fire and rescue service policy writers and all managers likely to take up the role of an incident commander will have been trained and competent in risk assessment. There is no mechanism for this to be assessed and there is scant evidence of robust and assured risk assessment training being delivered by fire and rescue services. The FBU's response (21 July 2016) to the coroner's letter pointed out that this issue had been raised in earlier inquests and inquiries arising from firefighter deaths in London (Bethnal Green), Warwickshire, Scotland and Hampshire.

(5) Response to concerns about Thermal Imaging Cameras (TICs)

The Home Office response correctly states that the OGBA does not contain advice and information with respect to the limitations of thermal imaging cameras. The FBU believes that it should be discussed in any NOG review of the OGBA, but in the meantime the Home Office should issue supplementary guidance to all fire and rescue services.

(6) Response to concerns about aerial monitors

The Home Office response on aerial monitors is extremely disappointing. Having acknowledged the inadequacy of the two cited pieces of operational guidance, the Home Office does not make clear that it will be referring the pieces of guidance to the OGSB for an urgent and immediate review.

In addition, the Home Office response states: *"The use of aerial appliances or towers is covered in individual fire rescue services policies and procedures"*. Although we hope and expect that this is correct, we are not convinced that the Home Office has any mechanism, method or practice to assure itself that fire and rescue services have the required policies and procedures in place.

(7) Response to concerns about 7(2)(d) inspections

The Home Office response cites *"The Fire and Rescue Service Operational Guidance-Operational Risk Information"* published in 2012 by DCLG's CFRA. However, despite the existence of this guidance, it is apparent to the FBU that it has not been observed in practice by fire and rescue services. We imagine this is because, as with the OGBA, the preface to the document states: *"It is a matter for each individual Fire and Rescue Service whether to adopt and follow this operational guidance."*

The FBU is entirely dissatisfied with the Home Office response.

In 2006, two firefighters Brian Wembridge and Geoff Wicker were killed in a fire and explosion at Marlie Farm near Lewes in East Sussex, where a large quantity of fireworks were in storage. The survivors and injured firefighters claimed for compensation from

East Sussex fire and rescue service (ESFRS), but this was not initially paid and as a consequence became the subject of legal proceedings.

One of the key and unambiguous strands of ESFRS case was that it was not negligent by way of improperly preparing crews, arguing that it was not obliged to ensure crews inspected risks on their station's territory, i.e. by what are referred to as 7(2)(d) inspections. This defence by ESFRS was heard in court during the trial dates 25 February – 20 March 2013 and 20 June – 1 July 2013. In his findings handed down on 30 July 2013 Mr Justice Irwin found: *"I have also concluded above that there was a failure to ensure that Marlie Farm was not only properly inspected, but that a 7(2)(d) card prepared and made available for firefighters attended the scene. I have indicated above what information would have been made available by such means" (Paragraph 232, High Court of Justice Queen's Bench Division, Case No. HQ10X1097, Judgement)*.

Some months after the judgment it came to our attention that ESFRS still refused to ensure that 7(2)(d) inspections were implemented by crews. Most worryingly, ESFRS specifically prevented the inspections at Marlie Farm. As a consequence, we wrote to the DCLG Fire minister on 9 January 2014 bringing this matter to his attention. The DCLG response dated 5 February 2016 did not attempt to comment upon, let alone address, our concerns in respect of 7(2)(d) inspections.

The CFRA guidance was issued in 2012. Yet throughout 2013, ESFRS maintained there was no obligation or requirement to ensure 7(2)(d) inspections were carried out, indeed they felt there was no necessity for them to do so. Despite the findings by Mr Justice Irwin, ESFRS consciously decided not to carry out 7(2)(d) inspections.

(8) Response to concerns about joint health and safety committees

The FBU finds the response unsatisfactory. The Home Office response does not suggest any corrective action to ensure compliance by fire and rescue services. The FBU is committed to working with fire and rescue services through joint health and safety committees to tackle these matters locally. However, a clear direction from the Home Office as well as high level coordination with the FBU would greatly facilitate this process.

The FBU has already taken steps to ensure that these matters are on the agenda for joint health and safety committees and that our representatives locally are fully briefed. An important element would be a public, rigorous statement from the Home Secretary outlining your commitment to a joint approach on matters pertaining to health and safety at all levels within the sector and urging fire and rescue services to ensure that the joint health and safety committee structures and underpinning consultation processes are key priorities.

(9) Response to concerns about fire risk assessors

The FBU finds the Home Office response unsatisfactory. We do not question the veracity of the description of steps taken, but we do question why those steps have failed and why the Home Office proposes neither any new steps/initiatives to address the failings of the measures in place nor any steps to assess whether the guidance for choosing a competent fire risk assessor has had any discernible impact. The document *"A Guide to Choosing a Competent Fire Risk Assessor"* was first published in February 2013. The incident where Stephen Hunt was killed occurred on 13 July 2013. It is over three years since its publication and two years since it was updated.

(10) Response to concerns about Home Office centralised measures

The FBU is fully involved in the National Operational Learning (NOL) project. This is a measure that will hopefully have an impact. But this will only be achieved in the short to medium-term as the project is still undertaking its work.

More immediate steps need to be taken and can be taken.

The first steps are:

- Ensuring guidance that requires to be reviewed be identified as a matter of urgency by the Home Office
- Home Office to bring this to the attention of NOG
- Home Office to ensure that a programme of urgent and immediate revision is commenced following the next meeting of the OGG on 17 October 2016
- Home Office ensures that sufficient resources are provided to NOG to undertake the necessary work in the shortest possible time.

You will be aware that NOG is due to conclude its work in 2018. The FBU wants to ensure that there is also an ongoing process beyond this date to ensure that any future review/ amendments can be actioned without delay.

In addition, the following steps must be undertaken by the Home Office:

- To identify what measures need to be taken to meet any gaps between the terms of reference of NOG and the requirements to satisfy the coroner's letter. Examples include: provision of training packages, collation of information regarding the training and assessment of policy writers and managers likely to be incident commanders on risk assessment
- To identify what steps are necessary to reverse the fragmentation of the service, which was raised in the Regulation 28 report.

Inspection

The FBU welcomes the government's decision to recreate a fire inspectorate, which we believe can provide an important vehicle for addressing many of the concerns identified above. Our officials are meeting with representatives of HMIC to outline our priorities and suggestions for an independent inspectorate.

The FBU believes the inspectorate must have an independent status and not be subordinate to HMIC. It should also have sector competence. The union wants the inspectorate to focus on matters of public safety and firefighter safety – operational matters rather than simply auditing accounts. Inspectors should also be consulting with FBU representatives during their visits and giving firefighters the opportunity to voice their concerns, rather than just listening to principal managers. The FBU is also seeking guarantees that private sector consultants will not be imported into the process, at huge expense, but bringing very little expertise.

A robust and independent inspectorate is vital, but it cannot be sufficient. There will not be an inspector on every fire station and at every major incident attended. The coroner recognised that FBU health and safety representatives have a key role in managing and monitoring any necessary steps required to improve matters on the incident ground.

Responsibility for improvements

The Home Office response to the coroner lays heavy emphasis and reliance upon CFOA. CFOA is a body with charitable status, not an author of policy. Operational procedures, training practice, assessment processes have been devised by the Chief Officers individually within

their services and collectively via CFOA to-date. CFOA does have a contribution to make, but it must be as a part of the fire and rescue operational sector as a whole and not in isolation. Quality outcomes are what are required and that is best achieved through information, processes and guidance produced by the knowledge, skills and professional inputs from the key sector organisations. This is best administered through a framework facilitated by the Home Office. The FBU believes that a task and finish group would ensure the lessons of Stephen Hunt's death and the coroner's concerns are acted upon throughout the service. This should consider all of the issues identified by the coroner, including what long-term measures need to be put in place.

Next steps
The FBU is compiling a report containing the correspondence arising from Stephen Hunt's inquest. This will include the coroner's report, Home Office responses and our own contributions. The union will also write to the coroner and the Health and Safety Executive, requesting their input to this process.

I stress that the FBU is committed to working with you to ensure that future firefighter deaths and injuries are prevented. Firefighter safety is a central priority for the union. I look forward to an opportunity to discuss these issues with you in the near future.

Yours sincerely

Matt Wrack
General Secretary

SECTION 6

The FBU wrote to the home secretary on 21 July 2016 in relation to the coroner's Regulation 28 report into the death of firefighter Stephen Hunt. This letter is published in this report on page 47-70. The union's submission highlighted several key concerns in relation to this incident and firefighter safety in general.

The FBU's submission also outlined the opportunities we now have to work together with central government and with others in the service to ensure that both the coroner's and our concerns are addressed.

On 1 September 2016, representatives from the FBU met with chief fire and rescue adviser Peter Holland and his team to discuss the recommendations in the coroner's report and a possible way forward. During this meeting Mr Holland indicated that the majority of the recommendations could be addressed by reviewing and amending guidance as part of the ongoing National Operational Guidance (NOG). This approach was later clarified via correspondence from his office *Regulation 28: Report on Action to Prevent Future Deaths – Stephen Alan Hunt*. This is published earlier in this report on pages 71-77.

The FBU followed this up by writing to the home secretary again on 3 October 2016 welcoming the opportunity to review and amend this guidance and giving our commitment to fully engage with this process. We outlined that we have already contributed to National Operational Guidance and will continue to participate as further improvements are made.

However the bulk of this subsequent letter reiterated that while guidance is extremely important it is not, by itself, sufficient and will not provide the full range of remedies required.

The letter revisited every concern raised by the senior coroner and evaluated the approach suggested by the Home Office. We outlined why the approach suggested was insufficient. We re-emphasised that any guidance review must be immediate, but that if it is not accompanied by an enforcement and training package it will not prevent some future firefighter deaths and injuries. This should be accompanied by a rigorous system of independent inspection which addresses such operational and training matters.

The FBU believes that there are at least five strands to making the improvements effective:

- an immediate review and (where necessary) amendment of the guidance – for example in relation to breathing apparatus. This must include a review of the training provided
- ensuring that this training is appropriate, consistent, effective, managed, recorded and scrutinised
- monitoring of fire and rescue services to ensure that they adhere to the guidance and the training packages - this should include an independent inspection regime
- review of incident command to ensure that the lessons taught as part of the guidance and training regimes are delivered and adhered to at incidents
- enforcement as necessary to ensure that the guidance and training packages are applied as proposed and not diluted or ignored.

The FBU supports steps taken by the Home Office to establish an independent fire inspectorate in England, which we believe could improve the monitoring and enforcement aspects required. We have stressed that a new inspectorate must be sector competent in order to understand the challenges of the occupation and the risks involved. We have

reiterated the failings associated with simply looking at CFRA and CFOA for guidance and suggested areas where the FBU can assist.

The FBU will meet with Home Office representatives involved in forming the inspectorate to discuss its remit and mode of functioning. We hope the proposed new inspectorate will concentrate on operational matters and on improving professional standards, which are crucial to firefighter safety.

However we fear that there will be too few inspectors to address the issues in each fire and rescue service or to be able to anticipate every major incident. The coroner recognised that fire and rescue authorities and the FBU both have a key role in managing and monitoring any necessary steps required in this remedy. We are taking steps to ensure that this will be on the agenda for joint health and safety committees in every fire and rescue service and that our officials are fully briefed. Every member of the FBU needs to take an active part in the collective safety measures that will best protect our members on the fireground.

The FBU is publishing this report as part of our ongoing campaign on firefighter safety. The union is determined to apply the lessons from Brother Stephen Hunt's death, which in several areas tragically reflect similar lessons identified from earlier such incidents. We want the lessons of other firefighter fatalities, injuries and near misses to be learned **and acted upon**.

The FBU will be organising meetings with members and officials, providing the tools to engage and campaign on this issue. FBU members are encouraged to take part in political lobbying, as we try to ensure that firefighter safety is given the priority it deserves. The union will continue to advocate central government structures involving the full range of fire service views and with the FBU central to the process to ensure ongoing action on firefighter safety.

All avenues will be explored as we drive this issue forward and members will be regularly updated on the progress of this campaign. FBU officials will be discussing this document at FBU brigade committees. FBU members are asked to consider all the elements contained within this report and to join the campaign to ensure that lessons around firefighter safety are learned once and for all.

Firefighter safety is a central priority for the FBU and this campaign is something you can play a part in.

THE FIRE BRIGADES UNION MOURNS THE LOSS OF
BROTHER STEPHEN HUNT AND DEDICATES THIS PUBLICATION
TO HIM AND ALL OTHER FIREFIGHTERS WHO HAVE DIED
IN THE LINE OF DUTY.

THE FBU IS COMMITTED TO ENSURING THAT LESSONS ARE LEARNED
SO THAT TRAGEDIES LIKE THESE ARE NEVER REPEATED.

REMEMBER THE DEAD – FIGHT FOR THE LIVING

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