MAKE FIREFIGHTER SAFETY A PRIORITY

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, the union has made every effort to help the service and governments learn the lessons from major incidents, especially from those where lives have been lost.

This briefing arises from one tragedy in particular: the death of 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.

His death was a tragedy that could have been prevented, and one that must never be repeated. We are committed to raising the issues connected with his death at every level of the fire and rescue service and with governments.

The FBU has published a 90 page report explaining our concerns. This briefing summarises these concerns and the steps we have taken to remedy the situation. But this is only the start of our campaign to give firefighter safety the priority it deserves. The union wants every member to take an active part in our campaign. We will not rest until these matters are tackled at every level.

Matt Wrack, General Secretary
November 2016

FBU REPORT TO THE CORONER'S INQUEST

As well as representing all FBU members involved with this incident, the union's regional officials in the North West of England carried out a painstaking investigation into the circumstances surrounding Stephen Hunt's death between 2013 and the beginning of this year. The investigation found serious failures at the incident, which contributed to the death and injury of firefighters. These include concerns about fire safety inspections, management and enforcement of fire safety legislation, training, communications, thermal imaging cameras, breathing apparatus procedures, integrated risk management plans, incident command systems, handover procedures, dynamic risk assessment, mobilisation policy and aerial appliances.

The FBU's report made 13 significant recommendations aimed at improving safety within Greater Manchester Fire and Rescue Service, which are applicable to every fire and rescue service in the UK. The report highlights repeated mistakes made in previous firefighter fatalities, alongside warnings given by the FBU to prevent further tragedies. The results of the investigation were presented to Nigel Meadows, the senior coroner who led the inquest into Stephen's death.

CORONER'S REGULATION 28 REPORT

The coroner's inquest took place in April-May 2016. On 18 May 2016, the inquest jury found that Stephen Hunt was unlawfully killed and that the fire was started deliberately by two juveniles.

As a result, on 8 June 2016 Mr Meadows produced a Regulation 28 (previously Rule 43) report, outlining the circumstances of Stephen's death and making important recommendations. The Regulation 28 report was sent to the home secretary with the requirement to respond within 56 days. The report was also made available to interested parties, including the FBU.

The coroner made 10 recommendations, briefly, for fire and rescue services to:

1. Reduce the risks associated with the physiological effects of working in a hot environment
2. Reduce the risks associated with the loss of communications at operational incidents
3. Undertake a review of the hand over of roles at incidents
4. Ensure that significant hazards and any safety control measures are the responsibility of the incident commander and should be recorded within each sector
5. Review the appropriate use of thermal imaging cameras
6. Review the deployment of aerial monitors
7. Review the circumstances in which inspections should be carried out

Significantly, the coroner also recommended that fire and rescue services:

8. Undertake these steps jointly by fire and rescue services and the FBU or other health and safety representatives on the health and safety committees
9. In addition, the coroner suggested that the home secretary ensure:
    - that fire risk assessors are adequately trained and qualified so as to be competent in the role, and
    - that the responsible person has the means to verify the competence of the person delegated as a fire risk assessor.
10. The findings of the inquest are disseminated down to all fire and rescue services.

FBU RESPONSE TO THE CORONER'S REGULATION 28 REPORT

The FBU welcomed Mr Meadow's thorough report. We believe he has produced one of the most comprehensive Regulation 28 (previously Rule 43) letters on firefighter fatalities in living memory, and that the concerns he raised could drive improvements in firefighter safety for the foreseeable future. In particular, we agree with the coroner that FBU safety reps can play an irreplaceable role in ensuring improvements are made in every fire and rescue service.

On 21 July 2016, the FBU sent the home secretary a detailed response supporting the coroner's report. The union's submission outlined concerns raised in the 16 other firefighter deaths at fires recorded in the decade before Stephen Hunt's death. For each of the coroner's recommendations, we provided evidence from previous investigations, coroners' Rule 43 letters and other reports (such as those of the Health and Safety Executive), which reinforce the point that systematic failures have been repeated over and over again leading to firefighter deaths, clearly highlighting that lessons have not been learned.

The FBU also provided important contextual background, including on cuts to fire and rescue services over the past decade. Our submission highlighted the institutional changes since 2004, which has seen the abolition of the fire service inspectorate in England and Wales, the abolition of the Central Fire Brigades Advisory Council (CFBAC) – the body dealing with professional standards and guidance, and the abolition of national standards of fire cover. The union pointed to repeated failures in areas such as risk assessment, incident command, training and BA procedures.

In conclusion, the FBU offered to work with the Home Office and other fire professionals, proposing the establishment of a forum to ensure the necessary changes raised by the coroner are carried out.

GOVERNMENT RESPONSE TO THE CORONER'S REGULATION 28 REPORT

On 1 September 2016, FBU officials met with civil servants, including the chief fire and rescue advisor for England, Peter Holland. We also received the Home Office response to the coroner's Regulation 28 report. The government's response stated that the home secretary had already announced a fire inspectorate would be established for England and that the chief fire officer's association (CFOA) was producing professional standards. The remaining matters would be dealt with under the national operational guidance programme.

FBU RESPONSE TO THE HOME OFFICE

On 3 October 2016, the FBU wrote to the home secretary replying to the Home Office response. The FBU has previously called for a fire inspectorate and is involved with the national operational guidance programme. However the union does not believe that guidance alone will prevent future firefighter fatalities and injuries. We do not believe the Westminster government has responded adequately to the coroner's report.

The FBU pointed out that at present the national operational guidance programme only runs until 2018. Its future beyond that time is uncertain.

Although much of this guidance is available, it is still a matter for local fire and rescue services whether to adopt and follow it. This is in contrast to previous practice – such as with TB 1/97 on breathing apparatus procedures, which stipulated that it "must be adopted by all firefighters in all brigades at all incidents".

A key concern remains the enforcement of guidance. Even with the changes outlined, there is still no suggestion of any mechanism to ensure compliance by fire and rescue services, nor that fire safety inspections and other preventative measures will be carried out and fire safety law properly enforced.

Finally the FBU reiterated that while chief fire officers will clearly need to be involved, setting professional standards cannot exclude the representatives of the workforce (the FBU) nor the employers (through the LGA and devolved bodies). The voice of firefighters needs to be fully represented if professional standards are to be embraced and implemented at every level of the service. The FBU has played a crucial role recently, working with key stakeholders in developing a robust and safe professional fitness standard for firefighters. The FBU must be involved in setting and reviewing professional standards.

NEXT STEPS

The FBU will campaign on firefighter safety to ensure that the lessons from Stephen Hunt's death are learned and safety measures implemented.

EVERY FBU MEMBER CAN

- join the union's campaign
- insist safety is made a priority
- demand safety training
- report incidents, near misses and other concerns
- discuss safety matters at work
- lobby politicians locally and nationally

FBU OFFICIALS SHOULD

- raise the coroner's report with principal managers
- ensure there are FBU safety reps on every watch
- organise an active health and safety committee in the brigade
- mobilise members to take up safety matters
- engage with managers on health and safety policy and enforcement

FBU officials will take our campaign to Westminster on 29 November, and we will raise these matters with devolved administrations. We will speak to ministers, local and national representatives, fire authority chairs, inspectors and chief fire officers.

The union can never back down when the safety of our members is at stake.