Hampshire Fire and Rescue Authority	**Item**	**14**
6 June 2012		
Shirley Towers Incident – Investigation Process		
Report by the Chief Officer		

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1 Summary

1.1 On the 6 April 2010 Hampshire Fire and Rescue Service (HFRS) responded to a fire in flat 72 Shirley Towers, Church Street, Southampton. During this incident tragically two firefighters, James Shears and Alan Bannon sustained fatal injuries.

1.2 In accordance with the Health and Safety at Work Act 1974, and the Management of Health and Safety at Work Regulations 1999, HFRS established an Accident Investigation Team (AIT) to investigate this incident. This paper summarises the Service's response to this incident and it's work with other agencies as part of the investigation.

1.3 A Coroner's inquest regarding the deaths of firefighters James Shears and Alan Bannon will commence on the 18.06.2012 in Southampton and is scheduled to take four weeks to complete.

2 Recommendation

2.1 The Authority note and endorse the Service's investigation process in response to the deaths of firefighters James Shears and Alan Bannon.

3 Introduction and background

3.1 In response to the Shirley Towers incident, the Service had to ensure compliance with health and safety legislation to investigate the deaths of firefighters James Shears and Alan Bannon. This loss of life is deemed to be 'death in the work place' and as such, also warranted separate investigations by Hampshire Constabulary and the Health and Safety Executive.

3.2 HFRS Response

An investigation team was established consisting of a team of five members of HFRS staff led by ACO Bob Ratcliffe. Terms of reference were established for the team outlining four phases to it's investigation:

Phase 1: Gather, record, copy, and log information relevant to the investigation.

Phase 2: Construct a comprehensive record of what happened at the incident and when it happened.

Phase 3: Establish why the events occurred and the associated risk control measures, (root cause analysis). This process to be informed by phases one and two.

Phase 4: Production of an investigation report incorporating an action plan and recommendations for it’s implementation.

Legal advice and representation for the AIT and the Service, continues to be provided through the Service’s corporate insurers, Zurich.

3.3 In addition to the Service’s own investigation team, the Service requested assistance (subsequently agreed), from West Midlands Fire and Rescue Service to provide independent fire sector advice and support to Hampshire Constabulary, and from London Fire Brigade to complete an investigation into the cause, origin and development of the fire.

3.4 In order to ensure a clear understanding of the structure of the investigation, joint agency terms of reference were agreed with Hampshire Constabulary, the Health and Safety Executive, London Fire Brigade and West Midlands Fire and Rescue Service.

3.5 In recognition of joint working and shared learning, the Service also established a memorandum of understanding with the Fire Brigades Union (FBU) investigation team. The Service’s AIT has worked closely with the FBU throughout the investigation sharing all information with them to assist with their own investigation.

3.6 The Service has worked diligently to learn and make improvements in response to issues identified during the investigation, a group was established to consider, prioritise and monitor improvements in response to these “emerging issues”. This group is the Organisational Improvement Steering Group (OISG). This group continues to monitor and audit the improvements and changes introduced across the Service.

4 Hampshire Constabulary Response

4.1 On the night of the incident the Police confirmed they would be conducting an investigation, this investigation was designated as “Operation Carrageen”. From this point the Police had primacy for all matters deemed relevant to the investigation. The key areas for the Police investigation were:

- To conduct a transparent, proportionate and independent investigation in the circumstances of the fire at flat 72 Shirley Towers to ascertain whether a crime had been committed.
- To act on behalf of the Coroner to investigate the cause and circumstances of the deaths and provide a report for the purpose of a inquest.
- To work together with partner agencies who have a legislative responsibility for investigation (HFRS and HSE).

4.2 During the completion of their investigation the Police identified and interviewed 34 key members of HFRS staff that attended the incident. Summaries of these statements will be submitted to the Coroner for the inquest. The Police were assisted during their investigation by a team of fire officers from West Midlands Fire and Rescue Service providing 'fire sector' support and also by London Fire Brigade for completion of the fire investigation. In addition, the Police also worked closely with the HSE investigation team throughout their investigation.

4.3 On completion of their investigation in September 2011, the Police concluded that no criminal offences had been committed and therefore no referral would be made to the Crown Prosecution Service (CPS). The Police have subsequently submitted a report to the Coroner.

5 Health and Safety Executive Response

5.1 The keys area for the Health and Safety Executive investigation were:

- To identify on-going Health and Safety issues relevant to the incident and location.
- To identify lessons learnt in respect of Health and Safety and promulgate them nationally.
- To conduct an investigation into any offences committed under Health and Safety legislation.
- Work in conjunction with the Police as agreed under the Work Related Deaths Protocol.
- To ensure representatives of the workforce are kept informed of information relevant to health and safety.

5.2 During the completion of their investigation the HSE interviewed 37 members of HFRS staff ranging from firefighters to senior managers regarding the Service's policies and procedures. These staff were identified on the basis of their role rather than having attended the incident at Shirley Towers.

5.3 In February 2012 the HSE confirmed they would not be instituting criminal proceedings against any party involved in the incident at Shirley Towers. The HSE have submitted a report to the Coroner; contained within this report are recommendations for consideration by the Service. These recommendations have been considered by the Service's OISG and a formal response made to the HSE and shared with the Coroner.

6 Coroner's Inquest

6.1 In response to the outcomes of the Police and HSE investigations, the Southampton Coroner Mr Keith Wiseman, will conduct an inquest into the deaths of firefighters James Shears and Alan Bannon. At an inquest dealing with a death in the work place, the Coroner will be supported by a jury consisting of members of

the public selected from a jury service list. The inquest will commence on the 18 June 2012 and is scheduled to take four weeks to complete. The venue for the inquest is the Southampton City Council chambers.

6.2 To inform the Coroner and the jury at the inquest, key reports have been submitted:

- HFRS Report
- Hampshire Constabulary Report
- HSE Report
- Fire Investigation Report
- FBU Report

7 People Impact Assessment

7.1 The proposals in this report are considered compatible with the provisions of the European Convention on Human Rights, the Human Rights Act 1998, and the Race Relations (Amendment) Act 2000.

8 Financial Implications

8.1 Funding for the establishment of the AIT and subsequent preparations for the Coroner's inquest has been provided from existing Service budgets.

9 Conclusion

9.1 The early establishment of a clear structure and formal agreements between the various agencies was very beneficial in conducting their respective investigations. The Service was proactive in the early establishment of a dedicated Accident Investigation Team, and the subsequent Organisational Improvement Steering Group. These structures and teams have ensured the Service has been able to learn from this incident and make improvements to the Service where required.

9.2 The Service has detailed welfare, communications, and contingency plans in place in readiness for the Coroner's inquest. On completion of the inquest work will continue to ensure all lessons are learned and information shared with other fire and rescue services and where necessary, improvements will continue to be made within the Service. This work, and that of the OISG, will be monitored and reported to the Performance Review and Scrutiny Committee in due course.

10 Background papers

10.1 The following documents disclose the facts or matters on which this report, or an important part of it, is based and has been relied upon to a material extent in the preparation of the report: **None**

Note: The list excludes: (1) published works; and (2) documents that disclose exempt or confidential information defined in the Act.