

Hampshire Fire and Rescue Authority

Performance Review and Scrutiny Committee

Item: 6

22 October 2013

Shirley Towers Incident – Organisational Improvement Steering Group update

Report by the Chief Officer

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1 Summary

- 1.1 Following the tragic incident at Shirley Towers in Southampton in April 2010 HFRS established an Organisational Improvement Steering Group (OISG) in order to assess and review the factors leading to the two fatalities, and the incident as a whole; and to take any and all necessary actions to improve performance at operational incidents.
- 1.2 Issues were identified by HFRS's own internal investigation team, by the Health and Safety Executive, by the Fire Brigades Union, and following the Coroners Inquest. In total 136 separate issues were identified and these were further subdivided into 198 items covering the entire incident and the full range of operational activities that took place.
- 1.3 Issues have been identified and addressed that whilst present at the incident did not directly contribute to the deaths of Ff's Shears and Bannon, as well as the most significant ones which could be seen as directly contributing. Throughout the process OISG has been clear that it has not been seeking to attribute blame, but has been ensuring that all the relevant lessons are learnt in order to improve firefighter safety at every incident.
- 1.4 In parallel with OISG dealing with the symptomatic issues arising from the incident, the Accident Investigation Team have been carrying out a root cause analysis so that we can fully understand not just what happened on the night, but also why it happened.

2 Recommendations

- 2.1 That the Committee endorse the progress made in dealing with the identified issues, and the improvements already in place in HFRS.
- 2.2 That the Committee endorse the plan to complete the role of the OISG and to develop the process used into an integrated improvement process for HFRS operational activity, managed by the Response Policy Group.

3 Introduction and background

- 3.1 Immediately after the Shirley Towers incident in April 2010 HFRS established the Organisational Improvement Steering Group to consider all aspects of the

operational activity on the night, analysing where performance could have been improved and making recommendations to ensure that any issues that arose would not be repeated elsewhere.

- 3.2 The OISG is made up of representatives from all relevant sections of the Service and examines all issues from an integrated and multi-disciplinary approach. The representative bodies are also standing members of the group.
- 3.3 The various contributors have identified 136 separate issues which have been further sub-divided into 196 items requiring action. These issues cover the entire range of operational activities at the incident from the time of receipt of the initial 999 call, and no issue was considered to be out of scope.
- 3.4 At the time of writing this report 12 of the 196 items were still outstanding (as shown in Appendix A), with work on-going on bringing them to a resolution
- 3.5 Significantly the proposed re-write on the national Breathing Apparatus Technical Bulletin 1/1997 has been delayed for a considerable time, and this is impacting on our ability to address some of the outstanding 12 items. We are led to believe that publication by DCLG is imminent.

4 Current situation

- 4.1 Significant work has been undertaken and a large number of changes and improvements to all aspects of operational activity have been introduced. The Accident Investigation Team continues to work on the root cause analysis and will be publishing their final report by the end of October 2013.
- 4.2 The work of the OISG is on-going and will continue to address the outstanding Shirley Towers issues and any new issues that arise out of the root cause analysis.
- 4.3 The Response Policy Group, as the body with the overarching responsibility for all operational matters will then look to merge the OISG, AIT and Significant Incidents Response Group into a single operational improvement group ensuring that we capture learning and improvement from all of our own incidents as well as from any significant incidents elsewhere in the UK or around the world.

5 Supporting our corporate aims and objectives

- 5.1 HFRS remains committed to being the best fire and rescue service. Ensuring that we make all of the necessary improvements from the tragedy of Shirley Towers is essential in achieving that aim.
- 5.2 This work directly supports the corporate objective of making life safer and improving the way we respond to and support incidents.

6 Risk analysis

- 6.1 Failure to thoroughly and accurately analyse what happened at Shirley Towers means that we risk similar incidents happening again in the future.
- 6.2 Our proactive approach and willingness to analyse and learn was undoubtedly instrumental in the HSE's decision not to take any action against HFRS. Without the work of OISG and the relevant individuals the service would have been at

greater reputational risk from any possible enforcement action.

7 People impact assessment

7.1 There is no impact outside current operating principles and practises.

7.2 The proposals in this report are considered compatible with the provisions of the equality and human rights legislation.

8 Environmental and sustainability impact assessment

8.1 There are no environmental or sustainability impacts

9 Resource implications

9.1 Human resources

Each OISG issue has different implications and consequential actions. There have been no additional human resource implications from the work of OISG. The Accident Investigation Team was established using existing personnel re-deployed from other departments.

9.2 Physical resources

Considerable additional equipment has been purchased as a result of the work of OISG based on the analysis of the issues, most notably the changes to breathing apparatus set communications, wire cutters and improved cylinder covers to prevent entanglement. This has been managed by the Response department and the Service Equipment officer in the normal way.

9.3 Information and communications technology resources

As above, a large number of additional radios have been provided across the service bringing improvements to every operational incident. Additionally the service has produced a comprehensive DVD package detailing the incident and the events leading to the tragic deaths, and this has been widely distributed to every UK fire and rescue service and other relevant partners.

9.4 Financial implications

To fund these resource implications as described above a one-off amount of £275,000 was provided from reserves.

10 Consultation

10.1 All relevant departments in HFRS were represented in the OISG as were the staff representative bodies. Additionally significant consultation has taken place with the Health and Safety Executive and others as this programme of work has progressed.

11 Conclusion

11.1 The work arising out of the Shirley Towers incident has been significant and is on-going. Unsurprisingly none of the issues were unique to this incident and all of the improvements are ones that will benefit the service as a whole at every operational incident that we attend.