Firefighter Fatalities at fires in the UK 2004-2013: voices from the fireground

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We have dedicated firefighters often working in very difficult conditions. In England alone between 1993/4 and 2003/4, there were 6 firefighter deaths at fires but in the next ten years 2004/5 to 2013/2014 this doubled with 12 firefighter deaths and one fire technician death. Additional death occurred in Scotland and Wales. Fatalities occurred at Bethnal Green, London 2004 (2); Harrow Court, Hertfordshire 2005 (2); Marlie Farm, East Sussex 2006 (2); Atherstone, Warwickshire 2007 (4); Dalry Rd, Edinburgh 2009 (1); Shirley Towers, Hampshire 2010 (2); Oldham Street, Manchester (1) 2013. Fatalities have often occurred in similar settings or similar circumstances along with an unknown number of serious injuries and near misses. Firefighting hazards and risks are high and self-evident and they may be complex events at one level but not all decades have led to multiple deaths and serious injuries and one death or serious injury is one too many.

The report, drawing on interviews with firefighters themselves as well as inquiries, inspection reports and trial papers, provides detailed recommendations to address the continuing threat of firefighter fatalities at fires. Brigade fatality investigations rarely, if ever, identify and acknowledge the direct and indirect roles that central and senior local government and brigade managers play in such events. Yet these bodies and their 'directors' are ultimately responsible for regulations, budgets, staffing, systems, training, equipment and resources, information, procedures and specific standard operating procedures that firefighters use. Budgets cuts in training, staffing, equipment and fire stations and continued operational duties of much older firefighters may also have serious impacts on firefighter safety at fires. These impacts may not emerge for some time. It is neither cost-effective nor morally acceptable to cut vital fire services in ways that may endanger both public and firefighter safety. It is very easy to lose sight of the causes of public sector expenditure cuts, who was responsible for them (in the global financial markets) and how we now choose to prioritise our spending in the light of such cuts for example in fire services.

Professor Watterson said "whilst the risks of firefighting are obvious, the scale of death and injury is unacceptable. Many risks are avoidable if appropriate management and systems, inspection and regulation, training and other related matters are in place. Good practice has sometimes been ignored so the problem is compounded by lessons slowly learnt, stifled communication of information, lengthy legal wrangles creating a justice deficit and organisational denials of accountability. Public and firefighter safety has not been prioritised when it should have been".

He added: "There should be defences in depth that run from the top of government, through regulators and brigades to the fireground - vital to protect firefighters on the fireground in all incidents- yet on occasions they have been missing and firefighters have been left defenceless and lost their lives. Risks may not have been 'highly calculated', assessed and reduced. Such risks cannot be removed but they can normally be managed far better by fire services, local and central government, and regulatory and inspection bodies."

In Britain since 2010, according to reports , there have been over 5000 firefighter jobs lost, 39 fire stations closed and response times increase substantially.

Recommendations of the report include:-

Government departments across the UK including the CFRA office

- The better regulation and red tape challenge agendas of the government have not been properly evaluated. There is little evidence to show that in practice fire health and safety laws, regulations and codes are applied when they should not be or that they weigh down the economy. Where such agendas are not relevant to fires, they should be abandoned
- The four governments should introduce occupational and public safety and health impact assessments prior to pursuing new policies and legislative changes that may affect firefighter and public safety. The costs of cuts in firefighter staffing, resources and not carrying out occupational health and safety activity in terms of human, social and economic damage should always be considered. These will balance regulatory impact assessments that focus on the costs of regulating and not the costs and consequences of not regulating.
- The departments should ensure that funding for fire safety is adequate and that measures it takes do not weaken the implementation of any of its regulations and guidance on fire safety
- To achieve and facilitate the above, the departments should ensure that there is a properly funded and staffed CFRA office or its equivalent. The CFRAs would be able to carry out audits under and inspect FRSs to check that public safety and firefighter safety measures are in place and effective.
- Hence the CFRAs or HM Fire Inspectorates should develop a programme to ensure all FRSs are reviewed with regard to their work both on community safety and firefighter safety
- The economic costs of such an office and unit would be partly covered by the reduction in firefighter fatalities, injuries and diseases, as well as by improvements in public safety, and so should be cost effective. Currently many of the costs of firefighter deaths and injuries are offset within the NHS and by communities and families of those affected firefighters
- CFRA/Chief Fire and Rescue Advisor's Unit (CFRAU) information should be widely disseminated along with key findings on fatalities and guidance on actions in the future to prevent such fatalities. This should entail a review of the fitness for purpose of Rule 43 letters from coroners or their equivalent to ensure much wider and quicker dissemination of key findings as well as action on them
- A fire safety and health forum, with all relevant stakeholders invited, should be re-established and funded by governments. It should serve all four UK countries. This should be linked to the development of better means for DCLG and others to engage with firefighters effectively in producing technical and other documents relating to fire health and safety
- The DCLG and similar ministries in the other countries should urgently set up a review of the failure of some brigades to act rapidly on recommendations from fire fighter fatality at fires reports.

Almost all of the fatalities discussed in this report, it should be noted, occurred post-2004. The CFRAs/HMIFs would be able to check national audits in brigades and inspect them including ensuring actions were taken on Rule 43 letters. CFRA reports should be widely disseminated along with key findings on fatalities and guidance on actions in the future to prevent such fatalities

HSE

- HSE should ensure there are sufficient staff and resources available to oversee the work of the fire services properly with regard to the health and safety of firefighters
- HSE should review its current guidance and reports on firefighter health and safety
- Data indicate that enforcement action by HSE is very limited, although quite possible, in the light of serious health and safety breaches by brigades. HSE should review its enforcement policy in the light of recent employer failures to safeguard fire fighters. It is unlikely that governments will introduce new or more stringent laws on fire safety in the near future but HSE should enforce existing laws better
- HSE should set up a new and regular inspection programme of FRSs to check that the findings of previous fatality reports and other evidence of hazards to firefighters – safety and health - are being fully implemented across the UK. This should be planned and extend beyond a simple paper and tick box exercise
- HSE should provide clear and publicly available (not informal) guidance to employers and employees on the priority that should be given to firefighter health and safety by employers
- HSE reports on fire fighter fatalities should be made available as fully, quickly and publicly as possible along the US lines for all to benefit from the information and analyses provided
- Future research by HSE should target major upstream threats and risks to firefighter health and safety and not marginal human resource topics
- HSE should draw on the extensive documentation of fire fighter fatalities that it has on file to extend and improve its advice to UK FRSs. Currently HSE does not appear to have a coherent picture of the key elements causing fatalities but only a fragmented view
- Consideration should be given to the establishment of a 'fire investigation unit' along the line of the Marine Accident Investigation Board (MAIB) or Air Crash Investigation bodies. Such a unit could pool resources from across HSE, CFRAU and the Fire Services College at Morton in the Marsh to investigate serious fire incidents

Laws

- Governments should prioritise public health and firefighter safety legislation over financial considerations. There is no evidence of either a compensation culture existing among firefighters or a trivial approach to health and safety operating in firefighting and there is widespread agreement about the hazards of the occupation
- Governments should ensure the health and safety impact of changes (and related possible adverse economic effects) on or reduction of laws, regulations, codes of practice and guidance relating to fire are as carefully assessed as the economic costs and consequences of bringing in new legislation

Legal matters - courts, inquests, Fatal Accident Inquiries (FAIs), Coroners and the Police including the Crown Prosecution Service (CPS) (England and Wales), the Crown Office Procurator Fiscal's Unit (Scotland) and the Director of Public Prosecutions (Northern Ireland).

- 'As justice delayed is justice denied', there should be a speeding up of processes relating to inquests, fatal accident inquiries and trials for workplace fatalities along with more resources and political will to pursue such cases
- Improved, expanded and increased training and briefings by CPS and other appropriate bodies is needed for UK police forces on manslaughter and corporate manslaughter and related laws that may apply when firefighter fatalities occur
- This should focus on building constructive relations with all parties involved, including FBU and avoiding confrontational, vexatious and incorrect investigations that have occurred in past incidents. There are examples of good and bad practice in police handling of fire fatalities and good practice should be rolled out
- There should be a review of the effectiveness of Coroners' Rule 43 letters and their limited take up by some fire brigades. Such a review may wish to consider better means to roll out recommendations and monitor their uptake. Training of coroners in utilising expert witnesses and writing comprehensive Rule 43 letters with regard to firefighter fatalities and related matters may be of value.

UK Fire and Rescue Services (FRSs)

- Examples of good practice in investigating and/or addressing health and safety that exist in all four countries should be systematically rolled out more quickly and widely
- Both fire fighters and fire officers' roles and workload need to be urgently re-assessed relating to the prioritisation of myriad, increasing and sometimes conflicting tasks that impact directly and indirectly on occupational health and safety
- FRSs should re-assess the nature, scope and application of systems affecting fire fighter safety especially with regard to the respective weightings given to behavioural and safe systems of work and effective high level risk management. This should help to further inform assessments and re-assessments of the workings and fit of generic risk assessments (GRAs(, dynamic risk assessments (DRAs), Analytic Risk Assessments (ARA) and related standard operated procedures (SOPs)

- Greater emphasis should be given to how defensive firefighting decisions are or are not taken in the light of recent incidents, the key principles of fire risk management and the impact of HSEs' 'Heroism' and 'striking the balance' outputs.
- FRSs should urgently review the extent to which they have fully implemented Rule 43 letters and incident reports on fire fighter fatalities at fires in so far as they have the authority to do so and document their findings
- All FRSs should review or revise specific aspects of their policies and procedures on firefighting where incident reports indicate this is necessary including information and training for control room staff
- FRSs should also where necessary re-assess external factors that have contributed to past fire fighter fatalities including the need for sufficient fire stations, sufficient trained and experienced firefighters, the right equipment, control rooms able to provide and receive accurate and rapid information on fires
- FRSs should also, where necessary, address more specific factors that contributed to previous firefighter fatalities and ensure they address the health and safety of those on the fire ground.
- This would include for example :
  - ensuring there is relevant, realistic , revised and regular training including the means to ensure relevant 'comprehensive' experience - where possible - for firefighters on incident command, fire and building science, standard operating procedures, GRAs and how they influence SOPs , DRAs and ARAs, risk management, BA usage, control and monitoring and other equipment training and experience, compartment and other search patterns, working in high temperatures and its effects, water supply to fires and to firefighters etc
  - These factors may be viewed as the 'bread and butter' of the fire service but it is very clear from examining past fire fighter fatalities that have occurred that they are not.
- The firefighters interviewed wanted FRSs and support bodies to ensure there are more effective approaches to bridging the theory/practice/experience gaps for fire officers in training and review activities. This was particularly pressing in incident command and control, especially control, as a number of the firefighter fatalities had occurred sometime long after fire fighters had reached the fire ground.
- Better mechanisms and practices are needed across the UK to improve and prioritise FRSs' investigations of fatal incidents to ensure they are as transparent and collaborative as possible. Currently the position is patchy

Local government - the Local Government Association England (LGA) and other similar bodies in Wales and Northern Ireland within in the UK

- Local authorities and their umbrella bodies should carry out good quality and rigorous occupational health and safety impact assessments of any proposed cuts in fire services. These assessments would include the economic consequences of cuts in the same way that regulatory impact assessments assess costs of regulations and proposed regulations
- Local authorities should re-assess the requirements needed for a safe fire service that will protect both the public and its own firefighters and make adequate

budgetary provision to meet those requirements in the light of recent fire fighter fatalities

- If public expenditure cuts prevent local authorities fulfilling these requirements, then local authorities and bodies such as LGA may need to challenge such cuts and ensure that their electorates and their employees are fully informed about the implications of the cuts to the public and fire safety
- LGA should evidence how they do and will audit and do and will prioritise firefighter safety effectively as well as public safety in their respective FRSs
- Through LGA and other public bodies, local authorities should be prepared to produce a UK-wide consolidated annual report on firefighter fatalities, injuries and diseases unless this is already done by national governments or HSE. The reports could be based on those from Brigade Chief Fire Officers (CFOs) who should produce a public consolidated brigade report each year on firefighter fatalities, injuries and significant near misses and actions that have been taken to improve firefighter safety documenting any good practice
- In 2014, COSLA, the Scottish local authority body, no longer had responsibility for fire as brigades had been consolidated into one national body, the Scottish Fire and Rescue Service
- The 'self-regulation' model for checks on local authority fire services created by central government and adopted by local government should be abandoned as it has failed to prevent several of the fire fighter fatalities discussed in this report. There should be a move back in all four countries to formal regulation and national inspections of fire brigades drawing on a reconfigured CFRA office and, where necessary, re-established and independent HMIFs

Availability of Statistics

- The Health and Safety Executive HSE should make available all reports of completed investigations of firefighter fatalities on its web pages that are not restricted by ongoing legal cases. This should be done as expeditiously as possible
- Each Fire and Rescue Service (FRS) across the UK should publish, including on its web pages, injury statistics and details of completed investigations of firefighter deaths at fires. This should be done as expeditiously as possible. There are examples of good practice to draw on: the NIFRS for example has an excellent data base on injuries to firefighters
- Each FRS should provide annual web-based reports on firefighter health and safety. These data should currently exist but may be 'hidden' from public view in brigades.
- Within the office of the Chief Fire and Rescue Advisor (CFRA), the data available under1 and 2 should be evaluated on a regular basis and used to produce publicly available annual or biennial reports as the CFRA has a strategic role
- FRSs and the CFOAs should provide regular publicly available reports on firefighter fatalities at fires and any other major incidents serious injuries and diseases and significant near misses when they occur and when they are legally able to do so
- Local government - the Local Government Association England (LGA) and other similar bodies in Wales and Northern Ireland within in the UK