SCOTTISH FIRE AND RESCUE SERVICE

The Board of Scottish Fire and Rescue Service

Report No: B/RR/03-17

Agenda Item: 11

Report to:	**THE BOARD OF SCOTTISH FIRE AND RESCUE SERVICE**
Meeting Date:	**31 AUGUST 2017**
Report Title:	**CRITICAL INCIDENT DEFINITION**
Report Classification:	**FOR DECISION**

Prepared by:	Martin Gordon, Area Manager Response & Resilience
Sponsored by:	Lewis Ramsay, Assistant Chief Officer, Director of Response & Resilience
Presented by:	Lewis Ramsay, Assistant Chief Officer, Director of Response & Resilience

Links to Strategy
The proposals contained in this paper support the strategic outcomes of Modernising Response and Workforce Development

Governance Route for Report	**Meeting Date**	**Comment**
Service Delivery Committee (SDC)	*6 July 2017*	*Definition was noted with feedback given*
SFRS Board	*31 August 2017*	*For approval*

1	**Purpose**
1.1	To present to the Board the proposed definition of the term “Critical Incident” for approval, allowing consistent application in planning and preparations across Scottish Fire and Rescue Service (SFRS) activities for operational response and business continuity.

2	**Background**
2.1	The SFRS operates in a complex environment of statutory and non-statutory duties performed in the service of our communities. These covering both response and prevention work.
2.2	The broad range of work and the nature of what the SFRS directly influences or responds to varies in severity and impact on communities, the SFRS, individuals (internal and external) and specific groups. The more severe impacts falling under the term ‘Critical Incident’.

2.3	To establish a suitable definition Critical Incident was considered in the context of impact. Therefore it is broader than the nature of the incident and the outcome in a purely operational response scenario but also takes into account events impacting on business continuity.

3	**Main Report and Discussion**
3.1	A Critical Incident should be considered as an event whether operational or non-operational in origin that has a major impact on the SFRS and/or the communities we serve. The following criteria is provided as examples of such events that would qualify as Critical Incidents but is not exhaustive. The ability to declare a Critical Incident should remain extant beyond a restrictive list but should fall within a broad criteria that considers the potential impacts as mentioned above. The criteria covering; ▪ Death on duty of a Firefighter, including Retained and Volunteer staff who die whilst responding to pager and enroute to their station. ▪ Significant equipment failure resulting in serious or potential injury/death requiring special measures to be implemented to address the implications of the event. ▪ Serious accidents resulting in life changing injury and/or has a fundamental impact on SFRS managing/operating processes/policies. ▪ Serious collisions involving SFRS vehicles, including, whilst on duty, flexi-duty mangers, resulting in death or life changing injuries to SFRS staff and or members of the public. ▪ All declared Breathing Apparatus emergencies. ▪ Death of member of the public, from fire, in any relevant or crown premises where SFRS has a statutory responsibility for enforcement of fire safety legislation. ▪ Incidents involving response to terrorism. Limited to an appropriate update as determined by the ACO/DACO Response & Resilience. ▪ Events involving large scale deployment of SFRS resources (including spate conditions). ▪ Incidents that are deemed to have significant impact on the community and/or generate significant political and/or media interest. ▪ Events and/or actions that result in the activation of business continuity plans. ▪ Incidents and/or events occurring out with Scotland that may have a potential to impact on our communities or generate significant political and/or media interest relevant to the capability of SFRS to respond to a similar type of incident.
3.2	The criteria detailed above is wide ranging and allows sufficient scope for interpretation so as not to limit the types of incidents or events that can be considered by the SDC, in the context of understanding the impacts on SFRS and how these are being managed. It is also the intention of the criteria to allow multiple incidents of a similar type (spate conditions) to be open to consideration, examples of which are shown below for illustrative purpose and again not exhaustive; ▪ Extreme weather resulting in wide area flooding. ▪ Multiple wildland fires. ▪ Extreme weather affecting business continuity.
3.3	The role of the SDC will be important in the provision of oversight and scrutiny of the response to and management of Critical Incidents. This scrutiny providing the necessary checks on required actions and their progress to assure continued improvement in service delivery and Firefighter safety. Thereby helping to ensure an effective delivery of service to our communities in the discharge of our statutory and non-statutory duties. An essential aspect of the role of the SDC in regard of Critical Incidents is the drive for improved safety of Firefighters and public.

3.4 **Case study:** Fire at Stewartville Street Glasgow.

(BA Emergency and the first example of activation of the OA21 protocol)

A BA emergency was declared when a firefighting team became trapped in a lift on the floor of a fire with no firefighting media to hand. The attending 3rd call officer initiated the Operational Assurance processes on the night of the incident.

The OA department conferred with the Incident Management team and agreed the key lines of enquiry for the investigation process. They gathered witness statements from the attending personnel and interrogated all historical data relating to the incident and the building in general. Further research was conducted to identify any similar historic incidents from legacy services and from the wider firefighting community to establish if there had previously been any operational lessons identified that would be of relevance.

Interim findings were produced which helped to influence the key lines of enquiry of the main Health & Safety incident investigation along with an eight point action plan for immediate implementation

The following points were identified as lines of enquiry for the lead investigator of the Health & Safety Investigation to consider.

- *Consider the merits of amending the high rise building Standard Operating Procedure to include information forbidding the use of any lift during an operational incident that is not fitted with a firefighter's override switch.*
- *Review existing policy to establish, whether all residential buildings in The SFRS service area of ground and five floors (or more) above, should be fitted with a guidance plate, or if such a practice should now be discontinued.*
- *Consider the benefits of Introducing a preplanning element to the high rise building inspection process, covering BA emergencies and what actions would have to be implemented to resolve one should it occur.*

  Ensure that every event where firefighters are unable to leave a lift car, and or travel directly to the floor involved is the subject of a Health and Safety investigation irrespective of lack of personal injury or property damage

The level 3 H&S event investigation was completed within six months and ratified by the OA Board. The associated action plan is currently being managed by the Operational Assurance team and will be subject to bi-annual audits from H&S colleagues until all learning has been embedded into the SFRS.

Examples of the 24 actions generated include;

7.	Commissioning an immediate review of the SFRS SOP High Rise Buildings to consider the adequacy of the arrangements with in for effectively dealing with medium rise buildings (5 to 7 floors). (Linked to insufficient pre-planning and operational tactics within SOP).			Response & Resilience Jim Quinn		
8.	Issuing an urgent instruction including information forbidding the use of any lift during an emergency incident that is not fitted with a firefighters switch. Amending the SFRS SOP High Rise Building to include the same information. (Linked to operational tactics within SOP).		Actioned under point 3 within OA21 by R&R through UOI process.	Response & Resilience Complete √		

3.5 The fulfilment of the above requires governance arrangements that facilitates the connectivity of the SDC with the daily business of the SFRS to ensure Critical Incidents are identified and reported.

3.6	The appropriate linkage as described above is via the Operational Assurance Board (OAB). This Board is chaired by the ACO Response and Resilience or his/her deputy who in turn would provide the input to the SDC. The OAB meets on a monthly basis and has well established provisions for the identification and management of Critical Incidents. The groups who form and report to the OAB are all in positions where incidents falling under the definition of Critical Incident will be reported to them.
3.7	The function of Operational Assurance staff is to monitor activity both internally and externally for significant events etc. They are therefore already established in the role of identifying and examining/investigating Critical Incidents and subsequently implementing improvement action plans. Regional Implementation Groups (RIGS) have been formed in each Service Delivery Area to support this and embed the lessons identified into business as usual. Each RIG is coordinated by a Local Senior Officer with reports on the progress and effectiveness of strategy being presented to the OA board.
3.8	It is these action plans along with a summary of the event that the SDC will be advised to allow progress to be monitored.
3.9	Notwithstanding the issues and governance around Critical Incidents the OAB take an active interest in monitoring activity to identify trends that may be deemed to have potential for a negative impact on the quality of service or compromise Firefighter and public safety. This proactive work may in some cases prevent the occurrence of a Critical Incident. Where there is a suspected trend that is a cause for concern a thematic review may be triggered. This facility may be available, with agreement of the ACO/DACO of Response & Resilience (subject to capacity), to study areas of concern raised by the SDC.
3.10	**Case study:** Example use of Trend Analysis. *Several significant RTC events involving SFRS appliances were subject to event investigation. Each of the investigations produced recommendations and action plans that were presented to the OA board for approval and implementation.* *The OA Board recognised the potential wider cultural issues associated with repeated events and instructed that a Driver Safety Group be formed to merge the action plans, but more importantly to take steps to address the wider issues. The four main action plans from incidents at Haddington, St Monan's, Inverness and Bathgate have been consolidated and the group have expedited production of the MORR policy and a Drivers Handbook.*

4	**Key Strategic Implications**
4.1 4.1.1	**Financial** N/A
4.2 4.2.1	**Legal** The SDC shall need to recognise the legislative environment in which the SFRS operates. It is also necessary to understand the security arrangements that are in place for information that could restrict what can be shared with the SDC in some instances.
4.3 4.3.1	**Performance** N/A
4.4 4.4.1	**Environmental & Sustainability** N/A

4.5 4.5.1	**Workforce** N/A
4.6 4.6.1	**Health & Safety** N/A
4.7 4.7.1	**Timing** N/A
4.8 4.8.1	**Equalities** N/A
4.9 4.9.1	**Risk** N/A
4.10 4.10.1	**Communications & Engagement** N/A
4.11 4.11.1	**Training** N/A

5	**Recommendation**
5.1	The SFRS Board are invited to approve the proposed definition of the term "Critical Incident" and the arrangements for oversight and scrutiny of the response to and management of Critical Incidents as set out in 3.1-3.3, subject to any amendments.

6	**Core Brief**
6.1	This paper provides details of the definition of the term "Critical Incident" allowing consistent application in planning and preparations across SFRS activities for operational response and business continuity.

7	**Appendices/Further Reading**
7.1	N/A