Organisational Learning

Final Report 2017/18

Humberside Fire and Rescue Service

MIAA

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1. Introduction, Background and Objective

The objective of the audit was to evaluate the design and test the application of controls around the procedures and arrangements in place for organisations learning from serious incidents or near misses. As part of agreeing the Terms of Reference for this audit it was agreed that we would use a specific incident for testing purposes as it was a significant incident for the service and was relatively recent. We therefore used the gas explosion at no 421 Beverley Road as the sample. The scope was however limited to the controls that had been applied at the point of the audit as some of the planned actions have not as yet been completed due to having to wait for the Coroner's inquest to be held and as some actions take longer to implement than other more immediate ones.

The incident happened on the 10th March 2017 at the above premises. The caller reported smoke in the building and the usual resources for this type of call was mobilised. The team identified a fire and crew entered the building to extinguish the fire. 90 seconds after entering the kitchen of the ground floor flat, an explosion occurred resulting in a fire ball engulfing the entire ground floor. It later transpired that the fire started within the cooker and that a sequence of events resulted in gas being ignited and an explosion occurring. Although two fire fighters were taken to hospital to be checked over, they were released without treatment. A casualty was later found however at the time it was not thought that the fire or explosion contributed to his death and the Coroners verdict was accidental death.

2. Executive Summary

High Assurance

Overall

As a result of this audit we are providing a high level of assurance that there are appropriate controls in place for organisational learning. This is based on our review of this particular incident and is in the context that some of the remedial actions have not yet been actioned but are being pro-actively monitored via an action plan.

Our audit concluded that the incident had been subject to a comprehensive investigative process by trained personnel that resulted in a number of reports being produced good practice and lessons learned identified. These in turn translated into action plans for improvement that are now being managed and monitored. There is an overarching Operational Assurance Plan in place (which was followed for this incident) and Standard Operating Procedures. We also reviewed evidence which highlighted good engagement with personnel via the usage of bulletins, de-briefs and operational flashes. Additionally, there was evidence of good reporting and oversight of the actions taken as a result of the incident.

We are making one recommendation concerning the provision of protected time for those involved in a significant investigation which should help ensure that reports are produced in line with any required timescales and lessons learned in a timely basis.

The following provides a summary of the key themes.

3. Findings, Recommendations and Action Plan

IDENTIFIED RISK	EVALUATION & SUPPORTING NARRATIVE	RISK CONTROLLED
Humberside Fire and Rescue do not learn lessons and therefore improve practice, as a result of a serious incident or near miss.	The following controls were found to be in place: **Framework** 1) There is an Organisational Operational Assurance plan and process in place and this was initiated for this incident. One aspect of the plan is to: 'play an essential role in measuring operational activities and competencies. It uses experiential learning from incidents and exercises as well as the use of debriefs, station plans and inspections to achieve this'. The document goes on to consider the review of significant events and safety critical events. Further enhancements to the monitoring system are being planned for implementation during 2018. This will include the Station Monitoring and Inspection process which has an in-depth assessment of all areas of the operational preparedness of the station. 2) The Fire Service has a number of Standard Operating Procedures, including Fires in Buildings. These are reviewed on a regular basis to reflect changes in practice that are required, including those after significant incidents. There was a revision to the above SOP after the incident. Control Gap There are no KPI's set in terms of the timescales for the various investigations to be completed. We were informed that the review would likely have been completed quicker had protected time been available. The Service should consider going forward when incidents of this nature have to be investigated is that protected time is made available for the investigation team – particularly the Lead Investigator. Unless this time is provided there is a risk that the investigation may not concluded on a timely basis and could result in potential lessons learned being missed and changes in practice not made resulting in a similar incident occurring again.	Mainly – refer to recommendation 1

IDENTIFIED RISK	EVALUATION & SUPPORTING NARRATIVE	RISK CONTROLLED
	<u>Investigation</u> 3) A separate Health and Safety Investigation was undertaken, which, as well as others, included five members of staff from the Fire and Rescue Service, with the Lead Investigator being Paul Clucas (GM Internal Services). These staff were trained in the investigation process, although the for some reason Paul Clucas was not showing on the system as having received the relevant IOSH training. We have since been provided with a copy of Paul's IOSH certificate and Paul has asked for the system to be updated to reflect this. A critical friend from another service was included as part of the investigation team to provide some challenge and QA to the investigative process and findings. 4) The formal Health and Safety report was produced on the 19th July 2017. 5) There was a separate investigation undertaken by the Fire Investigation Officer, Andrew Kamis which concentrated on establishing how the fire started. The Fire Investigation Officer also report externally to the HSE and have arrangements in place with Regional Level 3 investigators - one was called out to this incident to commence a joint investigation. <u>Learning</u> 6) A comprehensive Operational Learning Plan to manage and monitor the actions required as a result of the incident. This includes details of the responsible Directorate, individual, timescales and a risk rating. We discussed this during this audit and there were no actions significantly past their implementation date. Two actions had September 2017 timescales, however these were due to be closed at the time of the closing meeting. This plan is owned and monitored by Service Support HS&E. 7) We reviewed the PDRpro Operational Assurance records of this incident and it appeared a comprehensive record of the incident and actions subsequently taken. It highlighted immediate learning points from the de-brief as well as areas of good practice, such as the handover from the IC (Allen Cunningham) was clear and sufficient, and that liaison with the police was very good. An initial PIN (potential for improvement notice) was created and dealt with – however all other areas for learning were included in the over-arching action plan. 8) An Operational Case Study was produced as an Appendix to the Health and Safety report by Paul Clucas following the incident which contained an overview of the incident and the main learning outcomes. 9) The Operational Case Study was shared internally, but also with the National Occupational Learning Network (NOL)	

IDENTIFIED RISK	EVALUATION & SUPPORTING NARRATIVE	RISK CONTROLLED
	user group for their consideration of whether there are any lessons to be learned on a national basis. 10) The CCTV images of the incident have been sent to all staff and all stations, and this is going to form part of further lessons learned/training with station managers in the coming months. 11) An Ops Flash was sent out in March 2017 to all stations, identifying three key learning points from the incident that personnel must adhere to at all times. These were: - Where incidents require the use of Breathing Apparatus (BA), only personnel under air should proceed beyond the ECO Board unless a specific identified short duration task is identified, and a DRA justifies it - Incident ground management, incidents are hazardous by their very nature and potential crime scenes, members of the public must be cleared to a safe place and prevented where possible from entering the scene of operations - Early consideration to the isolation of services, (where practical) this is particularly important when committing BA crews into buildings as this will potentially eliminate the hazard and reduce the level of risk to fire fighters. 12) Initial de-briefs were held on the 10th March 2017 and 26th April 2017 for around 25 operational staff (including managers). We reviewed the list of people that had been invited to the April meet which was targeted at key staff and managers and the detail that was supplied to the meeting. 13) The Coroners Verdict in September 2017 relating to one of the occupants of the building was accidental death and there was nothing further for the Fire Service to consider. 14) The Fire Service website contains a number of articles in relation to the incident, as well as some CCTV footage. Monitoring/Oversight 15) The incident was included on the Directorate Risk Register and on the 18th April, it was agreed by CMT to put it onto the Corporate Risk Register. This risk register is monitored on a regular basis and was originally scored 70 – but as at December 2017 was 45 as actions started to be implemented. 16) The actions identified as a result of the various reports that have been produced have been reported to several groups and committees over the period, including CMT, GAS (latterly 18th September 2017 and 27th November 2017) and the Fire Authority. .	

The review findings are provided on a prioritised, exception basis, identifying the management responses to address issues raised through the review.

To aid management focus in respect of addressing findings and related recommendations, the classifications provided in Appendix B have been applied. The table below summarises the prioritisation of recommendations in respect of this review.

Critical	High	Medium	Low	Total
0	0	1	0	0

Other detailed findings and recommendations are set out below.

Detailed Recommendations

1. Resourcing	Risk Rating: MEDIUM

Control design

Issue Identified – Protected time is not made available to the Health and Safety Investigation Team (particularly the Lead Investigator) to undertake the investigation when a significant incident takes place.

Specific Risk – The investigation is not concluded on a timely basis and results in potential lessons learned being missed and changes in practice not made resulting in a similar incident occurring again.

Recommendation

1) Protected time is made available for the investigation team (particularly the Lead Investigator) to enable a comprehensive report to be produced within agreed timescales. This should be agreed at the outset of the investigation.

Management Response (Remedial Action Agreed) - Agreed

Responsibility for Action – Director of Service Support

Deadline for Action – **Deadline to be agreed**

Follow-up

In light of the findings of this audit we would recommend that follow-up work to confirm the implementation of agreed management actions is conducted within the next six months.

Appendix A: Terms of Reference

Overall System Risks

The key risk being considered in this audit is that Humberside Fire and Rescue do not learn lessons and therefore improve practice, as a result of a serious incident or near miss.

Objectives

The objective of the audit is to evaluate the design, and test the application of controls, around the procedures and arrangements in place for organisational learning from serious incidents or near misses.

Scope of Work

Incident number 4986 – gas explosion 421 Beverley Road Hull – will be used as the audit sample for this audit. The audit will cover the relevant procedures for investigating the incident, reporting it and learning lessons. The scope will be limited to the controls that have been applied to date as some of the planned actions have not yet happened due to the coroner's inquest being relatively recent.

Key Contacts and Report Distribution

The key contacts for the review will be;

Name	Title	Report Distribution
Steve Topham	Director of Service Support	PDF
Simon Rhodes	Corporate Planning Manager	PDF
Paul Clucas	Group Manager, Internal Services	PDF
GAS Committee		PDF

Data Protection and Freedom of Information

All documents acquired or created by us during the course of this assignment remain the property of the client.

MIAA are, thus, considered as a data processor rather than a data controller and are not, therefore, directly subject to the requirements of the Data Protection Act. No information relating to this, or any other, assignment will be directly disclosed to a third party by MIAA in response to a subject access request. Any requestor will be advised that they should approach the client.

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These principles will also be applied in respect of any request for information relating to this, or any other, assignment under the Freedom of Information Act.

Your Acceptance

Please do not hesitate to contact MIAA should you have any comments regarding the Terms of Reference (these will be assumed as agreed if MIAA are not informed otherwise).

Limitations inherent to the internal auditor's work

We have undertaken the review of the process, subject to the following limitations.

Internal control

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

The assessment of controls relating to the process is that at . Historic evaluation of effectiveness is not always relevant to future periods due to the risk that:

- The design of controls may become inadequate because of changes in the operating environment, law, regulation or other; or
- The degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We shall endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes

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Appendix B: Assurance Definitions and Risk Classifications

Level of Assurance	Description
High	Our work found some low impact control weaknesses which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. Therefore we can conclude that the key controls have been adequately designed and are operating effectively to deliver the objectives of the system, function or process.
Significant	There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their impact would be minimal or they would be unlikely to occur.
Limited	There are weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.
No	There are weaknesses in the design and/or operation of controls which [in aggregate] have a significant impact on the achievement of key system, function or process objectives and may put at risk the achievement of organisational objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

Report Distribution

Name	Title	Report Distribution
Steve Topham	Director of Service Support	PDF
Simon Rhodes	Corporate Planning Manager	PDF
Paul Clucas	Group Manager, Support Services	PDF

Discussion meeting held with

Name	Title	Date
Paul Clucas	Group Manager, Support Services	22/12/2017

Review Completion

Name	Planned Date	Actual Date
Fieldwork Starts	13/10/2017	13/10/2017
Discussion Document to Client	13/11/2017	25/01/2018
Responses by Client		5/02/2018
Final Report		22/02/2018

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Acknowledgement and Further Information

MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation, and is for your sole use. If you have any queries regarding this review please contact the Audit Manager. To discuss any other issues then please contact the Director.

MIAA would be grateful if you could complete a short survey using the link below to provide us with valuable feedback to support us in continuing to provide the best service to you.

https://www.surveymonkey.com/r/MIAA_Client_Feedback_Survey