Effective fire safety not only relies on the physical measures provided within a building but also on the management structure that supports it. The NHS in Wales benefits from a structured approach to the management of fire safety through Health Technical Memorandum 05-01 Managing healthcare fire safety (Welsh Edition) which is mandated for the NHS in Wales by the Welsh Government. However, even with this supporting structure, the management of fire safety presents many challenges for Health Boards/NHS Trusts. With increasing activity from the Fire and Rescue Service through audit and enforcement together with a rise in fire incidents in 2012, failures can have far reaching outcomes both for organisations and individuals. This article discusses the structures in place for managing fire safety, the enforcement process and some case studies of notable fires in healthcare.

NHS management structure

HTM 05-01 Managing healthcare fire safety provides the framework for fire safety management in Wales. The document states that it builds upon the Welsh Government’s fire safety policy. The aims of this policy require those responsible for fire safety within healthcare premises in Wales to:

- Comply with legislation;
- Implement fire safety precautions through a risk-managed approach;
- Comply with monitoring and reporting mechanisms appropriate to the management of fire safety; and
- Develop partnership initiatives with other agencies and bodies in the provision of fire safety.

HTM 05-01 also sets out the responsibilities for those tasked with the management of fire safety. These extend through five distinct levels:

- The Health Board/NHS Trust – has overall accountability for the activities of the organisation.
- The Chief Executive - responsible for ensuring that current fire legislation is met and that there are appropriate policies and programmes of work in place to improve and maintain fire precautions.
- The Board Level Director with responsibility for championing fire issues at board level.
- The Fire Safety Manager has a wide ranging set of responsibilities that include risk awareness, compliance with legislation, development of fire strategy and training programmes amongst many others.
- The Fire Safety Advisor provides technical expertise to the Fire Safety Manager on items such as application and interpretation of Firecode, advising on policy and developing training programmes.

The NHS in Wales then has a well developed, tried and tested model in place for the management of fire safety in its buildings. As part of the NHS Wales Shared Services Partnership, the Facilities Services directorate maintains a fire safety section that also supports Health Boards on fire safety matters.

Fire safety enforcement

The introduction of the Regulatory Reform (Fire Safety) Order 2005 (FSO) brought all aspects of Healthcare activities under the legislative umbrella for fire safety. This piece of legislation was the first Order to be introduced under the Regulatory Reform process and replaced over 100 pieces of legislation associated with fire safety. Previous fire legislation did not capture all areas of healthcare buildings. The FSO, which came into force in 2006, is enforced by the local Fire and Rescue Service (FRS) for the vast majority of buildings, including all those associated with healthcare. The legislation places the responsibility for the management of fire safety matters in hospital buildings firmly on the owners of the risk i.e. the Health Boards/NHS Trusts. The legislation requires that a suitable and sufficient fire risk assessment is in place that identifies any shortcomings in fire safety provisions and that there is an action plan in place to address those issues. The FSO also requires the appointment of a ‘responsible person’ to oversee the fire safety arrangements for the organisation and the building.
FRSs carry out audits of the fire safety arrangements to assess the adequacy or otherwise of the measures in place in order to ensure good fire safety standards. This can and does include night time visits to hospitals to check on such items as escape routes, housekeeping and staff training issues. Where these arrangements are not up to standard, the FRS can issue notices to improve certain arrangements and in extreme circumstances can close down areas or buildings and prosecute those responsible for the deficiencies.

As well as general fire precautions, the FSO also requires that equipment provided for fire safety is also maintained to an appropriate level. Those responsible for maintenance issues may well come under some scrutiny by the FRS in the event of failings due to lack of maintenance. Indeed, a fire alarm engineer served a custodial sentence for failing to properly maintain a fire alarm system in a case brought by an English FRS.

In terms of enforcement, the FSO carries some considerable risk to individuals who the courts find guilty of breaches of this legislation. It is likely that when the FRS proceeds with a prosecution, the action will be taken against those with managerial responsibility for the failings. It will ultimately be for the FRS to decide who is prosecuted but those who have some form of managerial responsibility for fire safety will not be immune from prosecution unless they can demonstrate due diligence by proving that they themselves are not at fault in the commissioning of the offence. These may be senior staff or at local level.

Interest from the FRS can come from a number of routes. It has been mentioned earlier that the audit process is one of those routes. A second route is action following a fire on the premises. The FRS will always carry out a ‘post fire’ review of the incident and will visit the scene of the incident from the fire safety perspective where it is deemed necessary. Again, any shortcomings in the response to the incident or the events that have led to it may result in enforcement action. The annual report into Fire Incidents for 2012, shortly to be published, will show an increase in the number of fire incidents.

❖ The ‘management’ of fire safety

Good management is an essential ingredient in ensuring not only compliance with fire safety legislation but also in ensuring that policies and procedures are well developed and properly implemented and complied with. Also, where an incident occurs, the outcome is greatly influenced by the management of that incident. Investigations into unsuccessful incident outcomes frequently reveal poor management as a considerable factor in the failings. Even a fire incident on an occupied ward can be considered as an event that requires to be effectively ‘managed’.
There are many fire incidents across Wales each year that have been managed effectively with successful outcomes. This was highlighted by the recent fire at Wrexham Maelor Hospital on 8 February 2013 which required the full evacuation of two wards and a special care baby unit at night. However, the need to continually monitor and improve fire safety management is something that should not be taken lightly.

❖ Case Studies

Over the years there have been a number of high profile fire incidents in premises providing healthcare. Those that have made the press include what is referred to as the ‘5 London Fires’, the Rosepark Fire and very recently, a fire in the Woodlands Psychiatric Unit of Ipswich Hospital.

It is interesting to review both the Rosepark incident and the one at Ipswich for a number of reasons. The incidents have a significant similarity in that a prosecution did not follow either incident despite there being multiple fatalities in the former incident and an injury in the latter. Both incidents, though, had similarities where ineffective management controls were evident.

* Rosepark

In January of 2004 a fire broke out in the Rosepark Care Home in Uddingston, Scotland. The fire resulted in the deaths of 14 residents. The catalogue of failings on the night were documented in a Fatal Accident Inquiry chaired by the Sheriff Principal Mr. Brian A. Lockhart some 7 years later following a protracted and complex investigation into the incident. Without going into the incident in depth, the Inquiry revealed huge failings in management of fire safety. Sheriff Lockhart stated that ‘Management did not have a proper appreciation of its role and responsibilities in relation to issues of fire safety’. However, the owners of the care home were not the only ones to receive criticism from Mr Lockhart. The authorities charged with overseeing the care home, the Building Regulations process and the Strathclyde Fire and Rescue Service itself received varying degrees of criticism. He said the "critical failing" was not to identify residents at the home as being at risk in the event of a fire, as well as failing to consider the “worst-case scenario” of a fire breaking out at night.

A further "serious deficiency" was found in the “limited attention” given to how residents would escape from the home in the event of a fire.

The sheriff said an adequate fire plan would have revealed the problems which eventually led to the deaths, such as staff not being properly trained in fire safety and the presence of an electrical distribution board in a cupboard which...
Following an investigation into the incident. The report produced by the Suffolk Fire and Rescue Service (SFRS) in October 2011, a fire occurred at the Woodlands Psychiatric Hospital Ipswich. The following information is taken from a report produced by the Suffolk Fire and Rescue Service (SFRS) following an investigation into the incident.

**Woodlands Psychiatric Unit, Ipswich**

In October 2011, a fire occurred at the Woodlands Psychiatric Hospital Ipswich. The following information is taken from a report produced by the Suffolk Fire and Rescue Service (SFRS) following an investigation into the incident.

‘At 15:20 on Wednesday 26th October 2011, the Woodlands’ AFA (automatic fire alarm) system activated showing a fire had been detected in ‘Poppy Bed 19’. The SFRS fire investigation which followed concluded that a patient had set the bedding in their room alight with a cigarette lighter and then stayed in the room as the fire developed.

CCTV footage of events in Woodlands at the time of the fire, requisitioned by SFRS from SMHPT as part of the fire safety investigation following the fire, has been an invaluable source of information on what occurred. The CCTV shows that staff members on the Poppy and Avocet wards did not respond immediately to the fire alarm and check the indicated location as would be expected by the units fire emergency plan, but carried on with their normal activities whilst a patient with mental health issues in their care was breathing in the toxic products of combustion in a room which was on fire.

The CCTV footage shows that 5 minutes and 20 seconds passed, and the Woodlands fire alarm log records that the fire alarm was silenced and reset several times, before any member of the Woodlands staff went to check the source of the fire alarm in the patients’ bedroom; despite all the fire alarm panels available to staff showing exactly where a fire had been detected. As a consequence of that delay, the patient was unresponsive and the conditions in the room were so bad that their assisted evacuation was not possible. The patient was therefore left in the smoke-filled bedroom until they were rescued by SFRS firefighters at around 15:48’.

The FRS carried out a full investigation into the incident and determined that there were several breaches of the FSO and that only recourse to the courts would be the appropriate action in these circumstances. However, due to legal issues surrounding a relatively recent Trust merger, it was found that the new Trust did not carry over legal liability for the former Trust and therefore a prosecution could not be pursued.

Given the serious nature of this incident together with the failings identified, it is very likely that, had the prosecution proceeded, there would have been some serious outcomes for individuals involved in this incident.

**Liability: corporate or personal?**

Prosecutions under the FSO are increasing, as is the audit and enforcement activity by the FRS. Across Wales there is some inconsistency of approach to the enforcement of the FSO in healthcare facilities. Nowhere is this more marked than in Abertawe Bro Morgannwg where the Board’s area is straddled by two FRSs. In South Wales in particular, where the FRS maintain a dedicated team of officers specialising in the healthcare sector, there is a clear difference in activity when compared with the other two FRSs in Wales. This has resulted in a number of enforcement notices being issued in the South Wales area. At least one incident caused the FRS involved to consider a prosecution. Deliberations are on going across the three FRSs with a view to having a more consistent approach to enforcement of the FSO across Wales but this is in its embryonic stages with no guarantee of change at the end of it.

So, where does the liability fall? In a severe failing where loss of life is experienced through fire it is likely that at least two actions will follow. These would most likely be through the Corporate Manslaughter legislation and most definitely through the FSO route. In the case of the former, liability falls on the organisation as the title suggests. However, in the case of the FSO, the liability falls directly on individuals who the FRS deems responsible for the failings. These individuals may be senior people in the organisation or local managers at ward or department level although those having direct responsibility for fire safety management would be the first port of call for the FRS. Those responsible for maintenance of equipment may also find themselves the subject of attention from the FRS if they are deemed responsible for the failings.

If an offence has been committed and a prosecution follows, the FRS will decide who those charges are brought against. It is almost certain that, at the end of a successful prosecution, the defendant will end up with a criminal record, a fine and possibly a custodial sentence.

For further information contact:
Gareth Lloyd on 029 2031 5530 or
e-mail: gareth.lloyd6@wales.nhs.uk