NFCC
National Fire
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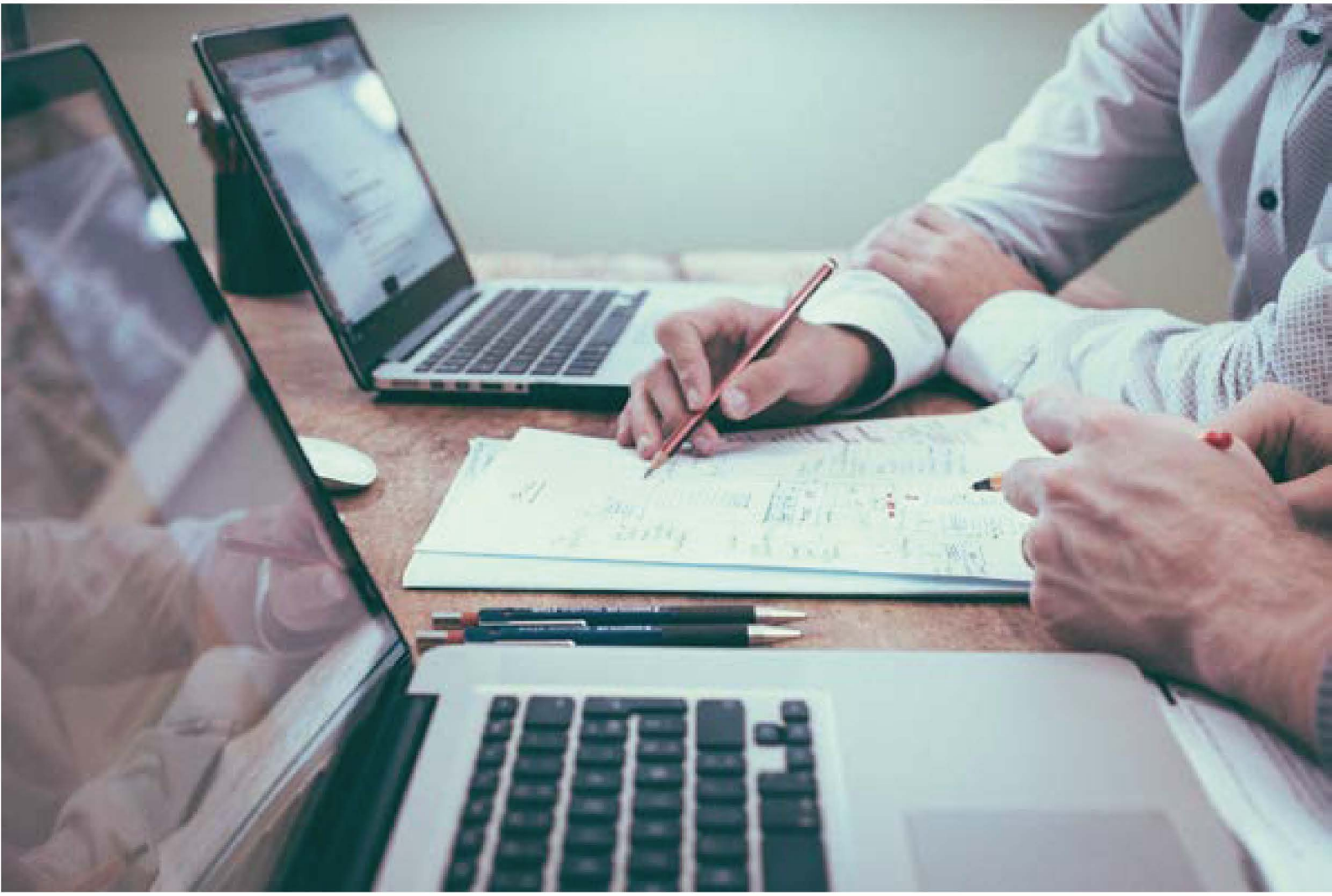
The professional voice of the UK Fire & Rescue Service

NFCC Report

Death in the Workplace

2020 Guidance for United Kingdom
Fire and Rescue Services



Contents

1 Introduction

1.1 This guidance document has been developed following the experiences of Fire and Rescue Service's, who have lost firefighters since 2005.

1.2 Such guidance can never be viewed as finished or complete but the authors' trust it will go some way in providing UK Fire and Rescue Services ("FRS") faced with the unexpected death of a member of staff, with useful assistance as they begin the challenge of conducting an investigation.

1.3 The unexpected death of a colleague in the workplace is a traumatic experience for the family and also for the colleagues that knew the deceased. Indeed it is likely that the emotional impact of the death will affect the whole FRS. This sense of loss may be exacerbated as the FRS conducts its investigation into the events leading up to the tragedy.

1.4 A death in the workplace is caused by a series of events, actions or inactions that, occurring in sequence, result in a tragic outcome. As such, it is rarely foreseen and almost never prepared for.

1.5 Fortunately, such instances are few and far between but this infrequency brings issues of its own, not least the inexperience of FRS's to deal with such investigations.

1.6 FRS's are urged to use this guidance as a foundation in order to produce their own internal policy in relation to a death in the workplace. They are further urged to test their response to such a tragic event, possibly by way of a table top exercise.

2 Initial Notification (and Immediate Action)

2.1 The initial notification of a death or serious injury will usually be passed to Fire Control who will inform the Duty Principal Officer (DPO).

2.2 Action: Prior to any further action the DPO must confirm the identification of the casualty(s). Accurate and speedy identification of the casualty should be undertaken ideally by someone that knows the casualty well. View with caution any names written on clothing (helmet/tunic, etc.) as instances are widespread of personnel using a colleague's kit.

In order to assist in the identification of the individual/s and their next of kin details, it is essential that FRS's ensure that access to personnel records (whether electronic or hard copy) are available to senior officers at all times. In addition, the importance of regularly reviewing and updating this information, to ensure its accuracy, should be recognised through robust processes.

2.3 Action: As soon as the identification is confirmed, the DPO must nominate an Officer to visit the family and break the news.

- Liaise with the Police regarding informing the next of kin. It is preferable for a joint initial visit to be arranged i.e. Police and FRS
  Note: duplicated visits are as insensitive as no visit.
- The duty for next of kin enquiries and notification sits with the Senior Investigating Officer (SIO) within the Police. A Family Liaison Officer may be deployed by the Police subject to the circumstances of the incident. Where appropriate the FRS will support the process of notifying the next of kin in consultation with the SIO
- Report to the Health and Safety Executive (HSE) under RIDDOR. Note: Road Traffic Collision's (RTC's) are not reportable under the RIDDOR regulations. It must be noted however, if the death of a FRS employee occurs on the incident ground whilst attending a RTC, this should be reported under RIDDOR regulations
- When the FRS selects a senior officer to visit the families, the FRS should consider the longer term likelihood of appointing a single point of contact for the family and the opportunity for continuity by using the same individual for both tasks. Whilst this single point of contact has traditionally been called a 'Family Liaison Officer' (FLO), experience has shown that this may cause confussion both for the family and the FRS between the police FLO and the FRS's FLO. In order to avoid this confussion it is recommended that FRS appoint a Family Support Officer (FSO) to fulfil the single point of contact role
- The FRS FSO role is to maintain contact with the family, and compliments the support given by the police FLO ensuring they are kept informed of progress with the investigation
- Police FLO and FRS FSO should set parameters of support to ensure a joint approach is adopted with the families interest at the fore-front
- A number of courses are available that provide guidance on how to conduct this difficult task. FRS should consider ensuring that they have a cadre of suitably trained individuals to undertake family liaison duties if required
- The Police will appoint their own FLOs to keep the bereaved, witnesses and other interested parties, such as the Coroner, informed of developments

2.4 Action: Implement initial welfare arrangements.

- Consider the emotional impact on personnel present at the incident and the need for relief crews
- Consider crews being retired off duty who were involved at the incident. Prior to either retiring off duty or returning to their home stations consideration should be given to obtaining contemporaneous notes. (See paragraph 9.1)

2.5 Action: Obtain Legal Advice/Assistance.

2.5.1 A death in the workplace will entail a joint Police and HSE investigation, as well as an Inquest where a Coroner, with the assistance of a jury, will determine the cause of death.

2.5.2 During this process, usually after the Inquest, there may also be a claim for civil damages by relatives of the deceased. It is vitally important therefore that robust and effective legal advice is sought at the earliest opportunity.

2.5.3 Often provision of such advice is included in the Insurance cover taken out by the FRS. Therefore as soon as the details of the death are known, the FRS should contact its Insurers to arrange the provision of legal advice.

2.5.4 Legal costs in the event of a Police / HSE prosecution and / or a jury Inquest can be considerable and FRS should check their policy provision with regard to legal cover. Specific advice should be sought on:

- privilege
- disclosure of documentation
- liaison with the Police, HSE and Coroner
- liaison with families and relatives
- liaison with employee representatives/Trade Union Representatives
- preparing staff for attendance at Coroners Court
- production of investigation reports
- records management and maintenance of an auditable trail.

2.5.5 The FRS insurers will want to know the circumstances of the death/s to assist the next of kin with interim payments from any Employers Liability arrangements.

2.5 Action: Appoint a Senior Officer to initiate the FRS investigation process.

2.6.1 There is a comprehensive summary and aide memoire in Appendix B providing a helpful checklist of considerations for the Senior Officers appointed to deal with the practical and organisational issues arising from the fatality at work.

3 Police / HSE investigation

3.1 Police

3.1.1 The Police will investigate a workplace death and take the lead to establish if offences under the Corporate Manslaughter and Corporate Homicide Act 2007 (i.e. deliberate intent or gross negligence or recklessness on the part of an individual or company) have been committed, and/or to ascertain if criminal offences have been committed relating to the cause of a fire or road traffic collision. If the death was due to an RTC they will carry out a detailed RTC investigation. Where relevant, the Police may request technical support from any appropriate health and safety enforcing authority - not just the HSE.

Section 25 of the Health and Safety at Work etc. Act 1974 (HSWA) defines an 'enforcement authority' as an authority responsible for the enforcement of any health and safety legislation.

This includes, for example:

- Local Authorities
- The Maritime and Coastguard Agency
- The Civil Aviation Authority
- The Office of Rail Regulation
- The Vehicle and Operator Services Agency.

This could also include an independent FRS for their professional support in fire investigation and/or technical advice and support with operational policy, procedure and guidance.

3.1.2 The Police will take primacy over any investigation into a death in the workplace. They will liaise with the HSE under a nationally agreed protocol and may carry out a joint investigation.

3.1.3 The Police may find it useful to request experts from the FRS to explain the workings of equipment, processes and procedures and to explain organisational jargon. The FRS will need to appoint someone to be responsible for this. All FRS's will have their own policies and procedures which will not always be in accord with each other; this should be factored into any advice provided.

Experience suggests that this might best be provided by an independent FRS and indeed would in most cases be insisted upon by the police.

Experience also shows that clear points of contact within the inter-organisational investigation structure assist the overall investigation process.

3.2 Health and Safety Executive (HSE)

3.2.1 If the FRS has been in charge of, or involved in an incident involving the serious injury or fatality of a member of staff, they must inform the HSE immediately. The HSE will need to know the name of the Police officer in charge of the investigation. If it is out of 'office hours' there will be a duty HSE Inspector who will be called out or may decide to pass it on to the local Inspector who will be more familiar with the FRS.

3.2.2 If the Police determine there is insufficient evidence that a serious criminal offence (other than a health and safety offence) caused the death, the investigation should, by agreement, be taken over by the HSE.

3.2.3 To discharge their functions, the HSE (or any other enforcing authority) can obtain further information under Section 27 of HSWA.

3.2.4 The HSE is responsible for enforcing health and safety legislation and will decide if any breaches have occurred which warrant a prosecution being brought. They may want to set up and agree meetings at regular intervals to review the progress of your investigation. In any such meeting

carefully consider the information provided and in particular, whether any information is protected by privilege. The information given to the HSE may be used as evidence in any future action including the inquest and potential prosecution.

3.2.5 The HSE may decide to 'triangulate' any response the FRS might provide on an issue. This process entails them visiting other work places e.g. fire stations, and asking questions there to see if the answers they receive match the official response from the Service. Experience suggests there are often variances between policy and practice.

4 Access to Evidence

4.1 Access to evidence held by Police

4.1.1 During the initial phase of the investigation, the Police will seize any and all items they feel are conducive to their investigation. This may include diaries, contemporaneous notes, log books, training records, equipment and any electronic devices that is potentially a source of evidence including personal mobile phones or tablets that have been used to take photographs. This list is not exhaustive. It is very important to keep a detailed record of all items seized by the Police.

4.1.2 Police will not release evidence until their investigations are complete and any legal action has been completed. It should be noted that the HSE also has powers to seize items relevant to an investigation under Section 20 of HSWA.

4.2 Evidence from FRS Personnel

4.2.1 The Police will want to speak with relevant individuals under the Police and Criminal Evidence Act 1984 (PACE).

4.2.2 If the Police suspect that an individual may have committed an offence they will ask to speak with them formally (under caution). The Police have the power to arrest an individual to secure attendance at an interview under caution if it is considered necessary.

4.2.3 In the event that the Police have passed primacy for the investigation to the HSE, the HSE may also request an interview under caution. However, unlike the Police, the HSE does not have the power of arrest and an individual may choose to provide a written response instead of attendance.

4.2.4 Legal advice should be sought by any individual who has been invited to attend an interview under caution. This may be covered under the terms of the FRS insurance policy and enquiries should be made in this regard.

4.2.5 The FRS should be aware to the potential for there to be a conflict of interest between the organisation and an individual. To provide an example, this may arise if the FRS is of the view that an individual has disregarded FRS policies or training in a particular situation. If this situation arises, the individual will require separate legal representation.

4.3 Witness statements

4.3.1 The Police and / or HSE will wish to obtain witness statements from individuals to inform their investigation. Employees they wish to interview may be either witnesses to the incident (that led to the workplace fatality) or individuals who can comment on FRS procedures.

4.3.2 The HSE will advise the FRS what information they may need, this could include speaking with witnesses themselves under Section 9 of the Criminal Justice Act 1967. This provides that a written statement signed by the person who made it, is admissible as evidence to the same extent as oral evidence given by that person.

4.3.3 Alternatively under Section 20 (2) (j) of HSWA, the HSE Inspectors have powers to compel an individual to provide information. This requires individuals to answer questions and to provide information as required. The individuals will be required to sign a declaration of the truth of their answers. A refusal to answer questions shall be admissible in evidence against that person in any proceedings.

4.3.4 However, under Section 28 of HSWA, no information obtained under this power will be disclosed without the consent of the person but this does not prevent disclosure to the HSE, a government department or any other enforcing authority.

4.3.5 All FRS witnesses will need to be supported both before and after the event by the FRS and provided

with suitable legal representation.

4.3.6 Where the interviews are not conducted under caution, the interviews may be arranged by the FRS. The person to be interviewed can be accompanied by a colleague, a legal advisor, a senior officer or a member of his/her representative body. Any person accompanying an interviewee must understand their responsibilities towards the person being interviewed, stepping in where they feel it necessary to request a break to discuss a point. They are not there to sway the witness in what is said in evidence.

4.3.7 The format for the interview will normally start with the individual giving a short account of their service life, experience etc. The interviews are usually recorded either audibly or via video. Interviewees should note that statements provided may be a summary and not a verbatim record of the actual interview. Accordingly some operational information could be omitted. (The Accident Investigation Team ("AIT") should request 'full' DVD copies of all interviews.). Experience indicates that the Police will also have transcribed copies of the interview that if requested by the FRS AIT and provided by the Police may be a valuable evidence source.

4.3.8 Additonally, the Police may allow the FRS AIT to provide questions, to inform the FRS internal investigation.

4.3.9 Witnesses should ensure they are content that the statement is a true and accurate recording of their account and includes all relevant details before signing it.

4.3.10 All staff required for interview should be briefed on the format, the expectations of the Police / HSE and their rights as a witness. In order to facilitate this brief experience has shown that the FRS legal team should be consulted.

4.4 Evidence Gathering Including Statements etc.

4.4.1 The Police are legally empowered to seize any evidence they feel necessary for their inquiries and will require the original items e.g. actual documents, not copies. Should this involve downloading data from a hard drive, the Police will wish to be present when this is done.

4.4.2 Initial Police evidence gathering and impounding of equipment may have taken place prior to the FRS AIT being set up i.e. at the time of the incident. Experience shows therefore that it is important for the FRS to appoint an individual officer to help facilitate the police gathering and recording accurately the items impounded.

4.4.3 The FRS should, wherever possible, ensure it takes (with the permission of the Police) copies of all documents seized.

4.4.4 The working arrangements with the Police will include the use of an Evidence Request Form which, on completion by the Police, will provide a record of all evidential items passed to the Police.

5 Inter-Agency Liaison

5.1 Police, Health and Safety Executive and other Agencies

5.1.1 The investigation will require close and ongoing liaison with the Police, the HSE and other agencies. An important first step in ensuring this liaison is managed and effective is the early production of an agreed Memorandum of Understanding (MoU) with the other agencies. An example may be found as Appendix H. In addition to those agreed with the Police and the HSE, FRS is advised to agree a MoU with the appropriate Trade Union.

5.1.2 It is vitally important that a robust and effective relationship is maintained between the Service and the Police, HSE and representative bodies.

Experience shows that where mutual trust exists, there are more opportunities for issues to be resolved without the need for a more formal prescriptive approach.

5.2 Crown Prosecution Service (CPS)

5.2.1 The CPS will decide whether there is sufficient evidence to warrant prosecution for manslaughter, murder or other criminal offence.

5.3 The National Fire Chief Council (NFCC)

5.3.1 The Chair of the National Fire Chief Council (NFCC) must be informed at the earliest opportunity of relevant details surrounding the fatality. The NFCC are the obvious contact for passing information to other FRS appertaining to the incident.

5.4 Representative Bodies/Trade Unions

5.4.1 The Fire Brigades Union (or other representative bodies) will carry out their own accident investigation. Under the terms of the Safety Representatives and Safety Committees Regulations 1977, Trade Union safety representatives are permitted to carry out an inspection of the workplace following a 'notifiable accident (occurrence and disease)', for the purpose of determining the cause. However, this visit would need to be permitted by the investigation body with primacy for the investigation.

5.4.2 Trade Unions may wish to inform the Police / HSE / Coroner of their intention to undertake their own investigation.

5.4.3 Early consultation with the representative bodies is essential to agree protocols for liaison and information sharing. Protocols will be influenced by:

- The Police's stance on information sharing
- The Data Protection Act and Freedom of Information Act
- FRSs legal advice
- FRSs Insurance procedures
- FRSs policies and procedures

Experience suggests that whilst the Police may share information with the FRS, it is unlikely that there will be any direct information sharing protocol between the Police and the representative body. Any information required by the representative body will almost certainly have to be requested via the FRS.

Experience shows that a joint investigation between the Servcie and a reperesentative body may be beneficial. Whilst this may be considered, caution should be taken as there may be a conflict of interest.

5.4.4 Specialist legal advice needs to be sought prior to any consideration to a joint investigation, with any

conflict being paramount on the agenda.

Experience shows that in any case, regular, open and honest dialogue between the FRS and the representative body can be incredibly effective in building mutual trust and reducing the potential for unnecessary conflict.

6 Fire and Rescue Service Accident Investigation

6.1 Appointment of Accident Investigation Team ("AIT")

6.1.1 To carry out an investigation into events, the FRS will need to appoint an AIT. The size and makeup of the team will reflect the complexity of the incident under investigation but would typically require the following skills as a minimum

- Detailed and comprehensive knowledge of Operational activities
- Detailed and comprehensive knowledge of Training activities
- The FRS Appointed Health and Safety Professional
- Effective report writing
- Administration.

Experience has shown that the investigation of a death in the workplace is a protracted process often taking several years to complete; this should be factored into staff planning and logistical considerations.

6.1.2 The AIT should be headed up by a senior officer/manager empowered to make executive decisions on behalf of the Chief Officer. Typically this would be a principal officer of Assistant Chief Officer rank or equivalent.

6.1.3 The AIT should agree the objectives of the investigation with the Chief Officer and regularly review this to ensure that the agreed objectives remain pertinent and appropriate.

6.1.4 The HSE and the Police recognise that organisations have an obligation to carry out their own internal investigations to identify the cause of the accident. Liaison with the senior investigating officers of these two organisations is a key role for the Head of the Service AIT.

6.1.5 Following appointment, an early consideration will be the production of Terms of Reference for the AIT (an example may be found as Appendix C).

6.2 Involvement of Other Agencies (FRS) to Undertake Specific Roles e.g. Fire Investigation

6.2.1 Where the death under investigation occurred at an incident, the FRS would be advised to request another FRS to assist with the investigation. This might include production of a fire investigation report (including cause and development). This will be particularly important, and vital to avoid conflict, if the incident occurs in a building that the FRS enforces in line with the Regulatory Reform (Fire Safety) Order or other fire safety law.

6.2.2 If, to illustrate independence and prevent conflict, if a FRS does ask for the assistance of another FRS, early agreement with the Police SIO is advisable.

6.2.3 Where the incident is likely to involve the investigation of FRS processes and procedures it remains an option for the Police to engage the services of another (independent) FRS to assist them in their investigation.

6.3 AIT Practicalities

6.3.1 The AIT will require a dedicated, private and secure office. It must be of adequate size and suitably equipped to accommodate the AIT and ideally provide sufficient space for meetings and private consultations. It is also advisable to have a dedicated cost centre which will provide an audit trail for all AIT costs.

6.4 Confidentiality Clause for AIT members

6.4.1 All members of the AIT (and other parties involved in the Service Investigation e.g. Fire Brigades

Union) must complete a confidentiality agreement, (an example can be found as Appendix C). The importance of information security and confidentiality must be communicated to all persons handling investigation information.

6.5 Filing System

6.5.1 The filing system will need to be comprehensive and cross-referenced to provide an auditable trail for future reference. It is essential that information is managed and maintained for evidential purposes and therefore numbered, dated and catalogued.

6.5.2 It should be ensured that the filing system meets the need of the AIT team and not the person that sets it up. It needs to be simple and intuitive so that one naturally goes to the correct section. Consider that the files may require to be accessed years on from the incident by personnel unfamiliar with the filing system. Appendix D suggests a few headings.

6.5.3 During the investigation, lockable storage, filing cabinets etc. are essential for securing research documentation and correspondence. The need for these can be avoided with the provision of a secure office.

6.5.4 Exhibits and impounded items may need larger storage facilities such as a designated secure room or larger cabinet which should be lockable.

Experience has shown that ultimately all documents can be scanned and stored electronically on a secure drive.

6.6 Security

6.6.1 Security is a fundamental requirement of the investigation if the evidence / statements etc. are not to be compromised. All members of the AIT should have signed a confidentiality agreement. All Data storage must be secure and access limited to the AIT. Electronic data must be stored on a secure drive and backed-up on discs (securely stored) on a regular basis in case of system failure. Access to the AIT office must be by invitation only.

6.7 Exhibit Inventory

6.7.1 A record of all exhibits held by the FRS AIT should be maintained to permit easy access when required. An example of a suggested layout can be found as Appendix J.

6.8 Organisational Improvement Steering Group (OISG)

6.8.1 The FRS should consider the introduction of an OISG. The purpose of this group is to consider and act on safety critical operational practice issues identified by and referred from the AIT, HSE, or other technical advisors to the investigation ahead of the publication of the final report, and to take action to address them as part of continuous improvement.

6.8.2 These issues might include operational procedures, communications, breathing apparatus procedures, incident command and control and operational policy and directives.

6.8.3 A major benefit of the work of this group is the robust audit trail of action it takes to address each issue. An example of typical terms of reference for an OISG can be found at Appendix I.

Experience shows that the HSE is particularly interested in any work undertaken to prevent a re-occurrence.

6.9 Data Protection

6.9.1 The FRS should consider the key principles under the General Data Protetcion Act 2018, when obtaining, storage, sharing and use of personal data. All FRS's have access to expert guidance on

data protection, freedom of information and disclosure.

6.9.2 Advice must be sought on the disclosure of information (including personal information) to third parties (including the media and representative bodies who are endeavouring to carry out their own investigation or other employees).

6.10 Media Strategy

6.10.1 The FRS should draw up a Media Strategy in liaison with the AIT and the FRS Legal Adviser. It should consider the following issues:

- Uncertainty of investigation outcome and what actions, if any, other interested parties may take - potential for prosecution
- Pre planning an overall approach to communications which can be adapted to changes in circumstances.

6.10.2 Statements from the FRS, whether in response to direct queries (reactive) or sent out to the media (proactive) may include:

- Expressing sympathy for the families/relatives
- Paying tribute to the individuals
- Emphasising previous safety record (if applicable)
- Explaining (name of Service) aim to learn lessons for the future
- Emphasising (name of Service) willingness to co-operate.

6.10.3 Statements should not:

- Provide detail about individual actions
- Criticise any individual
- Criticise another service
- Debate any issues
- Pre-empt the findings of the Coroner; Police or any other agency.

6.10.4 Good practice recommends that:

- Statements are prepared for a range of scenarios
- FRS staff are advised to refer all calls/enquiries from the media to the FRS Communication Department.

6.10.5 Any media strategy will need to be extended to cover aspects of the funeral and memorial service arrangements e.g. notifying the general public of date, times, disruption to local services and road closure etc.

Experience shows that it is important to agree a joined up approach to information sharing across all agencies that can be released to the media.

7 Fire and Rescue Service Welfare

7.1 General Welfare Considerations

7.1.1 The FRS Welfare Adviser (SWA) or Occupational Health Manager (OHM) must be informed of the death as soon as the facts are confirmed.

7.1.2 Consideration should be given to the support available from the Fire Fighters Charity (FFC) who can offer a wide range of supportive measures including counselling and respite care.

7.1.3 Consideration should also be given to what information it is appropriate to pass to Fire fighters and the method, especially for those directly involved in an incident and those involved in proceedings, for example, an inquest.

Experience has shown that after any traumatic incident, such as a death in the workplace, enormous emotional pressure is felt by the workforce. This is particularly so amongst those working with the deceased at the time of the accident.

Experience has also shown that the welfare of the AIT is very important. They will, by the nature of their appointment on to the AIT have been directly involved at the incident, however, they will be absorbed by the incident for possibly many years.

7.2 Bereaved Family Liaison and Welfare

7.2.1 The FRS has a moral responsibility for the welfare of the bereaved family. Early appointment of a FSO will assist in the healing process by ensuring the wishes of the family are passed speedily to the FRS. Already noted previously experience shows that identifying this individual as a Family Support Officer may prevent confusion with the police FLO and reflect better the role they will undertake.

7.2.2 Depending on the circumstances, experience has shown that bereaved family members may want to view the body of the casualty at the earliest opportunity. Where-ever possible, early consultation with responsible parties such as the Hospital should be undertaken and the parameters for any viewing should be clearly set out.

7.2.3 On occasions the scene of the incident has become a focal point for attention. The request for scene visits by bereaved family members, politicians (both local and national), should be balanced against the safety of those wishing to visit the scene and ongoing operations and investigation.

7.2.4 The FRS should consider how the anniversary of the accident will be recognised and indeed for how many succeeding years. This may be affected by the timing of the Inquest which could take place several years after the death(s).

7.2.3 Consideration will need to be given to a budget for the funeral and/or memorial services. Who is going to pay for what? The family may want to pay none or for some, if not all the service arrangements, depending on the whether they blame the FRS for the death for example.

7.2.4 Early consideration should be given to the fact that the family may not be in an immediate position to contribute to a funeral or memorial service.

8 Fire and Rescue Service Accident Investigation (Methodology):

8.1 AIT Guidance

8.1.1 Guidance has been produced by the HSE to provide a framework for carrying out an accident investigation:

- HSG 65 Manging for Health and Safety
- HSG 245 Investigating Accidents and Incidents
- HSG 48 Reducing Error and Influencing Behaviour
- Memorandum of Understanding (Death at Work).

8.1.2 Additionally, there are three documents which emphasise the importance of working together to thoroughly investigate work-related deaths:

Work-Related Deaths (ACPO, HSE, CPS, BTP, LGA)

- A Protocol for Liaison
  http://www.hse.gov.uk/pubns/wrdp1.pdf

- Investigators Guide
  http://www.hse.gov.uk/pubns/wrdp2.pdf

- Guidance on the timing of Criminal proceedings
  http://www.hse.gov.uk/pubns/wrdp3.pdf

8.2 Impound and Collect all Equipment Immediately

8.2.1 Unless the Police or HSE have previously removed evidential items as exhibits, the FRS should impound all equipment pertinent to the investigation e.g. BA Board, BA Log books, training records etc. Detailed records should be maintained of where the items were located (possibly with the aid of a photograph), when they were impounded, who impounded them, where they are being held, when they were handed over to the AIT etc.

8.2.2 As soon as practicable, the equipment should be examined and sent for scientific analysis if deemed necessary. The Police and HSE must be consulted before taking any action on items of potential evidence. Delay can cause deterioration in the condition of equipment etc.

9 Evidence Sources

9.1 Contemporaneous Notes

9.2.1 FRS personnel involved in the incident should be requested to record their personal account of their actions contemporaneously. They should be advised to ensure they have a copy in the event that their notes are seized by the Police. Writing contemporaneous notes can be quite a skill and guidance me be offered as to what points should be included. Experience shows that good contemporaneous notes include;

- Time of arrival at the incident
- Role at the incident
- Actions taken
- Instructions given
- Instructions received
- Actions witnessed first hand
- Decisions made
- Rationale for decisions

Personnel should be encouraged to provide a copy of these notes to the FRS AIT.

9.2 Other common evidence sources

9.2.1 Whilst initial accounts produced by individuals involved at the incident will provide one of the best evidence sources for investigation teams there are many others that will need to be considered. Below is a list of the most commonly examined evidence sources that will need to be collected, catalogued and examined in order to determine cause and identify learning opportunities.

- Control Tapes - recordings of the radio messages, telephone calls and other communications e.g. call out sheet
- Contemporaneous notes of all staff involved in the incident
- CCTV - many buildings have this installed both internally and externally - the Police may already have seized this but they may provide the Service AIT with copies if requested
- Drones in use by FRS or other partners (or public)
- CCTV from Fire Appliances if applicable
- Statements - copies of Police witness statements (public and FRS employees) may be given to the Service by the Police providing the witnesses agree
- Consider conducting interviews of Service personnel - take into account the potential for emotional overload of staff. Seek the agreement of the Police and the HSE before carrying out any interviews
- Fire Investigation information (if death was at a fire)
- Forensic Collision Investigation (if death involved an RTC the Police will carry out a detailed Forensic Collision Investigation but may not share information due to criminal case preparation)
- Medical reports from post mortem via Police on cause of death (assists with ascertaining PPE performance etc.)
- Photographs, CCTV, mobile phone pictures (Service and public if provided)
- Training records, internal memoranda and correspondence, promotion records
- Standard Test records
- Photographs/video taken at the incident scene
- Service procedures and policies.

9.3 Interviews of FRS Staff

9.3.1 Any death in the workplace will be investigated by the Police and the HSE. This investigation will almost certainly require personnel to be interviewed.

9.3.2 The interview statements may or may not be released to the FRS. Objections from the individual, perhaps under instruction from the Trade Union, may mean that the Police will not release the

statements. If they do decide to release the statements to the FRS AIT it may be many months before they do this.

9.3.3 An early decision will therefore need to be taken as to whether or not the AIT interviews their staff. In their considerations the FRS will take into account:

- The potential for increasing the emotional loading of personnel
- The view/permission of the Police for conducting such interviews
- The opportunity to ask questions on areas not covered by the Police interviews.

9.4 Timeline of Events

9.4.1 The FRS investigation timeline will usually start with the time the incident occurred and finish with proceedings whether that is a prosecution or inquest. Therefore the intervening period is the time available to the FRS to conduct its investigation.

9.4.2 The investigation process will require the production of an action chart to plot the movements and actions of all personnel for each minute. Commonly referred to as a 'STEP' analysis - Sequential Timed Event Plotting. There are several options.

9.4.3 STEP is a proven method of accident investigation which provides a method for plotting the sequence of events in an accident, to understand the interactions between people and the circumstances that gave rise to the accident within a given time frame.

9.4.4 One option, for incidents with a small time frame and with few people involved, is to use 'post it' notes stuck on the wall. This is very flexible and allows action notes to be easily moved as more information comes to light. This approach has worked effectively for several FRS's. For the larger scale incident the use of Microsoft Word offers certain advantages including electronic file and ease of circulation to other agencies.

9.4.5 Timeline software is also available, one example being 'Timeline Maker Professional'. Experience shows that this is particularly useful for incidents over a longer time period and / or involving a larger number of individuals.

9.4.6 Using the evidence and information available to construct the accident sequence will reveal the factors that influenced the critical events during the specified time scale. The grid will :

1. Establish a time period: e.g. from time of initial 999 call to FRS to removal of casualty from the incident ground.

2. Map the time: across the top, ideally in one minute segments. Individual actions should be inserted into the appropriate 'box'. Hard times are typed on a plain white background whereas estimated times (estimated time is the time attributed to a non-timed occurrence that best fits within the events that have known and accurate timings from accredited sources e.g. Fire Control Tape or CCTV.) might be shaded in a different colour to aid clarity.

3. List all personnel: initially involved directly in the incident. Latterly it will probably be possible to remove those personnel that had no part in the critical actions. The names should be listed in the left hand column.

   Experience shows that it is a good idea to initially group individuals into one of the following four categories; 1. Significant involvement 2. Some contributory actions 3. Minor actions / points 4. No issues or contributory involvement.

4. Identify significant occurrences from timed sources: These can be obtained from the Fire Control log/tape, CCTV, BA Telemetry etc. These should be inserted across the top row in the appropriate minute segment. To aid clarity it is useful to use a different coloured background for these entries.

5. Establish the actions: of each individual involved between these time slots from their contemporaneous notes and statements. Cross-referencing the notes of an individual's actions will also assist in providing details of other people's actions i.e. what they saw and witnessed going on around them.

9.4.7 Once the actions have been agreed and plotted on the STEP chart, the next step is to start constructing a timeline/chronology of events. Initially it will be useful to include three columns. Column one will be for the time (either actual or estimated), the second column is for the event occurring and the third will be used to detail the evidence source. The evidence can be deleted from the final report but serves as a useful indicator of how the time and event were identified.

9.4.8 An example of a draft chronology layout can be found below:

Time	Occurrence	Evidence Source
08:56	A third pump, the Water Tender (46WT) from Riverdale, books in attendance.	Fire Control Tape and LA CCTV
08:57	**Fire is growing slowly behind the bottom left lounge window. Black smoke emissions are blowing in a westerly direction.**	**LA CCTV**
08:58 Est Time	WM Hatcher, Ffs Dollery, and Thomas descend the stairs to the 7th Floor. Ff Williams stays to flake out 2 lengths of hose in the 9th floor lobby.	Statements P2B(26-32) W231 (3)
09:08 Est Time	Ffs Troke and Jeynes are instructed by CM Maynard to commence an ICS log.	Statements 873 (1) S853 (1)
09:15	A second crew (Red Team 2) comprising of Ffs Stephens and Scarlett are sent to the Bridgehead.	LA CCTV 02 Front lobby

Fig 1: Example of a draft chronology showing Time, Occurrence and Evidence source.

10 Principal Areas of Investigation Analysis

The four principal areas for research as part of the accident investigation include:

- Operational Policies and Procedures
- Training and Competence
- Equipment and PPE
- Supervision and Management.

(NB where a fire investigation is being undertaken or other professional investigation, this may reveal other associated indirect or direct causes to the accident).

10.1 Operational Policies and Procedures

10.1.1 It is important to secure copies of all pertinent guidance/service orders/policy documents etc. in force at the time of the incident. Identify the date these documents were last updated and if the current editions were held in the workplace.

10.1.2 Consider if the current procedures and policies adopted by the Service were suitable and sufficient to ensure personnel could deal with this incident safely.

10.1.3 Ascertain what procedures were adopted by personnel at the incident and whether they were in accordance with Service Policy and procedures.

10.2 Training and Competence

10.2.1 Review individual training records to ascertain if and when personnel were trained in the current policies and procedures required during the incident.

10.2.2 Consider if the existing systems and processes within the Service were adequate and appropriate to ensure personnel were competent to deal with the incident.

10.2.3 If appropriate, identify the frequency of site specific inspections to the premises involved.

10.3 Equipment and Personal Protective Equipment (PPE)

10.3.1 Identify what equipment was in use at the incident. Consider whether adequate and appropriate plant, substances and equipment were available and/or used to control the risks relating to this incident.

10.3.2 Identify the clothing and any personal protective equipment e.g. fire kit worn by the deceased and impound (if not already done so by the Police).

10.5 Supervision and Management

10.5.1 What risk assessment process or safe systems of work were followed and what management systems were in place?

10.5.2 Consider if the existing arrangements within the organisation were suitable and sufficient to ensure personnel could deal with this incident. This section will include operational management, incident command, dynamic risk assessment and supervision.

11 Statutory responsibilities and Legislative Requirements

Consider the legal obligation imposed on the FRS, key legislative documentation includes;

- Health and Safety at Work etc. Act 1974
- Subordinate legislation: Regulations and Approved Codes of Practice
- British Standards
- CE and International Standards.

11.1 National Guidance

11.1.1 National guidance may be issued in the form of:

- National Operational Guidance
- National Opertational Learning – Action Notes
- Fire Service Training Manuals
- Fire Pro Death Guidance

11.2 FRS Policies and Procedures

11.2.1 Internal FRS Policies and Procedures that could need examining may include:

- Service Information System e.g. Service Orders/Bulletins
- Safe Systems of Work and Technical Guidance
- Risk Assessments.

11.3 HSE Guidance Documents

11.3.1 Within HSG65 a methodology for investigation - Analysing the causes of accidents and incidents - suggests looking at the Failures in Risk Control Systems to establish immediate and underlying causes.

11.4 Document Examination Considerations

11.4.1 Once this information has been collected, verified and evidenced as factual, the basis of the investigation report can be started by comparing local policies and procedures, against national guidance and any legislative requirements.

11.4.2 Consider where these do not match, identify potential gaps in local policy and procedures and areas for change and improvement. Produce a learning log of these gaps.

Experience has shown that this learning log will have singular or groups of issues that should be assigned to one individual department head to resolve. It should also include an agreed completion date and someone from the AIT to oversee progress. This creates a complete audit trail from identification of the issue / gap to full remedial action.

12 Investigation Report and Learning:

12.1 Investigation Report

It is recommended that legal advice is sought prior to preparation of the investigation report which is marked as privileged.

This is a sample of the detail an incident investigation report might include:

12.1.1 Synopsis

- Introduction and name of investigating officers
- Summary of background details: date, time, location, name of injured, names of witnesses, incident number/type/crews attending, details of senior officers etc.
- Précis of what occurred.

12.1.2 Report Body

- Provide a factual account of events leading up to accident - using the STEP chart or a narrative
- History and previous near misses or incidents - consider national events (NOL)
- Consider statutory and legislative requirements - employer/employee responsibilities
- Compare national guidance (fire service circulars, training manuals, ACOPs etc.) against local FRS procedures
- Provide separate sections on the analysis of each of the research areas using the HSG 65 model to establish the adequacy of:

    - Operational procedures, policies and safe systems of work
    - Training, instruction, competence
    - Equipment used and personal protective clothing
    - Supervision, management and incident command including dynamic risk assessment.

12.1.3 Findings and Conclusions

- Summarise both the direct and indirect cause - if known
- Include any apparent deficiencies contributing to the accident.

12.1.4 Recommendations and Action Plan

- Make the final recommendations, in agreement with the Service Leadership Group/Management Team
- Produce an Action Plan with timescales based on the assessment of risk and allocated to named individuals.

It is strongly recommended that the FRS accident investigation report is kept in draft until the conclusion of the inquest. Part of the Coroners role is to consider if any action need to be taken to prevent future death. (See paragraph 13.13). Until all due consideration is given to these findings it is highly unlikely the FRS report can be finalised.

12.2 Operational Learning

12.2.1 It is essential that the learning points identified during the investigation are promulgated as soon as practicable. Within the FRS this can be undertaken in a variety of ways:

- Operational Bulletins
- Routine Orders/Notices
- Training Notes/Drills/Exercises.

12.2.2 Externally the issues must be raised with the National Operational Learning Secretariat. In addition to this, it is beneficial for a copy of the investigation report (including the findings), to be sent to every fire and rescue service within the UK. This release is dependent on no pending legal action and the necessary legal permissions having been granted.

12.2.3 It is also accepted that each of the FRS Advisors from across the UK will receive copies of the investigation report.

12.2.4 If the HSE have served an Improvement Notice on the organisation, inevitably, some actions will already be in progress.

13 Coroner's Inquest Process

13.1 The Purpose of an Inquest

13.1.1 Inquests are held in specialist Coroners Courts presided over by a Coroner. The procedures and powers differ from those of other courts. There are about 140 Coroners districts. A coroner's powers and duties are set down within The Coroners and Justice Act 2009, the Coroners (Inquests) Rules 2013 and the Coroners (Investigations) Regulations 2013.

13.1.2 Inquests are fact-finding inquiries, which aim to establish the identity of the deceased and where, when and how the deceased came by their death. The answers to the first three questions are often known or are answered relatively easily. The focus of the majority of inquests tends therefore, to be on establishing how the death occurred. This question is not limited to establishing the medical cause of death and may involve an examination of the circumstances in which the death occurred. The conclusion must be in a prescribed form and must make the following findings:

- The name of the deceased (if known)
- The injury or disease causing the death
- The time, place and circumstances at or in which injury was sustained
- The conclusion of the Coroner or jury (as the case may be) as to death
- The registration particulars.

13.1.3 The proceedings are intended to be inquisitorial rather than adversarial. It is not the Coroner's role to apportion blame against an individual or an organisation for the death. An inquest does not involve opposing parties setting out to prove that their version of events is correct as in a criminal or civil trial. The strict rules of evidence that apply in criminal courts do not apply at inquests.

13.2 How the Coroner is informed of a Death

13.2.1 A coroner will consider holding an inquest when they are informed that there is a dead body of a person within their jurisdiction and there is reasonable cause to suspect that:

- the deceased died a violent or unnatural death,
- the cause of death is unknown, or
- the deceased died while in custody or otherwise in state detention.

13.2.2 The Coroner will usually be informed of a death by the local Registrar of Births and Deaths, by a doctor.

13.2.3 It is normal practice for the Coroner, on receipt of an interim report from the Police, to open the Inquest and immediately adjourn it pending further enquiries.

13.3 Time Limits

13.3.1 The Coroners (Inquests) Rules 2013 state the Coroner must complete an inquest within six months

of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicable after that date. The Coroners and Justice Act 2009 states if a Coroner fails to hold an inquest within 12 months they must notify the Chief Coroner. However, a death in a workplace usually requires a complex Police and HSE investigation and it is unlikely an inquest will be held within this time period.

- In the event of a firefighter death at an incident a post mortem will be carried out and the Coroner may not release the body to the family for some time. Not only does this have the potential to prolong any anguish for the family but it also makes it problematic for the organisers of a funeral to set dates and time when booking venues and key people.

- It is important to establish good links with Coroner's office at the earliest opportunity to maintain dialog and help influence timescales.

13.3.2 Further, an inquest will not be held if there is an ongoing criminal investigation into the death with the possibility of charges for an offence which will address the question of "how" the death occurred namely murder, manslaughter (corporate or individual), infanticide and causing death by dangerous or careless driving. If the CPS proceeds with such charges and a trial is held then the Coroner may consider that there has been a substantive hearing about the death and that a full inquest is unnecessary. This decision is at the Coroner's discretion.

13.4 Pre Inquest Review

13.4.1 Increasingly, Coroners are holding pre-inquest reviews or case management conferences to deal with issues that if not addressed before the hearing, might require the inquest to be adjourned. Issues for pre inquest review hearings might include:

- Jury
- Disclosure (extent and timing)
- Scope of the inquest
- Experts
- Timing
- Location
- Issues relating to anonymity
- Witnesses
- Documentary evidence

13.5 Submission of Reports

13.5.1 Prior to commencement of the inquest the Coroner will call for reports from relevant investigating agencies. These normally include reports from the Police, the HSE, the employer and the representative body. These reports are key pieces of evidence in the inquest and are used by the Coroner to answer the questions detailed in 8.1.2 above. All reports considered by the Coroner will be circulated to the other properly interested persons at an inquest (see below).

13.6 Properly Interested Persons

13.6.1 There are no “sides” at an inquest there are what are called “Properly Interested Persons” (PIP). A PIP is someone who has a specific interest in the investigation or inquest. The Coroners and Justice Act 2009 states the following will be regarded as PIPs.

(a)a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister;

(b)a personal representative of the deceased;

(c)a medical examiner exercising functions in relation to the death of the deceased;

(d)a beneficiary under a policy of insurance issued on the life of the deceased;

(e)the insurer who issued such a policy of insurance;

(f)a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so;

(g)in a case where the death may have been caused by—

(i)an injury received in the course of an employment, or

(ii)a disease prescribed under section 108 of the Social Security Contributions and Benefits Act 1992 (c. 4) (benefit in respect of prescribed industrial diseases, etc),

a representative of a trade union of which the deceased was a member at the time of death;

(h)a person appointed by, or representative of, an enforcing authority;

(i)where subsection (3) applies, a chief constable;

(j)where subsection (4) applies, a Provost Marshal;

(k)where subsection (5) applies, the [F1Director General of the Independent Office for Police Conduct] ;

(l)a person appointed by a Government department to attend an inquest into the death or to assist in, or provide evidence for the purposes of, an investigation into the death under this Part;

(m)any other person who the senior coroner thinks has a sufficient interest.

13.6.2 Once the Coroner has taken a witness through their evidence, each of the PIPs will have the opportunity to ask questions.

13.7 Notification of an Inquest

13.7.1 An inquest must be held in public unless the Coroner considers it necessary to exclude the public in the interests of public security. It is not technically necessary to give public notice of the holding of an inquest, although it is universal practice to do so, often by answering enquiries from the media.

13.7.2 There is, however, a requirement for notice of the time and place of the inquest to be given to the PIPs.

13.8 Opening of an Inquest

13.8.1 The Coroner will open the inquest, when there is a jury, by swearing in the jury members. The Coroner will then provide an overview of the process and procedures of the inquest, the role of the Coroner's Court and a very brief outline of the issues of the case.

13.8.2 The Coroner will decide what evidence is to be called and in what order. There are no strict rules of evidence.

13.9 Witnesses

13.9.1 The Coroner will decide which witnesses to call and how best to secure their attendance.

13.9.2 Witnesses can be compelled to attend an Inquest provided they are within the United Kingdom. The Coroner can obtain an injunction to restrain someone from leaving the country, if the witness has been properly served.

13.9.3 All evidence is given by either swearing an oath or affirming. Perjury is committed if untruths are told.

13.9.4 The Coroner should be addressed as sir or madam.

13.9.5 The first witness after the family identification evidence will often be the pathologist who conducted the post mortem and they will explain the medical cause of death. This will be followed by other medical evidence such as toxicology reports and paramedic witness statements. Witnesses of fact such as eye witnesses will usually come next, followed by expert witnesses such as incident investigators or specialist HSE inspectors.

13.9.6 While the layout of every Coroner's Court is different, generally speaking, the witness will sit/stand at the front of the Court next to the Coroner's bench and facing the Court. The jury will sit to one side of the Court. Members of the public and media will be located to the back of the Court.

13.9.7 All questions to the witness should be relevant to one of the four questions the inquest must answer. The Coroner is required to exclude or disallow any question which they consider not to be relevant or otherwise not a proper question.

13.9.8 It is normal practice for witnesses to sit in court when evidence is given.

13.9.9 Witnesses are usually released at the end of their evidence unless there is a good reason for not doing so. There is a provision for jurors to require witnesses to be recalled should they require further clarification on a point of fact as can the Coroner or PIPs, at the Coroner's discretion.

13.10 Juries

13.10.1 A jury is comprised of between 7 and 11 members taken from the Crown Court Jury List. There are some circumstances in which the summoning of a jury is compulsory:

- Deaths in prison
- Deaths in industrial accidents
- Deaths occurring in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public
- Deaths occurring in Police custody or resulting from an injury caused by a Police Officer in the purported execution of his duty.

13.10.2 There is nothing to prevent the Coroner having a jury in any other case, if they believe there is 'sufficient reason' for doing so. Practice varies widely.

13.10.3 Persons are qualified to act as jurors only if they are qualified to do so at the Crown Court, the High Court or County Courts and there are also some limited categories of additionally excluded persons such as people having connection with a prison where someone has died.

13.11 Summing Up and Conclusion

13.11.1 The Coroner must sum up the facts heard during the inquest if there is a jury. The Coroner must direct the jury on the law and on the standard of proof relating to those determinations which the evidence is capable of sustaining. This is for the Coroner to decide, applying much the same criteria as a judge in a criminal trial. This may be the subject of legal argument. If there is no jury, there is no legal requirement for the Coroner to sum up or state any facts that they have found beyond those that are set out in the form of the inquisition but it is almost universal practice to state the findings of facts and the reasons for reaching the conclusions that have been reached.

13.11.2 If there is a jury, the jury alone retires, no-one must accompany them, they can take exhibits, videos, etc., and they may return to court for clarification of directions. This should be done in open court with everyone present

13.11.3 The jury should be afforded enough time to consider their decision. A Coroner does not have to take a majority verdict; however, this can be accepted provided that no more than two dissent. This could, theoretically, result in a 5-2 decision. The Coroner must accept a unanimous verdict, even if it appears to be perverse, but may address the jury and seek to re-direct their considerations if they appear to be on entirely the wrong track. If the jury cannot agree, the Coroner may discharge them and a fresh inquest will have to be held.

13.12 Determination or finding

13.12.1 There is a popular misconception that the determination or finding is the short conclusion often reported in newspapers. In fact, the technical meaning of the determination or finding is all the information required by the Inquisition. The name of the deceased, the injury or disease causing death, the time, place and circumstances at or in which the injury was sustained other relevant registration particulars, for example, whether the deceased was male or female and finally the conclusion as to death. There are a number of potential common conclusions as to death. For example, natural causes, industrial disease, accident or misadventure, suicide, unlawful killing and an open verdict.

13.12.2 A Coroner or a jury can also return what is known as a narrative conclusion which is a factual statement of the events causative of death.

13.12.3 The evidential test against which all conclusions have to be set is on the balance of probabilities (i.e. the civil standard of proof) except in the cases of suicide and unlawful killing where the test is beyond reasonable doubt (i.e. the criminal standard).

13.12.4 The findings of an inquest are those set out on a form of inquisition.

13.12.5 Findings must not be framed in a way that appears to determine any person's criminal or civil liabilities.

13.13 Prevention of Future Death Reports

13.13.1 Under Schedule 5, paragraph 7(1) of the Coroners and Justice Act 2009 and Regulation 28 of the Coroners (Inquest) Regulations 2013, if anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future, and in the Coroner's opinion, action should be taken to prevent it, the Coroner must report the matter to a person who the Coroner believes may have power to take action.

13.13.2 There is no legal requirement to actually take the steps proposed by the Coroner but an organisation is obliged to respond. The response must give details of any action which has been taken or is proposed to be taken, or provide an explanation when no action is being proposed.

13.14 Article 2 Inquests

13.14.1 Article 2 inquests are an enhanced form of inquest flowing from Article 2(1) of the European Convention on Human Rights; the right to life. The Coroner has an obligation to carry out an effective investigation into cases where Article 2 may have been breached where the state is involved. This typically includes NHS trusts, Local Authorities and can also refer to FRS.

13.14.2 An Article 2 inquest is likely to be held where there is an arguable case that the death was as a result of systemic failure rather than mere/operational negligence. There is no procedural difference in the way that an Article 2 inquest is conducted, however it will inevitably be a lengthier and more in depth investigation and the Coroner is likely to allow a wider range of questions and in some cases more leniency to the family in terms of the questions they raise.

13.14.3 A narrative conclusion will be returned in an Article 2 inquest.

14 Service Funeral/ Memorial Service

14.1 An early consideration following the death of a member in service must be the arrangements for any FRS involvement in the funeral. As soon as is sensitively possible, the FSO should approach the family to ascertain the FRS involvement. Every FRS will have its own arrangements for staging a full Service funeral.

14.2 Death in service – would normally be afforded a fire service funeral
Death at an incident – would normally be afforded a full honours funeral
The difference being that full honours would attract a higher profile in the media and national VIP and dignitaries would attend.

14.3 It is an opportunity for family, friends, colleagues and the wider general public to show unity and togetherness during such a sad occasion. It should not be understated the amount of 'Closure' that the funeral provides for a lot of people.

14.4 The FSO plays a pivotal role in ascertaining information for the funeral / memorial arrangements during a very upsetting and difficult time for the deceased's family.

Experience shows that leaving a proforma with the family so they could fill it in when they felt able is very beneficial.

14.5 This proforma needs to be secular and consider all common religions and the family's expectations.

14.6 The release date of the body is key to making the funeral service arrangements, however, experience shows that booking different dates to ensure venues and key people are secured is advisable.

14.7 To prevent any further distress and miscommunication it is very important that any new information is cascaded by the FRS in the following order: Family – Watch/Department of the deceased – FRS wider workforce – Other FRS/ agencies – Media/Social media

14.8 There will be a need to establish a funeral team quickly to not only make any necessary funeral arrangements but to also provide reassurance to colleagues that the deceased will be given a significant funeral. The team will also need to manage/prevent good willed people from self-deploying to make arrangements for the funeral and prevent contacting the family directly.

14.9 To make the necessary arrangements for a fire service or full honours funeral it requires a multi-agency approach and will necessitate a Tactical Co-ordination Group being set up to plan for and manage the event on the day.

14.10 Where the family request a service funeral, experience has shown the benefit of setting up a Post Incident Programme Board to liaise with the family and other interested parties, and to draw up plans for approval by the family. The planning process will cover multifarious issues but experience suggests the following may be worthy of consideration.

- Open Service condolence book (include electronic media)
- Regular briefing for staff on funeral arrangements
- Mapping of funeral route and release to press
- Production of media packs
- Chief Officers pre-recorded press release thanking community for their support
- Permission from family to site cameras in and/or near to the church.

14.11 It is also necessary to consider whether the family would like a memorial service to be held to commemorate the life of the deceased.

14.12 The marking of the anniversary is a sensitive issue and requests for such may arise from both the family and personnel representing the station/location of the deceased. Typically these events might be held on the first anniversary of the death - if the inquest has still to be convened on the second anniversary, consideration might be given to officially marking that event.

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- Mr Neil Gibbins for his observations offered after being an expert witness for the Coroner during the inquest.

16 Appendices:

Appendix A: Glossary of Terms

ACO	Assistant Chief Officer
ACOP	Approved Code of Practice
ACPO	Association of Chief Police Officers
AIT	Accident Investigation Team
BTP	British Transport Police
CCTV	Closed Circuit Television
CFO	Chief Fire Officer
CFRAU	Chief Fire and Rescue Service Advisory Unit
CM	Crew Manager
CPS	Crown Prosecution Service
DCO	Deputy Chief Officer
DPO	Duty Principal Officer
CFRAU	Chief Fire Officers Advisory Unit
FBU	Fire Brigades Union
FFC	Fire Fighters Charity
FLO	Family Liaison Officer
FoI	Freedom of Information
FRS	Fire and Rescue Service
HSWA	Health and Safety at Work Act 1974
HSE	Health and Safety Executive
HSG 65	Health and Safety Guidance Document 65
LGA	Local Government Association
MoU	Memorandum of Understanding
OHM	Occupational Health Manager
OISG	Organisational Improvement Steering Group
PACE	Police and Criminal Evidence Act 1984
PPE	Personal Protective Equipment
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995
RTC	Road Traffic Collision
PFD	Prevention of Future Death report produced by the Coroner following the inquest
SIO	Senior Investigating Officer (usually Police)
STEP	Sequential Timed Event Plotting
SWA	Service Welfare Adviser
UNISON	Public Service Trade Union
WM	Watch Manager
FSO	Family Support Officer
NOG	National Operational Guidance
NOL	National Operational Learning

Appendix B: Sample FRS Checklist and Summary of Considerations

Roles

- Fire Control to inform Duty Brigade Manager who informs CFO, DCO & other PO's/Directors
- Fire Control to inform HSE, H&S Officer, Occupational Health
- The Brigade Manager arranges contact with families – ensuring close liaison is maintained with the Police
- The Police will expect a single point of contact within the FRS
- Principal Officer appointed to lead the FRS Accident Investigation Team
- Appoint FRS Accident Investigation Team - ensure liaison with the Senior Police Investigating Officer (SIO)
- FRS Legal Advisor to be appointed - check FRS Insurance legal cover.

Head of FRS Accident Investigation Team

- Consideration of membership of the Accident Investigation Team
- Lead and manage the Accident Investigation Team
- Lead officer to liaise with team appointed to conduct the Fire Investigation
- Appoint Officers for particular roles:
    - Agency Liaison Officer - FBU, Police, HSE
    - Develop interagency Memorandums of Understanding (MoUs) for inter-agency working

Welfare

- Initial contact with family - Police or Principal Officer - consider choice of FLO provision for longer term liaison
- Appoint a Family Support Officer for liaison with the immediate next of kin
- Viewing the body of the casualty
- Post-traumatic stress counselling for those directly involved in the incident and also the remainder of FRS
- Provision of legal advice for next of kin - this is often taken on by the representative body, FRS to ascertain
- Initiate Death in Service grant as soon as possible
- Trust Fund - this is often organised by either the FRS or Representative body
- Notify the Fire Fighters Charity
- Rehabilitation requirements of those suffering emotionally or physically
- Family to decide arrangements for a Service funeral - Fire Service Chaplain (Family decision)
- Ongoing information (updating families throughout investigation - use of FLO)
- Releasing of uniform for the funeral
- Consider implications for when the involved crews are next on duty
- Consider the welfare of the Investigation Team.

Representative Bodies

- DPO to inform the Representative body as soon as practicable following the incident
- Establish protocols/MoUs for interagency working
- Joint investigation with FRS or separate investigation (likely)
- Consider regulations (consultation with employees regulations; safety committees and safety reps)
- Interviews are to be held away from FRS facilities
- Information requests required in writing (logged and recorded).

Health and Safety Executive

- Ensure early liaison with HSE
- Keep HSE updated
- HSE may make written contact with families
- Release exhibits/analysis reports
- Establish contact with Local Authority/Fire Authority as appropriate.

Police

- Have primacy for investigation - although they will review their role as the investigation proceeds and may cede this to the HSE
    - Liaise with Coroner re investigation progress and outcomes
    - Inform families / next of kin (request consideration of a joint visit with FRS FLO)
    - Interview witnesses
    - Will require breakdown of FRS terminology
    - FRS should maintain a good rapport with Police to ensure the sharing of resources and information
    - Use Police interviews in lieu of additional FRS interviews.

Legal Advice

- Seek advice immediately on litigation issues e.g. inquest process
- Obtain advice on
    - Report drafts prior to submission
    - Data Protection & Freedom of Information
    - Disclosure matters
- Consider potential for Corporate Manslaughter charges
- Consider potential for Criminal Action
- Consider use of external expert legal advice (check Insurance legal provision)
- Where appropriate, initiate hardship payments as soon as possible
- Contact specialists within the field
- Attend meetings with FBU and Police
- Expect Civil claims following Coroners/Criminal Court proceedings
- Maintain close and ongoing liaison with the FRS Insurance company.

Budget

Initiate Budget (and code) for costs associated with the investigation and the coroner's inquest for:

- Secure Accommodation
- Welfare (psychological help - counselling)
- Consider temporary replacement of staff where appropriate
- Police interviews - photos/video/transcriptions
- Consumables
- Additional IT costs
- Secure storage
- Consultant fees
- Transport
- Scientific analysis
- Overtime or time-off-in-lieu and wages compensation - reimbursement for part-time staff
- Inter-regional support costs (over border assistance)
- Contingency plan for unforeseen expenditure.

Administration

- Resource appropriate for anticipated demands
- Separate admin office to be available - data protection and F.O.I
- Staff to be familiar with FRS terminology
- Equipment requirements include computers, photocopiers, scanners and secure IT
- Audit trail and continuity of evidence - logging phone calls and forwarding messages
- Document control - gather receipts and log everything
- Set up filing system, labelling, bagging and storing information
- Arrange meetings and organise interviews - take minutes
- Assist Coroner and attend inquest
- Potential for extended investigation time
- Administration of the interview process with the Police and HSE.

This is intended as a checklist for senior officers/managers immediately following the incident.

Aide Memoire for Death in the Workplace

- The first priority is to consider the emotional needs of the family and those closely involved. It is very easy to fall into the trap of trying to separate out management of the incident from those emotional needs and you should not attempt to do that.
- Inclusion of those personally involved in all communications is key in terms of the tributes and media strategy; particularly in the initial period, but also ongoing (those personally involved include the line managers, as well as close colleagues and family).
- Timing of the release and early notification of communications to those closely involved is particularly important.
- Building an open, trusting relationship with the media is vital. This helps to control access to the families by the media and avoids any speculation.
- You need to work hard to build your relationships with external agencies, particularly the Police, maintaining a dialogue through testing times.
- Seek assistance from those outside the FRS who have experienced similar events, don't be afraid to ask for help - people will give it willingly.
- Visible, clear leadership is vital to maintain the confidence of the organisation. Ensure you create the capacity to allow the Chief to constantly provide that role.
- You will be emotionally affected yourself, therefore double check your decision making with an objective external view.
- You need to accept that the investigation will take a long time. It needs to be properly resourced and sustained and you will need to look for your best talents; both as leaders, investigators and administrators.
- Do your utmost to agree working protocols with other agencies, particularly the Police, Health and Safety Executive, but also, Representative bodies. There are MoUs available.
- In the initial stage, deal with the event and response through a command structure, but then manage the transition to a clear business focussed structure, using programme management.
- Remember that this is a business continuity event so use your existing plans to assist you.
- Quickly decide on what is no longer a corporate priority and stop or delay doing it.
- HR information needs to be immediately accessible - ensure you have those gate keepers available to you.
- Family Support Officers are incredibly important both in the short, medium and long term - choose carefully.
- Make sure your staff complete contemporaneous notes.
- Don't under estimate the resource requirement to properly manage honour, tribute and fundraising activities. Establish a board of trustees.
- The resilience of your top team (SMT) will be severely challenged - consider appropriate rostering and/or sharing arrangements.

Appendix C: FRS Accident Investigation Team: Sample Terms of Reference

Introduction

1 On (Date), (Name) Fire and Rescue Service attended an incidental (Address). During the course of operations, a firefighter (Name of deceased) sustained fatal injuries.

2 In accordance with the Health and Safety at Work Act 1974, and the Management of Health and Safety at Work Regulations 1999, (Name of FRS) will complete an investigation regarding this incident.

Investigation

3 (Name) Constabulary are charged with determining the circumstances surrounding the deaths at work in order to inform the coroner's inquest. Additionally, the investigation will determine if a 'criminal offence' has been committed.

4 Delete if not applicable: The (Name) Constabulary investigation is being supported by (Name) Fire and Rescue Service (technical advice) and (Name) Fire and Rescue Service (cause, origin and development of the fire) and is being monitored by the Health and Safety Executive.

5 (Name) Fire and Rescue Service, on behalf of (Name) Constabulary, will undertake the fire investigation.

6 The Health and Safety Executive (HSE) is responsible for enforcing work related health and safety legislation under the Health and Safety at Work Act 1974.

7 Joint agency terms of reference, produced by (Name) Constabulary, have been agreed between (Name) Constabulary, the other (Names) Fire and Rescue Services and the HSE.

8 The FRS has a duty to provide (Name) Constabulary with information as requested in order to assist them with their investigation. To facilitate this, the FRS Accident Investigation Principal Lead (Name) will meet on a regular basis with the (Name) Constabulary Senior Investigating Officer (SIO). The (Name) Accident Investigation Team consists of:

9 Phase 1 of the FRS Accident Investigation is to gather, record, copy and log information relevant to the incident.

10 Phase 2 will run concurrently with Phase 1, and will construct a comprehensive record of what happened at the incident and how it happened. This approach will be in line with HSG 65 and HSG 245 guidance.

11 Phase 3 will be to establish why the events occurred and associated risk control measures. This process will be informed by Phases 1 and 2.

12 Phase 4 will be the production of an investigation report incorporating an action plan and recommendations for its implementation.

13 The FRS Principal Head of the AIT will manage strategic issues and liaise with other agencies, i.e. Police, the National Fire Chiefs Council (NFCC), HSE, Fire Brigades Union (FBU), regarding the investigation.

14 The Representative bodies have been invited to work in partnership with the FRS Accident Investigation Team in line with HSE recommended good practice for safety representative involvement in investigations into workplace accidents. The Representative bodies may be asked to undertake specific tasks to support the investigation.

Appendix D: Sample Confidentiality Statement

(Name) Fire and Rescue Service Accident Investigation Team

1 Employees shall not, except as authorised by the (Name) Fire and Rescue Service or as required by their duties under their employment contract or as provided in law, use for their own benefit or gain or divulge to any persons, firm, company or other organisation whatsoever any confidential information belonging to (Name of Service). This relates to information or to dealings which may come to their knowledge during their employment. This restriction shall cease to apply to any information or knowledge, which may subsequently come into the public domain other than by a breach of this clause. Any matters relating to health, safety and welfare will be reported to the Principal Lead of the Accident Investigation Team on the 'issues' form.

2 All records, documents and papers which reasonably could be considered to be confidential (whether designated as such or not), together with any copies or extracts thereof, made or acquired by Employees in the course of their employment or duties shall be the property of the (Name of Service) and must be stored, used, duplicated, managed, translated and returned to the (Name of Service), as directed or, in the absence of such direction, in accordance with (Name of Service) policy and best practice.

3 Confidential information shall include, but not be limited to, all information which has been specifically designated as confidential by the (Name of Service), and any information which relates to the commercial or financial activities of the (Name of Service), the unauthorised disclosure of which would embarrass, harm or prejudice the Fire Authority, or (Name of Service) employees or their agents and partnerships.

4 Information relating to (Name of Service) employees of a confidential nature is not to be disclosed. The (Name of Service) considers unauthorised disclosure of employee's confidential information a serious matter that may lead to disciplinary action.

5 Under the Computer Misuse Act (1990) and the Data Protection Act (2018), it is a criminal offence to use computers without authorisation or tamper with data or computer equipment or divulge information stored therein.

6 Membership of a Trade Union or any relevant societies or organisations which may conflict with the investigation must be declared below:

.....

I acknowledge that I have received, read and understood the above statements and agree for a copy of this document to be kept on my Personnel Record File (PRF).

Signed	
Print Name	
Date	

To be returned to Director of Human Resources, Service HQ.

Appendix E: Sample File Headings for Filing System

File 1 AIT Reports

File 2 Briefing Notes

File 3 Briefing (Media)

File 4 Briefing (Public)

File 5 Briefing (Staff)

File 6 Barrister

File 7 Confidentiality

File 8 Control Room

File 9 Coroner/Inquest

File 10 Equipment

File 11 Exhibits

File 12 Families File

File 13 FBU

File 14 Finance

File 15 Fire Authority

File 16 Fire Investigation

File 17 Fire Safety

File 18 General Investigation

File 19 HSE

File 20 Information Request

File 21 Insurance

File 22 Investigation Notes

File 23 Learning Log

File 24 Legal Advice

File 25 OISG

File 26 Operational plans

File 27 Other Brigades Advice

File 28 Personnel Files

File 29 Photographs

File 30 Police

File 31 PPE Press

File 32 Research

File 33 Service Orders

File 34 Staff Interviews

File 35 Station (affected)

File 36 Terms of Reference

File 37 Training Analysis

File 38 Training / NVQ

File 39 Video Footage Info

File 40 Welfare

File 41 Witness Statements

Appendix F: Sample Communications Strategy

A Communications Strategy is also required to ensure that the correct approach is taken in communicating with families, watch members and colleagues, authority members, all internal staff and the wider fire service community.

The Communications Strategy should consider:

- Issuing regular and timely updates to all staff and members. Consider issuing daily updates immediately after the incident and also during the period of the inquest
- Always inform staff of updates before the media, particularly potentially sensitive ones
- Face to face briefings from the Chief Officer and regular visits from senior managers to stations. Face to face communication during this time is very important
- Constant reminder of welfare support and contact details
- Guidance on fundraising
- Development of intranet pages relating to honours and tributes, investigation, donations and collections.

Appendix G: Sample Media Strategy

The FRS should draw up a Media Strategy for the immediate response and media handling at the time of the incident and also for the longer term media management. A Media Strategy is also required for pre, during and after the inquest.

The Media Strategy for immediate use should be drawn up and agreed with the Incident Commander and Chief Officer. The key media lines taken in the very early stages of the incident and the tone of the messages will set the scene for the duration of the incident, investigation, inquest and beyond so consider them carefully and ensure agreement with the Chief Officer.

The longer term Media Strategy should be developed in liaison and agreement with the AIT and the FRS Legal Advisor to ensure information given to the media is correct and does not jeopardise the investigation or reputation of the FRS.

The Media Strategy should consider the following:

- Immediate media management at the scene of the incident and back up office support for 48 hours after the incident
- The uncertainty of the investigation outcome
- Being flexible as and when new information comes to light, you may need to change your approach
- Identification of key FRS spokespeople, ensuring they are trained to field media enquires during a major emergency
- Ensure the FRS meets its legal responsibilities to warn, advise and inform members of the public
- Clear roles and responsibilities for members of the communications team
- 24 hour rota for the media and communications team for the week after the incident (at least)
- The timing of confirmation of fatalities, names and photographs
- Coordination of information release and messages with other necessary and key agencies
- Advice to the families, watch and staff on handling media approaches
- The set up and management of a press conference
- Timing for media interviews with the Chief. HFRS Chief Officer led the press conference the day after the incident and then only did pre-recorded interviews before the funerals
- Press officer support on affected stations
- Media approach at key milestone points, such as wreath laying on the station, one week on from the incident, funerals, memorial service, one year on, end of Police investigation, outcomes of HSE investigation
- Regular media monitoring to allow for inaccuracies or sensitivities to be picked up and challenged
- Always remember there is potential for the crisis to escalate or additional/new crises to emerge.

Within the Media Strategy, also consider your social media plan and how you will use and manage your presence on social media in the immediate, medium and longer term. Your social media plan should consider:

- Management of condolences
- Approach to inappropriate comments
- Timely and frequent updates and messages from the FRS
- Constant monitoring to gauge opinion
- Advice and guidance to staff on their social media usage
- Linking up with ‘unofficial’ condolence pages.

Statements and interviews should use consistent and agreed lines that are used throughout the process. Statements and release of information on social media should:

- Express sympathy for the families, relatives, friends and colleagues
- Pay tribute to the individuals and those tackling the incident
- Emphasise any positive points sensitively if appropriate i.e. number of lives saved, no one injured, safety of surrounding buildings maintained
- Commitment of the FRS to learn lessons for the future
- Emphasise full commitment and willingness to co-operate with the investigation
- Confirm location, timings and actions, as appropriate

- Confirm that families have been informed.

Statements should not:

- Confirm fatalities or names until families have been informed
- Speculate on any of the circumstances of the incident - cause, failings or procedures
- Criticise any individual or agency
- Pre-empt, speculate or comment on findings of the Police investigation, HSE investigation or findings of the Coroner.

Appendix H: Sample Memorandum of Understanding

Memorandum of Understanding between **(Insert Name)** Constabulary Investigation Team and the **(Insert Name)** Fire and Rescue Service Investigation Team.

The Investigation into the Death of Firefighter **(Insert Name) (Insert Date)**

MEMORANDUM OF UNDERSTANDING
BETWEEN **(Insert Name)** CONSTABULARY INVESTIGATION TEAM
AND THE **(Insert Name)** FIRE AND RESCUE SERVICE FRS INVESTIGATION TEAM

Introduction

This memorandum of understanding (MoU), agreed between the **(Insert Name)** Constabulary investigation team appointed to investigate the circumstances of the fire at **(insert details)** and the investigation team appointed by **(Insert Name)** FRS to carry out an internal investigation into the incident, sets out the principles for liaison between the agencies.

The aim is to ensure that effective investigation and data sharing processes are in place in order to facilitate an independent and transparent investigation by **(Insert Name)** Constabulary. Although **(Insert Name)** Constabulary has primacy for the investigation into the deaths of the fire fighter it is accepted that **(Insert Name)** Constabulary will have to communicate with personnel from **(Insert Name)** FRS on a regular basis to request information and provide updates where appropriate.

This MoU has been developed from the Investigation Strategy and Terms of Reference agreed by the lead Agency on the **(Insert Date)**

The Senior Investigating Officer for the Police investigation is **(Insert Name)**.
The FRS Accident Principal Lead is **(Insert Name)**.

Requests for Information by **(Insert Name)** Constabulary

(Insert Name) FRS has a duty to provide the Police with information as requested in order to assist with the Police investigation. The Police may request information from **(Insert Name)** FRS either verbally or in writing.

If (Insert Name) FRS are not prepared to supply information, document or exhibit as requested by **(Insert Name)** Constabulary, reasons for this refusal should be given in writing.

Communication

The SIO will formally meet with the **(Insert Name)** FRS Accident Investigation Principal lead on a periodic basis to provide an update on the Police investigation. The format for these meetings will be as follows:

- General update on Police Investigation
- Update on planned Police activity and timescales
- Significant safety issues identified
- Local and national lessons learnt (subject to disclosure criteria test)
- Requests by **(Insert Name)** Constabulary for further information disclosure by **(Insert Name)** FRS
- Request by **(Insert Name)** FRS for disclosure of material by the **(Insert Name)** Constabulary investigation team.

It is accepted that it may be necessary for members of the **(Insert Name)** FRS investigation team to communicate with members of the Police investigation team on a regular basis (particularly at the start of the investigation when information is being requested and secured). Although this is accepted protecting the independence of the investigation is paramount and it is essential that there should be a sterile corridor between the two investigation teams.

All communication between **(Insert Name)** Constabulary and the **(Insert Name)** FRS investigation team will be recorded and retained in line with the disclosure provisions of the CPIA 1996.

Any difficulties in communication between the two teams will be dealt with by the SIO and the FRS accident investigation principal lead.

Members of the **(Insert Name)** FRS investigation team should not attempt to communicate or request information from FRS personnel from **(Insert Name)** FRS who are working as part of the Police investigation. All communication and requests for information by **(Insert Name)** FRS should be to the SIO or other Police personnel who are part of the team. This is to protect the integrity and independence of the investigation.

Destructive Testing of Exhibits/Equipment

The Police investigation team has a statutory duty to present to a Coroner's Court or Criminal Court the 'best evidence' available. On occasions this may be considered to be the physical evidence in the state in which it was recovered. However, in order to establish the cause of the death the team may need to undertake further tests to develop further evidence that will modify the condition or possibly destroy some part of the item.

If the SIO plans any forensic testing which is likely to modify/destroy the condition of any exhibit (Insert Name) FRS will be given prior notification of this testing in order that they can consider sending a representative to oversee the testing. The results of such tests will not necessarily be disclosed to **(Insert Name)** FRS immediately after the test is complete to protect the integrity of the ongoing investigation.

In relation to planned forensic testing or testing of equipment which is likely to be non-destructive, (Insert Name) FRS will be invited to make representations as to the type of testing carried out. The SIO will give consideration to any representations made but will have the finally decision with regard to any forensic submissions or testing of equipment.

Interviews of **(Insert Name)** FRS Personnel

A detailed interview strategy is currently being prepared by the Police investigation team in liaison with **(Insert Name)** FRS and other Representative bodies. In carrying out interviews with **(Insert Name)** FRS personnel, the general principles will be adopted. They are as follows:

- **(Insert Name)** Constabulary has primacy for the interview of all witnesses. The **(Insert Name)** FRS will not carry out interviews or take witness statements from any member of **(Insert Name)** FRS without the prior agreement of the SIO.

- Once all relevant information/evidence has been obtained from a witness, at an appropriate time, the SIO will give consideration to disclose the content of the interview to **(Insert Name)** FRS. If having been provided with details of the witness account **(Insert Name)** FRS wish to carry out additional interviews with the witness a formal request must be made to the investigation team for the Police to consider.

- A list of all persons who the Police wish to interview/take statements from will be forwarded to the **(Insert Name)** FRS investigation team and the FBU in advance. **(Insert Name)** FRS (with assistance from the FBU) will arrange interviews at suitable times; facilitate the change of duty rotas etc. in order that these interviews can be carried out at the earliest opportunity.

- All members of **(Insert Name)** FRS who are asked to provide a witness account can be accompanied by a friend, representative and/or a legal advisor. Witnesses will be asked not to select persons who attended the incident at **(Insert address of incident)** on the **(insert date)** as supporters to prevent any subsequent allegations of collusion. (Insert Name) FRS will not insist on the attendance of a senior member of staff when firefighters are interviewed (as per normal protocol). If a witness requests that they are accompanied during a witness interview by a senior member of **(Insert Name)** FRS, **(Insert Name)** FRS will supply a senior officer who is not part of the investigation team and had no involvement in the incident under investigation. Any senior member of **(Insert Name)** FRS who attends an interview at the request of a witness will be instructed not to discuss the content of the witness testimony with the **(Insert Name)** FRS team or any other member of **(Insert Name)** FRS.

- The Police will request that 'significant interviews' (interviews with key members of staff who had an important role in the incident) are conducted at dedicated Police witness suites and that the accounts given are visually recorded. The Police will facilitate any requests from a witness that the interview takes place at a different location e.g. fire service building. A witness interview will not be visually recorded if the witness objects to this.

- Details of interviews with individual witnesses (summary of interview, statement and transcript) will not be disclosed to **(Insert Name)** FRS immediately after the interview of a witness. The SIO will determine an appropriate time when such disclosures will be made on the basis of the status and developments of the ongoing investigation.
- The same process will be followed if the Police wish to interview a witness under caution. In such circumstances, the member of staff will be offered legal advice as per normal Police provisions.

The Sharing of Information

It will be the decision of the SIO when to release information and material to the **(Insert Name)** FRS investigation team. Any decision to disclose information will consider the balance in supporting the **(Insert Name)** FRS investigation with protecting the integrity of the ongoing Police investigation. The principle that **(Insert Name)** Constabulary have primacy for the investigation will be at the forefront of every decision to disclose information. No information will be disclosed which may damage the ongoing Police investigation.

The SIO will consider all written requests for disclosure from the **(Insert Name)** FRS investigation team. Following such requests a written record will be made of any information disclosed and any decision not to disclose the information.

Where appropriate, the SIO will seek advice from the force legal advisor and the CPS regarding whether to release the information to the **(Insert Name)** FRS investigation team.

Safety considerations are of paramount importance and it is fully accepted that the investigation may uncover information that may assist in informing the FRS safety procedures. Where the investigation identifies a potential risk to FRS personnel, the public or serious procedural failures that may expose others to harm advice will be sought from **(Insert Name of any assisting FRS)**, HSE and Chief Fire and Rescue Advisor (CFRA) regarding the most appropriate channels to communicate this information to provide advice and guidance to FRSs and other statutory bodies.

In deciding whether to disclose information regarding safety matters that arise during the investigation, the following distinction will be made between:

(i) Safety Critical Information - Immediate release will be required
(ii) Safety Relevant Information - Safety information where there is not an immediate risk to FRS personnel or the public. When such issues are identified a disclosure test will be applied to balance the benefits and requirements of disclosure with the likely impact on the ongoing investigation.

Signatories

Police Senior Investigating Officer **(Insert Name)**……
(Insert Name) Constabulary

FRS AIT Lead Officer **(Insert Name)**……..……..
(Insert Name) Fire and Rescue Service

Dated ……..

Appendix I: (Sample) Organisational Improvement Steering Group Terms of Reference

(Insert Name) Fire and Rescue Service
Accident Investigation - Address of incident and Date

The Management of Health and Safety Regulations 1999, Regulation 5 and supporting HSE best practice guidance requires employers to ensure they adequately investigate the immediate and underlying causes of incidents and accidents to ensure that remedial action is taken, lessons are learnt and longer term objectives are introduced.

Improvements made during the course of the investigation will demonstrate that the FRS is acting proactively and learning from the accident.

It is therefore incumbent on the FRS to make improvements as soon as reasonably practicable when information comes to light that suggests that the health, safety and welfare of employees or others may be affected by related activities.

The Accident Investigation Team (AIT) may, through their investigation processes, identify issues that prompt consideration for organisational improvements to be made. These issues might eventually be raised in the final investigation report and recommendations; however, it might not always be appropriate to wait until the final report is issued to take action on making improvements.

It is important to note that some of the issues raised might not be directly attributable to the cause of the accident, but they are nevertheless considered as items for improvement for the benefit of the FRS.

In order to progress these matters an Organisational Improvement Steering Group (OISG) will be established involving key members of the FRS who, through their role, will consider any issues raised and allocate resources accordingly to the actions that are agreed. This is important because some actions may have an impact across all areas of the organisation.

The Organisational Improvement Steering Group may consist of:

- (Service Delivery) - Chair
- (Service Delivery Response)
- (Service Delivery Protection)
- (Head of Training)
- (Health and Safety Manager)
- (AIT Admin Support)
- Member of AIT as appropriate

Note: A nominated deputy will attend if any of the above is unavailable.

The purpose of the Organisational Improvement Steering Group is to:

1 Identify and review all issues raised by the FRS Accident Investigation Team
2 Agree and record the expected actions/outcomes for each of the issues raised and place on an issues log
3 Develop an interim action plan, identifying key objectives, key tasks, resource implications, lead officers and timescales for completion
4 Monitor progress and update the AIT Lead Officer, FRS Management Team and Representative Bodies
5 Issue appropriate and timely communications to staff on the improvement actions being taken.

Appendix J: Sample Exhibit Inventory

(Insert Name) Fire and Rescue Service - Accident Investigation - **(Incident address)**

Serial No	Exhibit No	Received From (Name and Organisation)	Date	Description	Comment	Location Stored	Logged Out To (Name)	Date	Date Returned
1	JEH/PW/01	Grace Dollery @ FRS	12 04 12	Notebook	Grace Dollery record of evidence continuity from 07 04 12 to 08 04 12	Exhibit box file 1 JEH-PW-01 – Grace Dollery Notes.pdf			
2	JEH/PW/02	Protection Dept., @FRS	12 04 12	Word document	Tudor House premises layout	Exhibit box file 1 JEH-PW-02 Tudor House Premises Layout.doc			
3	JEH/PW/03	Ella Rose, @FRS	16 04 12	Email	RIDDOR form for Katie Bates	Exhibit box file 2 JEH-PW-03 RIDDOR Katie Bates.htm			
4	JEH/PW/07	Sam Stephens, @FRS	19 04 12	Paper document	Bristol care package record for Katie Bates fire kit	Exhibit box file 2 JCEH-PW-07 - Care package for Bates fire kit.pdf			
5	JEH/ST/14	Kristy Victoria, @ FRS	20 04 12	Excel document	Mosaic profile of Tudor House	Exhibit box file 1 JEH-PW-14 Mosaic Profile.xls			
6	JRB/ST/2	Paul Jack, @ Police Digital Forensics	21 04 12	DVD	Digital images of fire scene at Tudor House	Exhibit box file 7			
7	JEH/ST/17	William James, FBU	21 04 12	Paper document	Bundle of email exchanges between @ FRS and FBU re high rise procedures	Exhibit box file 3 JEH-PW-17 - Emails between FBU and @FRS			