NHS Trust Chief Executives
NHS Foundation Trust Chief Executives
NHS Trust Boards

NHS Estates and Facilities Policy Branch
Room 2W59
Quarry House
Quarry Hill
Leeds
LS2 7UE

Our ref: PR/DF/FSO
Gateway Reference Number: 18654
31st January 2013

Dear Colleague,

FIRE SAFETY DUTIES

Following an investigation into a fire at a hospital in October 2011, the local Fire & Rescue Service (FRS) felt that there was compelling evidence of inadequate fire safety governance and intended to prosecute the NHS Trust concerned. Unfortunately, between the fire and the conclusion of the report, the trust had merged with another, and criminal liability had not transferred to the new merged organisation. This resulted in the FRS being unable to undertake the prosecution. Having had this brought to the attention of the Department of Health, steps have now been taken to ensure this situation cannot arise with any future mergers/acquisitions. It should be noted that whilst it was fire safety matters that brought this issue to light, it could in fact relate to any other health & safety type incident.

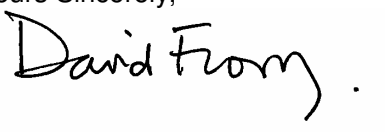
The report identified a catalogue of failings giving rise to the mismanagement of fire safety across the organisation. There are lessons for the NHS to learn from the publication of the report by the FRS, as many of the areas of concern appear to be issues that are easily resolved. The annex to this letter identifies the key findings of the FRS report and should be referred to.

In November 2012, London Fire Brigade served an Enforcement notice on a separate NHS Trust for similar failings.

This level of apparent mismanagement and lack of governance of fire safety issues gives rise to overall concerns about patient safety. Therefore, NHS Trust and NHS Foundation Trust Chief Executives, and Trust Boards are reminded of their duties under current fire safety legislation – the ***Regulatory Reform (Fire Safety) Order 2005***. Consequently, I would advise that immediate steps should be taken to review fire safety across your organisation to ensure those duties are being met and that patient safety is not being compromised.

If you require any further information or advice regarding the contents of this Dear Colleague Letter, then please contact Peter Sellars, Head of Profession (peter.sellars@dh.gsi.gov.uk) or Paul Roberts, Fire Policy Lead (paul.roberts@dh.gsi.gov.uk).

Yours Sincerely,



David Flory
Deputy NHS Chief Executive

cc. Sir David Nicholson, NHS Chief Executive and Chief Executive, NHS Commissioning Board
Karen Wheeler, Director General – Governance, Operations and Assurance, Dept. of Health
Peter Sellars, Head of Profession – Governance, Operations and Assurance, Dept. of Health
David Whiteley, Programme Lead – Governance, Operations and Assurance, Dept. of Health

Annex

The main findings of the report into the fire at an NHS Trust in October 2011 were:

- Failing to suitably assess, monitor and supervise means for starting a fire on the premises. (Article 8 of The Order)
- Failing to ensure that those employees who have no authority, designated role, or relevant training are not allowed to access the fire alarm control panel. (Article 8 of The Order)
- Failing to carry out a suitable Fire Risk Assessment before occupying the premises. (Article 9 of The Order)
- Failing to suitably assess individual patients to evaluate their level of dependency in the event of evacuation, or the level of fire risk they may pose to themselves and others. (Article 9 of The Order)
- Failing to suitably review and revise the Fire Risk Assessment. (Article 9 of The Order)
- Failing to translate the Fire Risk Assessment findings into action. (Article 11 of The Order)
- Failing to ensure that fire exits are unlocked during a fire emergency. (Article 14 of The Order)
- Failing to provide employees with the suitable information of their nominated duties, nor the appropriate training and support to ensure their competence when their role has been designated with specific duties in the event of an emergency. (Article 15 of The Order)
- Failing to undertake practice fire drills on wards. (Article 15 of The Order)
- Failing to provide an employee with suitable training or support to ensure their competence for their nominated role, eg; the nomination of a member of staff as the Responsible Person on the without their knowledge. (Article 18 of The Order)
- Failing to ensure that staff are familiar with the emergency fire action plan. (Article 19 of The Order)
- Failing to ensure that staff received refresher fire safety training in the prescribed period. (Article 21 of The Order)
- Failing to ensure that staff received premises specific fire safety training when they started in a new workplace. (Article 21 of The Order)

It was the opinion of the FRS that in order for these failings to have developed, the strategic management arrangements in operation at the Trust were materially ineffective. In particular, the FRS investigation, which was based upon documents and information provided by the Trust, witness statements, responses to interviews under caution by employees and evidence such as CCTV images and the fire alarm log, identified that the failings detailed above can be attributed to the following:

- Ineffective strategic management systems depending on delegated individuals to report concerns or issues to senior accountable managers. There was little evidence to suggest that routine superintendence consistently occurred to ensure that fire safety management systems and procedures were working or being implemented effectively.
- Ineffective monitoring or auditing of staff fire safety awareness, performance and training (at all levels of management.)
- Staff fire safety training, fire practise drills, and the fire safety equipment testing and maintenance regime at the Trust were being administered in such a way by the Fire Safety Manager and Estates department team that the front-line personnel at the unit had little awareness of or engagement with the routine fire safety activities and tasks in their workplace.
- A lack of instruction, training and support for individuals in key fire safety related functions. In particular, staff (including line managers) at the Trust had not been provided with

suitable, premises specific, training to inform them of the fire risks and procedures in a newly opened building.

- A lack of competency assessment or assurance - staff were routinely being nominated into roles or designated with emergency duties of which they were not aware and for which they were not fully competent.
- Poor communication arrangements - key fire safety information was available on the Trusts online ‘Smartline’ system and across a range of Trust documents, but its communication to staff was either non-existent or ineffective.