



HM Fire Service Inspectorate

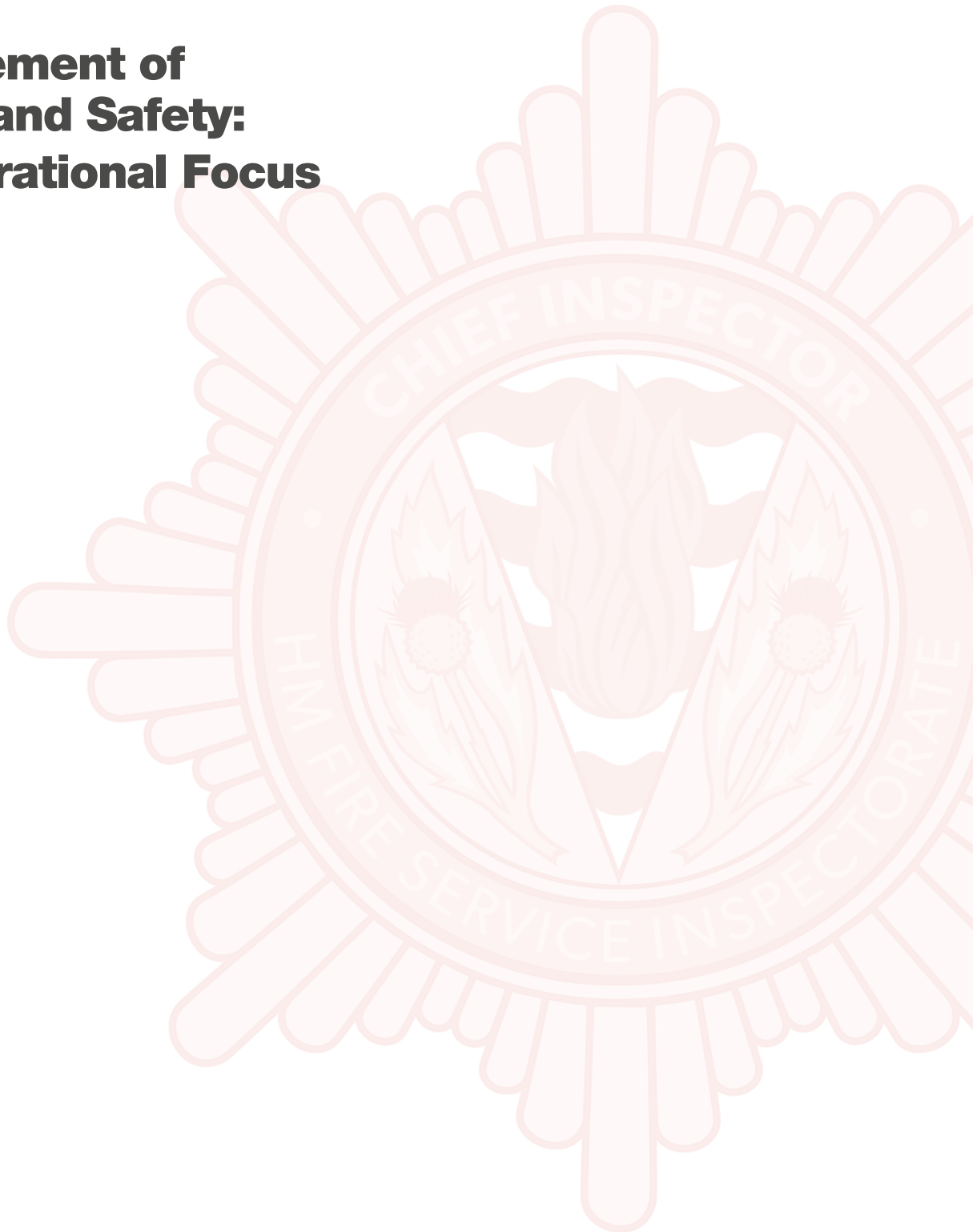
Management of Health and Safety: An Operational Focus



Integrity, Objectivity, and Fairness.

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Acknowledgements

We are grateful to the Scottish Fire and Rescue Service (SFRS) Strategic Leadership Team (SLT) and the SFRS Board for their positive contributions and assistance in meeting our requests. We are also grateful to those members of staff and stakeholders who provided us with information and contributed constructively to our interviews and fieldwork.

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A quality assurance process assisted us by challenging a draft of this report. Quality assurance was carried out by John Buckley QFSM, Chief Fire Officer, Nottinghamshire Fire and Rescue Service, who had no participation in the inspection.

All the members of the inspection team contributed to the development of this report and the quality assurance provided a professional challenge to the contents, assumptions and conclusions made. However, the Chief Inspector takes sole responsibility for the report, its contents and conclusions.

- Our report reflects the circumstances at the time of our visits and interviews which were undertaken between April 2021 and January 2022. The SFRS is continuing to change and evolve, consequently, material changes may have occurred since the writing and publication of this report.

Laid before the Scottish Parliament by HM Chief Inspector of the Scottish Fire and Rescue Service under section 43C(5) of the Fire (Scotland) Act 2005 April 2022 SG/2022/71

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Executive Summary

The aim of this Thematic Inspection was to assess the effectiveness and efficiency of Health, Safety and Welfare arrangements in place within the Scottish Fire and Rescue Service (SFRS) with a particular focus on health and a safety in an operational context. In doing so we have given consideration to the governance and management, policy and planning, training and recording arrangements.

We have also considered organisational culture in relation to Health, Safety and Welfare and focused on how Health and Safety (H&S) is centred on firefighter safety. In addition, we have reviewed how the Service is using national learning, data and other information to reduce risk and improve the overall safety and welfare of its staff.

We found that the SFRS has a good understanding of its duties relating to H&S (as per our scope and outline). It has structures in place for setting direction, organisational policy, and developing and producing procedures across the Service. These support the strategic planning function and both tactical and service delivery.

The Service has placed a strong focus on H&S and has brought together departments to support improvements in the understanding and promotion of H&S at all levels. It has developed detailed plans, and has structured reporting and monitoring processes in place.

We do, however, believe that there are areas that could be improved and we trust the eight Recommendations, detailed later in the report, will assist the Service improve its performance and organisational culture, reducing the likelihood and/or impact of H&S events.

We have also identified twenty-five Areas for Consideration. We acknowledge that the SFRS already has some knowledge of what could be improved; however, we have identified areas that may be new and worthy of consideration. We recognise that there are a number of ways to address these Areas for Consideration. How to prioritise and achieve this is of course a matter for SFRS to determine.

Within this report, we have identified nine Areas of Good Practice. These were either directly observed by Inspectors or raised by staff as either local or national issues. We consider it important to bring focus on these areas to allow the Service to consider sharing good practice where appropriate.

Some of the findings within this report could be viewed as 'cultural' issues either falling into organisational, managerial or safety-related areas. Some of the issues described are behavioural or value-driven.

During our inspection we observed some inconsistency in the understanding of some of the terms used to manage H&S in Service Delivery. This may be due, in part, to the challenges the Service faces relating to staff turnover, and in the associated maintenance and acquisition of knowledge and experience. These are areas for the Service to address for sustainable improvement in its H&S culture.

Within the scope of this inspection it was not our intention to examine all aspects of H&S compliance; it was, instead, to focus on areas of business where H&S impacted upon operational response.

Overall, we found it reassuring that we had no reason to raise any 'safety-critical areas' i.e. an issue requiring immediate action. However, we recognise that there are areas that could and should continue to be reviewed, evaluated and improved.



Image courtesy of SFRS Corporate Communications

Introduction and Background

1. The SFRS, as an employer, has responsibility to ensure the safety of its staff, in line with the Health and Safety at Work etc. Act 1974 (HSWA)¹ and associated Regulations.
2. The HSWA includes a requirement on employers to provide information, instruction, training and the provision of supervision as is necessary to ensure, so far as is reasonably practicable, the health, safety and welfare of its employees. The ability for SFRS to capture, record, and track relevant information is another essential component in the demonstration of compliance with duties under the Act.
3. Employees of the SFRS have a duty under HSWA to take reasonable care for their own health and safety and to cooperate with the employer to enable the SFRS to comply with its duties.
4. The SFRS has statutory duties as an employer under the Management of Health and Safety at Work Regulations 1999 ('the regulations') to manage the workplace appropriately in relation to health and safety (H&S) and to put arrangements in place to control H&S risks. The regulations place a duty on the SFRS as an employer to review workplace activity, such as preventative and protective measures, as well as undertaking and reviewing risk assessments. In the case of the SFRS, H&S responsibilities include operational activities on the incident ground.
5. Fires and other emergencies attended by Fire and Rescue Services (FRSs) are by their very nature, hazardous operations. The Health and Safety Executive (HSE) sets out how it will enforce H&S legislation in the UK FRS in the document '*Striking the balance between operational and health and safety duties in the Fire and Rescue Service 2010*'².
6. There are two other national documents that are relevant to H&S in the FRS. The first is a joint statement from the Chief Fire and Rescue Advisers in England and Wales, and HM Fire Service Inspectorate in Scotland, in conjunction with the HSE entitled – *Health and Safety in the Fire and Rescue Service – Embedding Lessons Learned 2015*³. This document reflects on a number of public reports on emergency incidents attended by FRSs, in which health and safety has been a leading theme. Secondly, *The Management of Health and Safety in the GB Fire and Rescue Service – Consolidated Report based on the 8 inspections completed by HSE in 2009/10*⁴, contains findings relevant to health and safety management in FRSs.
7. Our *Scrutiny Plan for 2016-21*⁵ identified firefighter safety as an area of interest for Thematic Inspections. Having considered a wide range of topics, and following discussions with the SFRS, the Chief Inspector opted to carry out a Thematic Inspection focussing on 'Health and Safety – An Operational Focus'.

1 [Health and Safety at Work etc. Act 1974 \(legislation.gov.uk\)](https://www.legislation.gov.uk)

2 <http://www.hse.gov.uk/services/fire/duties.pdf>

3 <https://www.webarchive.org.uk/wayback/archive/20190901145709/https://www2.gov.scot/about/public-bodies/HMFSI/Reports-Publications>

4 [THE MANAGEMENT OF HEALTH AND SAFETY IN THE GB FIRE AND RESCUE SERVICE \(hse.gov.uk\)](https://www.hse.gov.uk)

5 [HM Fire Service Inspectorate in Scotland: Chief Inspector's plan - 2021 to 2024 - gov.scot \(www.gov.scot\)](https://www.gov.scot)

About the Inspection

8. Her Majesty's Fire Service Inspectorate in Scotland (HMFSI) is a body that operates within, but independent of, the Scottish Government (SG). Inspectors have the scrutiny powers specified in section 43B of the Fire (Scotland) Act 2005.
9. This inspection is conducted under those powers conferred on the Chief Inspector under sections 43B and 43C of the Act and was initiated by the Chief Inspector on his own volition. Further information about HMFSI can be found in Appendix 1.
10. A draft outline was prepared which defined the scope of the inspection. This was consulted upon with the SFRS prior to fieldwork commencing.
11. The aim of this inspection is to assess the effectiveness and efficiency of the Service's governance and management, policy and planning, training and recording with an operational focus. We considered the extent of the following aspects of Health, Safety and Welfare as specified in the inspection outline:
 - evidence exists of an embedded positive health and safety culture;
 - that the SFRS meets identified legislative general duties and guidance document requirements;
 - the organisation has a structure, is adequately resourced, has qualified people, is aware of its responsibilities, and adequate resources are made available to meet requirements;
 - that there is active participation by an engaged workforce at all levels including the SFRS Board;
 - there is an effective management and recording system; including evaluation and relevant performance and benchmarking measures;
 - that proactive as well as reactive monitoring systems are in place;
 - that sufficient resilience exists in systems and resources;
 - there is an awareness of the organisation's risks and that they are managed effectively;
 - suitable and effective operational training is in place;
 - that the SFRS enables operational staff to remain effective and safe when responding to emergency incidents – demonstrating a 'Risks vs Benefits' culture;
 - that the SFRS responds to operational and training accidents and incidents effectively and efficiently to assist learning, demonstrating how learning is shared and improvements monitored and managed;
 - that the SFRS has suitable systems in place to support the workforce in managing their welfare; and
 - to consider examples of how Operational Assurance has improved H&S and organisational learning to improve service response.

12. The intention of this report is to set out the facts and present the Chief Inspector's independent view of the current arrangements. Where appropriate, we will, make recommendations, identify areas for consideration and highlight good practice. Recommendations and any associated action plan developed by the Service will be monitored in line with existing arrangements.
13. In this report our findings include Recommendations, Areas for Consideration and Good Practice:
 - **Recommendations** – these are areas that we believe will have a significant impact both within the scope of this report and will bring broader organisational benefits.
 - **Areas for Consideration** – these may be delivered as described or in other ways as determined by the Service, they should deliver improvements to the organisation and staff over a given time period.
 - **Good Practice** – activities raised by SFRS staff during interviews and supported by our professional judgement as having a positive impact on H&S within the Service.
14. There are occasions where our observations could be reported against more than one heading. Our aim is to ensure that our findings are allocated in the most appropriate place, or places, to give a comprehensive understanding of our investigations.
15. We acknowledge that due to the timescale for completing this work, which was partly affected by the impact of Covid-19, the SFRS may have already considered and addressed some of the issues identified.

Methodology

16. The inspection methodology used is similar to our Local Area Inspections (LAIs) and previous Thematic Inspections. It provides a structure to our inspection which is risk-based and proportionate.
17. The inspection commenced with a desk-top review of the SFRS's policy, procedures and data in relation to how the Service complies with its H&S duties for operational response. This included interviews with:
 - SFRS Board member
 - Chief Officer
 - Assistant Chief Officer (ACO) - Director of Service Delivery
 - ACO – Director of Training, Safety and Assurance
 - Service Delivery Area (SDA) Deputy Assistant Chief Officer (DACO) - North, East and West
 - Head of Safety and Assurance
 - Members of the Training, Safety and Assurance team

- Representative bodies and other staff groups
 - Police Scotland
 - The HSE
 - Senior and Middle Managers (Directorate and SDA)
 - Area Commanders
 - SDA Group Commanders with Safety and Assurance Liaison Officer (SALO) reference
 - Fire Station and Directorate based supervisory managers (Watch Commanders and Crew Commanders)
 - Operational Crew (Watch Commanders, Crew Commanders and Firefighters)
18. We had intended to visit a number of Service premises across Scotland, including fire stations covering all duty systems, to analyse records and determine the understanding of the staff using H&S related systems. Unfortunately our planned programme had to be amended to ensure adequate Covid-19 control measures were in place. This was necessary to protect all those we needed to engage with and to comply with relevant restrictions in place at that time. Consequently we reduced the number of physical visits and introduced 'virtual' interviews using video technology. Despite these restrictions we undertook a sample of visits and engaged with an appropriate number of staff members to allow us to reach the conclusions within this report.
 19. The data and information supplied to us was used to cross-reference the written policies, procedures, reports and used to triangulate information we received in our interviews. Performance data supplied to us in relation to H&S and other data taken from published sites is used, as necessary, to give context and inform the report.
 20. This inspection was not intended to be a comprehensive in-depth audit, albeit it is sufficiently detailed in order for the Chief Inspector to give a professional judgement on the activity and suitability of the Service's H&S arrangements within an operational context. It has established, to the Chief Inspector's satisfaction, the facts needed to draw conclusions, make recommendations, identify areas for consideration and highlight good practice where appropriate.
 21. The SFRS has a programme of internal audits, routine H&S inspections and fire station audits which involve a detailed inspection of aspects of its activities. We did not want to duplicate or encroach on that work. We did take these audits and inspections into consideration whilst carrying out our own work. Unfortunately, due to the Covid-19 pandemic and the restrictions imposed from March 2020, the SFRS had no choice but to cancel much of the work planned in this respect.
 22. The sampling methodology that we adopt is not designed, nor guaranteed, to identify all potential areas for consideration or good practice; we intend that it is a proportionate activity that provides sufficient detail and engagement, comparable with other inspections that we have carried out.

23. Within this inspection, we also reviewed actions taken by the SFRS following previous inspection reports. These included H&S related themes that were identified during LAIs. The themes included:
- the use of the recording systems (previously RIVO and currently TASS (Think, Act, Stay, Safe);
 - the level of understanding among personnel of the importance of 'near miss' reporting, that may be a factor in the low reporting of 'near miss' incidents. During previous LAIs we have noted that 'near miss' events are more often in non-operational or training environments and that 'near miss' reporting from the incident ground is less frequent;
 - the limited amount of H&S input to new staff on courses such as Task and Task Management (TTM) which appear to be the only input given to a new entrant in relation to H&S;
 - fire station facilities for cleaning and securing PPE;
 - perceived inadequacy of torches and incidents of breathing apparatus radios being turned off accidentally;
 - shortcomings regarding test records for equipment and the variances between records;
 - an increase in the number of H&S events in some Local Senior Officer (LSO) areas which may not reflect the national position;
 - Retained Duty System (RDS) staff desire to increase practical training, as they consider too much time is devoted to theoretical training, completing training records and other management activities;
 - the volume of new information issued to station-based staff (including H&S issues), leading to concerns that safety-critical information could be missed; and
 - a perceived lack of training among some staff on the process for carrying out Analytical Risk Assessments (ARA) or other H&S related duties.
24. Our report is the product of reviewing and analysing the current data, engaging with a wide range of SFRS staff and external stakeholders, and considering evidence from our previous Thematic Inspections, LAIs and other inspections. It is reflective of the circumstances at the time of our interviews and visits undertaken from April 2021 to January 2022.
25. During the inspection, HMFSI provided regular feedback to key SFRS staff including senior managers, so that any significant emerging issues and themes could be discussed and acted upon as required.

Our Findings

Plan – Setting the direction

Organisational Culture

26. As described by the HSE 'Culture' can be understood as *'the way we do things around here'*. Culture forms the context within which people judge the appropriateness of their behaviour. An organisation's culture will influence human behaviour and human performance at work. Poor safety culture has contributed too many significant events and personal injuries.
27. An organisation's culture can have as big an influence on safety outcomes as the safety management system. 'Safety culture' is a subset of the overall organisational culture. Many organisations talk about 'safety culture' when referring to the inclination of their employees to comply with rules or act safely or unsafely. However, the culture and style of management is even more significant, for example, a natural, unconscious bias for outputs over safety, or a tendency to focus on the short-term and being highly reactive. Success normally comes from good leadership, good worker involvement and good communications⁶.
28. The HSE document HSG 65⁷ is recognised as a principal document for the successful management of H&S. It was originally created in 1991. It has moved away from using the POPMAR (Policy, Organising, Planning, Measuring Performance, Auditing and Review) model of managing H&S to a 'Plan, Do, Check, Act' approach.
29. The **Plan, Do, Check, Act** model achieves a balance between systems and behavioural aspects of management. It also treats H&S management as an integral part of good management generally, rather than as a stand-alone system.

⁶ [Human factors/ergonomics – Organisational culture \(hse.gov.uk\)](https://www.hse.gov.uk/human-factors/ergonomics-organisational-culture/)

⁷ [Managing for health and safety \(HSG65\) \(hse.gov.uk\)](https://www.hse.gov.uk/hsg65/)

30. Table 1 shows the ‘Plan, Do, Check and Act’ model and how it can be applied in the work place.

Plan, Do, Check, Act	Conventional Health and Safety Management	Process Safety
Plan	Determine your policy - Plan for implementation	Define and communicate acceptable performance and resources needed
Do	Profile risks - Organise for health and safety - Implement your plan	Identify and assess risks - Identify controls - Record and maintain process safety knowledge
		Implement and manage control measures
Check	Measure performance (monitor before events, investigate after events)	Measure and review performance - Learn from measurements and findings of investigations
Act	Review performance - Act on lessons learned	

Table 1 The read-across between ‘Plan, Do, Check, Act’ and other management systems HSG 65 page 7/72

31. During our information review we were pleased to see that a number of policies and procedures embedded the ‘Plan, Do, Check, Act’ methodology and adopted other similar HSE guidance. We think this approach assists the SFRS.

Good Practice 1 – A number of the SFRS H&S policies and procedures align with the principles within HSG 65 and other HSE guidance documents, utilising the ‘Plan, Do, Check, Act’ methodology.

32. The SFRS is committed to consultation and we heard this across the Service in many aspects of the H&S arrangements. There is evidence of an improved cross-directorate and inter-departmental working.
33. Whilst this approach is to be applauded, there was also a perception among some staff that a ‘top down’ culture existed, with the support departments being prescriptive in their requirements or unwilling to make changes if they haven’t suggested them. The pace and speed of action at times appears slow to end users and this can lead to frustration and prevent innovation.

Leadership

34. The SFRS has a number of published core values: *'Safety, Teamwork, Respect and Innovation'*, which were adopted following a cultural staff survey in 2014. These values are often quoted by managers when describing the Service culture towards H&S. Safety appears to be important and an integral part of the culture of operational staff. During our discussions with senior leaders, they recognised that the organisation's core values may need to be revisited as there has been a high turnover of staff since the current values were introduced. The majority of staff we engaged with felt that safety would probably remain a core value. The aspiration of senior management is to embed organisational values, particularly safety, within promotion processes and appraisal systems, which will assist with employees understanding and embracing core values.

Area for Consideration 1 – The SFRS core values including 'Safety' could be embedded further into organisational processes such as promotion, selection and appraisals.

35. During our interviews we witnessed, and were informed of, a positive cultural change towards H&S in recent years. The Service has reviewed and re-organised its structures so that Training, Safety and Assurance fall under the control of one Directorate. This is seen as a positive step across all levels of the organisation. Part of this structural change is the creation of the National Safety and Assurance Board (NSAB) which has overall responsibility for the scrutiny, prioritisation and decision making involving strategic management of H&S. Assistant Inspectors from HMFSI are invited to attend these meetings as observers and give feedback to the Chair routinely.
36. Sub-groups reporting to the NSAB involve specialist managers and advisors who prepare, support and provide data to scrutinise investigations and events. Each of the three SDAs has a Safety and Assurance Improvement Group (SAIG) involving each LSO Safety and Assurance Liaison Officer (SALO) and their deputies. We were pleased to see that H&S appears as a standing agenda item at many management meetings and is actively monitored locally and nationally through action plans, updates and reports.

Good Practice 2 – The restructure of H&S into the Training, Safety and Assurance Directorate is seen as positive across the organisation, streamlining governance and reporting, with H&S as a standing agenda item in relevant management meetings across the Service.

Governance

‘The HSE describes the essential principles for leading health and safety⁸ as being:

Strong and active leadership from the top:

- visible, active commitment from the Board;
- establishing effective ‘downward’ communication systems and management structures;
- integration of good health and safety management with business decisions.

Worker involvement:

- engaging the workforce in the promotion and achievement of safe and healthy conditions;
- effective ‘upward’ communication;
- providing high-quality training.

Assessment and review:

- identifying and managing health and safety risks;
- accessing (and following) competent advice;
- monitoring, reporting and reviewing performance.’

37. During our fieldwork staff expressed, on a number of occasions, that the recent re-structure aligning Operational Assurance (OA), Training and H&S under one Directorate was a positive step for the SFRS H&S provision. The use of sub-groups and the SAIGs, ensure that there was adequate and consistent governance and management at the operational and delivery end of the business across the SDA.
38. The SFRS Board plays a significant part in setting the strategic direction for the Service and provides scrutiny of the Service’s performance and its management accountability. We believe the Board role could be enhanced if consideration was given to designating a member as a ‘lead’ and a potential ‘champion for H&S’.

Area for Consideration 2 – The SFRS should consider establishing a designated SFRS Board member as H&S lead or champion.

⁸ Essential principles: Leading health and safety at work ([hse.gov.uk](https://www.hse.gov.uk))

39. We are aware the SFRS is developing a written H&S strategy to support its ongoing commitment to improving H&S. Having this strategy signed off by the Board would link the Service management to the ultimate governance mechanism of the SFRS and demonstrate a commitment to all staff and a fully integrated systems approach to H&S.
40. Most large organisations have management processes or arrangements in place to deal with payroll, personnel issues, finance and assurance – managing H&S is no different.

Legal Duties

41. The Management of Health and Safety at Work Regulations 1999⁹ require employers to put in place arrangements to control H&S risks. Organisations should have processes and procedures required to meet the legal requirements, as the regulations state this should include:
 - a written H&S policy;
 - assessments of the risks to employees, contractors, customers, partners, and any other people who could be affected by their activities – and record the significant findings in writing – any risk assessment must be ‘suitable and sufficient’;
 - arrangements for the effective planning, organisation, control, monitoring and review of the preventive and protective measures that come from risk assessment;
 - access to competent health and safety advice, for example, see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;
 - providing employees with information about the risks in the workplace and how they are protected;
 - instruction and training for employees in how to deal with the risks;
 - ensuring there is adequate and appropriate supervision in place; and
 - consulting with employees about risks at work and current preventive and protective measures.
42. We found that the SFRS senior management has a good understanding of its legislative duties, the need for compliance and the principles of H&S management. This is well documented in the way policy and procedures are designed and constructed. The SFRS has a developed relationship with representative bodies and engages regularly with them on matters relating to improving H&S. All representative bodies operating within the SFRS are invited to be members of the NSAB.
43. We were given a recent example of the benefits of good staff representative body relations; the FBU has supplied information to the SFRS on contaminant and decontamination research which is an area of mutual interest and an emerging topic across the fire sector. The sharing of this information may prevent duplication and assist in developing control measures. We were pleased to hear that the SFRS

⁹ [Legal duties – Managing health and safety at work - HSE](#)

Property team has developed a layout for new and refurbished fire stations that identifies clean and contaminated areas: the application of this will assist in reducing cross contamination. However, we recognise that physical improvements will take time to implement across the estate.

Management Culture

44. There are multiple layers of management involved in controlling H&S within the SFRS and the hierarchal nature of the uniformed Service involves managers at all levels, including members of support staff who hold senior roles within H&S. This is a sensible approach and helps ensure that H&S is not viewed as mostly applicable to 'Emergency Operational Response', but relevant and important to all staff and functions and is embedded throughout the Service.
45. We identified a number of issues in relation to management's approach and were unable to identify the exact reason for these issues or where the perceived barrier existed. Most of the issues we identified were known to the more senior levels of management. Managers were often aware of issues but not escalating appropriately. Examples of issues shared during our fieldwork include: where personnel are asked to train for risks that are not foreseeable in the station response area, or where insufficient time is available to undertake particular work. We challenged managers about these issues and heard responses that included: 'I don't have the authority' or 'it has been discussed at management meetings'. It appears that whilst some Flexi Duty Officers (FDOs) know what areas they have responsibility and accountability for, they lacked clarity and certainty on their ability and authority to make decisions. This may of course be in part an issue of confidence or experience among particular officers; however, parameters of devolved responsibility and levels of autonomy should be made clear to all in management positions.
46. Accountability, decision making and levels of authority are confusing for staff in the SFRS. The Fire (Scotland) Act 2005 defines the body corporate to be known as the 'Scottish Fire and Rescue Service' or (referred to in the Act as 'SFRS'); the other identified roles are Chief Officer (schedule 1A, section 7) and Local Senior Officer (Chapter 8A, section 41J). The Scottish Fire and Rescue Service uniformed role structure identifies nine managerial levels. The roles of DACO are senior to the LSOs and seem to hold much of the decision making authority within Service Delivery Areas. Directors are clearly more senior than DACOs. Perhaps in part due to the relationship between those engaged in service delivery and those leading other 'functional' references, the lines of decision making and accountability are at times unclear to many, including Inspectors and SFRS staff at lower levels.
47. A number of strategic managers we interviewed believed that their decision making has no boundary. This was a surprise to the Inspectors as all management levels have boundaries on their delegated authority. When we asked managers at lower levels if they were clear as to the extent of the limit of their authority, we were not given an assurance on what delegated boundaries had been put in place.

48. We were told that the Service has a desire to empower staff and move decision making to the lowest suitable level within the organisation (subsidiarity). This aspiration should be clearly described, with clear parameters to decision making authority for the job or role.
49. Some middle and supervisory managers failed to demonstrate clear accountability and responsibility when we questioned them regarding H&S-related matters. Many said 'we raised this' or 'it's not my decision'. We also heard during our interviews that some Service Delivery managers and staff think they are not able to innovate. We were given an example where station-based staff had suggested a simple scheme to isolate contaminated PPE when returning from incidents, but were unwilling to take action. This suggestion appeared to be an effective method of reducing staff exposure to contaminants and easy to adopt across the SDAs with no cost. Managers should be prepared to encourage, develop, test, and evaluate suggestions and maximise the innovation and creativity of staff.
50. We acknowledge that responsibility and accountability ultimately sits with the Chief Officer. It is however not appropriate for the head of the organisation to make all decisions. As such the Service has put structures in place to empower relevant members of staff to make decisions and take action on behalf of the organisation.
51. The SFRS needs to be clear on the accountability and decision making authority of its staff. The existing position whereby managers lack this clarity leads to frustration and has the potential to compromise the H&S of staff through inaction or waiting for a decision that could involve safety-critical areas of the business.

Area for Consideration 3 – The SFRS should introduce clarity on the accountability and decision making authority of all levels of managerial staff to improve H&S management and delivery.

H&S Plans

52. The National H&S Improvement Plan is the driver of the H&S priorities for the Service. This is a document that is regularly reviewed and drives the action plans throughout the Service. The plan is well understood by the specialists and SDA H&S teams. Key performance indicators are linked to the plan for monitoring and informing. We saw the use of data and other relevant information being displayed on H&S noticeboards at fire stations, although this was not always consistently applied nor was the most up-to-date information used.
53. We understand that the Head of H&S is looking to broaden the planning process to engage earlier with key stakeholders. If achieved, this would address some of the concerns identified to us regarding planning arrangements. Some staff in SDAs do not feel that their contribution to the H&S planning framework is considered early enough within the process, and that planning is a one-way, top-down approach. They also expressed concerns that some of the actions are not specific enough to clearly understand which can lead to delay, frustration and confusion when trying to provide evidence that the action is completed.

Area for Consideration 4 – The SFRS should ensure there is early engagement with relevant internal stakeholders to ensure their priorities and ideas are considered within future H&S plans.

Good Practice 3 – H&S teams across the SFRS pro-actively follow up and report progress on improvement/action plans which ensures an organisational focus on the importance of H&S.



Image courtesy of SFRS Corporate Communications

Policy

54. The SFRS, like many large organisations, has a plethora of documents for delivery of its business objectives. Among these are numerous documents that relate specifically to H&S. During our data request we accessed over 111 documents that contain in excess of 3,000 pages. The volume of documents was routinely discussed during our fieldwork and this discussion included document size and suitability. Some documents have similar titles to others and there appear to be opportunities for some documents to be combined. There is limited end user engagement in the design and content of documents and processes, and this may explain why some documents and processes are perceived not to be ‘user friendly’.
55. During discussions on language and terminology within these documents, we asked about the role of the ‘Risk Owner’. Despite a definition of this role being included in all H&S documents, some staff below the most senior levels were uncertain of who the individuals are or what role or post was accountable, and how those responsible would be held to account.
56. The Service recognises that the scale and size of its administration and the volume of policy and procedure documents has an impact on operational Service Delivery staff. Unless steps are taken to radically redress the current position, safety-critical information may be missed due to the volume of information required to be routinely absorbed by operational staff.
57. The Service has commenced a number of projects to address this issue, including the Document Conversion Project. This however, is not a quick fix and currently is only being applied to policies and procedures within the Operations function.

Recommendation 1 – The outcomes of the Document Conversion Project currently being carried out in the Operations function, should be evaluated and the benefits extended to other SFRS Directorates, including Training Safety and Assurance (TSA).

Leading and managing for health and safety¹⁰;

‘There is a need for a sensible and proportionate approach to risk management, in short, a balanced approach – this means ensuring that paperwork is proportionate, does not get in the way of doing the job, and it certainly does not mean risk elimination at all costs.’

Judith Hackitt, HSE Chair, Page 14/62

¹⁰ [Managing for health and safety \(HSG65\) \(hse.gov.uk\)](https://www.hse.gov.uk/hsg65/)

Do – Management Arrangement, Systems and Practices

Structures across the SFRS

58. The SFRS is a very large organisation with approximately 7,900 members of staff. There are seven Directors who are accountable to the Chief Officer. The H&S function sits within the TSA Directorate and has twenty-two members of staff and the Operations Assurance team a further seven. There are specialist and multi-disciplinary functions within headquarters and SDAs. It is organised to deliver its services and functions by using line management and hierarchal structures from headquarters through to SDA and LSO areas.
59. We recognise in this report that recent organisational restructures have been viewed in the main positively. The Service should however ensure that structural changes do not occur too frequently as they can be unsettling, and at times lead to disruption for teams and individuals. Re-structures should be embedded and evaluated prior to further changes to reduce any potential negative impact.
60. Whilst each SDA has allocated H&S advisors to manage H&S issues locally, the resources vary across each area. Because the structure is similar in each SDA, this assists staff who move from one SDA to another to have a consistent understanding of arrangements.
61. The Head of H&S advised us of a desire to further re-structure teams within their control. When we spoke with the OA team, members acknowledged that operational staff do not fully understand the different roles undertaken by the H&S and OA teams. They accept that there are some H&S challenges to ensure actions and recommendations are prioritised and closed appropriately.

Area for Consideration 5 – The SFRS should ensure that staff understand the roles and the functions of specialist teams; such as OA and H&S, particularly those working within the RVDS staff groups.

62. We believe these teams are fully aware of the areas that would benefit from improvement. Following an evaluation of the arrangements; adapting the delivery model that relates to OA and H&S should meet the needs that have been identified.
63. The SFRS has a number of staff groups and many have different working conditions. It is disappointing to note that some SFRS support staff and teams have a poor understanding of the role of Volunteer Firefighters. It was positive, however, to hear that the OA team was developing an engagement process with all fire stations to develop mutual understanding, and improve awareness of the role of the team. The team will also ensure that all staff are aware of the processes that are required to be used by all operational personnel, to drive operational learning and improvement.

Guidance Documents

64. The Directorate H&S team is proactive in the development of new policies and procedures for all staff. The specialist nature of the operational response environment is such that there is a need for the H&S team to work closely with other specialist teams including Operations, OA and Training. Development of policy and procedure and other such information is best done in a collaborative way, appropriately engaging with the end user, and should be tested to ensure that the guidance can be actioned in the operational environment.

Area for Consideration 6 – The SFRS should ensure that H&S Policies and Procedures are designed, developed and tested in conjunction with all duty systems prior to issue.

65. Whilst the range of guidance documents in use is extensive, the design of these documents is not always consistent and does not always focus on the needs of the end user. Document types include: policy and procedure, management arrangements for H&S, Urgent Instructions, Service Delivery Alerts, Safety Bulletins, Awareness Briefings, task cards, etc.
66. During our inspection we found many documents to be significantly large in size and complexity. Long and complex reference documents would benefit from a flow chart or similar to assist the user. If the recipients of this information are expected to remember safety-critical information, then information must be clearly and readily identifiable. All information that is required to be referenced should be made available to staff in an easily understood format via mobile data devices, individual notebooks or by some other means.
67. The SFRS has a large work force. Approximately 80% of its Community Fire & Rescue Stations operate with part-time 'On-Call staff' working the Retained Duty System (RDS) or Volunteer Duty System (RVDS). RVDS personnel have limited time available for station-based activities. The design and size of policy and training packages do not match the time available to these staff groups. The SFRS is reliant on its RVDS workforce to deliver its statutory duties and should look at the organisation 'through that lens' when designing and producing its documentation and training materials.
68. During our interviews we asked staff 'which documents had the highest priority?' Some identified 'Urgent Instruction' as the highest level, however, none were able to prioritise beyond that point and many were unclear on any level of prioritisation of the documents discussed.

Area for Consideration 7 – Documents that contain safety-critical information should be readily identifiable to the relevant staff. There is a lack of clarity on document types and their importance relative to each other, this and the volume of documentation leads to information overload and could place staff and the organisation at risk.

69. We understand that the SFRS Operations Department has been looking at the structure and content of their documents via the Document Conversion Project mentioned previously. We think it important that this work delivers documents that are

more suited to the needs of the end users. The outcomes of this piece of work should be evaluated to see if the principle could be used across the Service and expanded to all departments. There is a real risk that individuals are left feeling overwhelmed by the expectation placed upon them to digest all the documentation.

70. We found that many staff think that policies and procedures are not only too long, but also too prescriptive and complicated. Many think that generally, documents are not designed to meet the needs of RVDS staff or specific staff groups like Operations Control (OC). Having reviewed many documents in preparation for this report Inspectors can fully understand this point of view.
71. While policy documents have review dates, many of the reviews are, in our opinion, excessively long (up to nine years from date of issue). Although review dates are part of the documentation formatting, as advised, they are not based upon any clear rationale and are inconsistent in application. Reviewing and updating policy is an important management function, reviews should be completed at a time commensurate with their importance; review dates should not be applied on an ad hoc basis.

Area for Consideration 8 – The SFRS should take steps to ensure that the frequency of H&S and OA audit and review stated in policy, is aligned to available resources and capacity.

72. The SFRS shares and receives H&S documents from outside of the organisation. During our inspection we were shown documents from the HSE, National Fire Chiefs Council (NFCC) central programme office etc. These documents are used to develop organisational learning and improvement as necessary.
73. We were pleased to see the SFRS senior post holders sitting on NFCC H&S groups working with the broader UK-based fire sector. In the summer of 2022, the Chief Officer of the SFRS was appointed as the NFCC lead for H&S.
74. As NFCC lead he is keen to ensure that H&S is not seen as a standalone subject but integrated in all FRS business, by building and developing the relationship with Occupational Health leads, he sees a link between H&S and Occupational Health.
75. During our discussion with the Chief Officer we spoke about national and sector H&S priorities which included: PPE, contaminants, and performance indicators. We agreed that the development of a set of performance indicators for the purpose of benchmarking would be beneficial, although this will be challenging given the differences in scale, activity, demand, risk etc. across the UK FRS.
76. The appointment of the SFRS's Chief Officer into this lead role should help ensure that the SFRS and the devolved administrations have a more visible presence at the NFCC. This should ensure any focus on relevant issues across the UK are appropriately influenced by the devolved administrations.
77. We anticipate this lead position will develop a stronger service focus on H&S as well as a drive to improve H&S across the Fire sector.

Good Practice 4 – At strategic level the SFRS has a good understanding of its duties, with regard to H&S and has a comprehensive suite of documentation to support its H&S objectives.

Responding to Emergency Incidents

78. The SFRS receives emergency calls into OC rooms located in three locations across Scotland: Dundee, Johnstone and Edinburgh. A new mobilising system is due to be installed in 2022/23 to replace the disparate legacy command and control systems. Part of the call handling process includes selecting a pre-determined attendance (PDA), which is the initial resource allocation for a given incident type. OC staff are able to adjust the PDA based upon their own risk assessment and the additional information received during the call handling process. This early assessment assists in the management and reduction of risk to responding crews.
79. The importance of the introduction of the new mobilising system should not be underestimated as it provides the link between communities, the SFRS and those responding to an incident, including other emergency responders. HMFSI has not explored any H&S issues that may emerge from this project, but we recognise the significance of the system in providing responders with accurate timely information, and giving re-assurance and confidence to those seeking assistance during an emergency.

Safety Culture

80. Operational staff who were interviewed were unclear of the SFRS's risk appetite. There is a perception by some operational crews that the Service is risk averse. This belief, and the resulting confusion, was supported by the inconsistent responses we received during our discussions with crews over subject areas such as; Operational Discretion, Firefighter Safety Resource and the Firefighter Safety Maxim. Incident Commanders and crews need to understand what the organisation's appetite to risk is to assist them in making command decisions in dynamic environments. This could be included within the Incident Command training (Level 1 to Level 4) to stimulate discussion and assist in a uniform and consistent understanding of risk appetite.

Area for Consideration 9 – Incident Command training should include the development of the understanding of individual and organisational risk appetite and the implications of its application at operational incidents.

Firefighter Safety Resource

81. The SFRS introduced a Firefighter Safety Resource (FSR) following the significant event investigation and debrief process that followed a tragic incident in 2009 which sadly resulted in the death of an operational firefighter.
82. Utilising the FSR at incidents, allows for a dedicated managed resource that has the objective of creating and maintaining an 'alternative withdrawal plan' for crews on the incident ground, greatly supporting firefighter safety. The resource provides Incident Commanders and crews with the assurance that even in the most complex incidents the maintenance of egress for crews is being considered throughout the development of an emergency incident. These arrangements are not utilised across the whole fire and rescue sector in the UK.
83. While this provision requires the use of an additional fire appliance and crew, the concept to manage a specific risk area on the incident ground is logical and well received by crews. Staff in urban areas are generally more familiar with the term FSR and what role it plays than staff in the rural parts of Scotland. Some crews we interviewed had been used for the FSR function at an incident and spoke positively about reducing risk to colleagues.
84. We are pleased to note that OC staff as part of the incident resolution process are responsible for nominating an appliance and crew as the FSR, and are integrated in the debrief process to ensure any lessons learned are shared.

Good Practice 5 – The adoption and provision of a dedicated Firefighter Safety Resource to certain incidents enhances Firefighter safety throughout Scotland. The SFRS should consider sharing information regarding these arrangements across the UK via the NFCC.

Use of Operational Discretion

85. Operational Discretion (OD) is generally well understood across the SFRS but we did find gaps in knowledge. Some staff interviewed, working across all duty systems were still unfamiliar with the term and its application.
86. During the interviews we found a few members of staff who had used OD at incidents and there was some confusion on what actions and activities would constitute OD. Most staff were aware that once OD is declared, OC creates a record of the event. Most of the staff we spoke with were not aware of the processes that follow and how OD is used to adapt systems of work and guidance.
87. All OD that is declared within the SFRS is monitored via OA and feedback is provided to those involved. The way this feedback is delivered will hopefully ensure OD is used when required and is not seen as a hindrance to command decision making.
88. We discussed OD with the HSE and were pleased to note that the HSE has no specific concerns about the application of OD within the SFRS.



Image courtesy of SFRS Corporate Communications

Risk Assessment Process

89. The Risk Assessment (RA) process is a significant contributory factor in managing safety on premises and at emergency incidents, and it forms an established part of the work of teams in the SFRS.
90. We are aware from our interviews that the quality and consistency of RA varies across the Service. In some areas the lack of station and off station training RAs, prevents crews from undertaking realistic training in 'off station' locations and is seen as a barrier to effective training.
91. The difference between and application of 'dynamic risk assessments (DRA)' and 'analytical risk assessments' (ARA) is relatively well understood, but we are aware that the debrief process has identified the lack of a written ARA as a repeated weakness in resolving complex incidents. The Learning Content Management System (LCMS) packages that cover ARA and DRA could be improved. The training packages are a repeat of the management arrangements, and are seen as too time consuming for RVDS crews to complete on their training night, and are not specific on why and how to complete the ARA documentation.

Recommendation 2 – The SFRS should revise and amend the LCMS packages on ARA and DRA to ensure that they focus on why and how to complete the documentation, ensuring the content is suitable for all Operational staff.

Firefighter Safety Maxim

‘At every incident the greater the potential benefit of fire and rescue actions, the greater the risk that is accepted by commanders and firefighters. Activities that present a high risk to safety are limited to those that have the potential to save life or to prevent rapid and significant escalation of the incident.’

This statement is known as the Firefighter Safety Maxim

92. During our fieldwork, we asked operational crews to explain their understanding of the ‘Firefighter Safety Maxim’, as it is important for assessing personal and organisational safety and exposure to risk at operational incidents. These components contribute to an understanding of the risk appetite of the SFRS at an organisational, team and individual level.
93. The responses we received varied significantly with some staff having a good understanding and knowledge while others had never heard of the term, which was quite concerning. However, once we discussed the subject in more detail around various scenarios and examples, it was apparent that most staff had a basic level of understanding of the concept and application in their own form of words and in practical terms.
94. The lack of knowledge and awareness around this area reinforces our comments with regard to the importance of the need for appropriate support and supervision, and the need for effective and suitable H&S training for all duty systems. Incident Commanders and crews need to better understand the organisation’s appetite for risk when making command decisions in dynamic environments. Some operational crews believe that the SFRS is ‘risk averse’ which could in turn influence their own thought process with regard to making operational decisions.

Area for Consideration 10 – The SFRS should ensure a consistent level of understanding of the ‘Firefighter Safety Maxim’ and how it links to the organisations risk appetite.

Personal Fitness and Standards

95. It is recognised that the work of firefighters can be dangerous and preparing firefighters physically and mentally for that environment should be part of a whole systems approach. Personal fitness is an important factor for firefighters, affecting their ability to undertake their duties.
96. There is an agreed national standard for benchmarking the level of fitness for firefighters and those responsible for managing them. This standard is used within the SFRS, however, staff are only tested every three years. Many FRSs in England and Wales test their staff annually and some more frequently.
97. In the SFRS H&S Annual Report 2018/19, there was significant reporting of fitness assessment outcomes of SFRS staff. However, in the subsequent 2019/20 report there is no equivalent information. We are advised that this is due to the responsibility

of monitoring and reporting fitness now being the responsibility of the health and wellbeing team. This creates a potential area of weakness where the earlier reported data may not be given the appropriate level of priority as the health and wellbeing function does not sit under TSA directorate.

98. As reported in the Health, Safety and Wellbeing Annual Report 2018/19¹¹ (page 42), of the 2,255 Firefighter, Crew Manager and Watch Manager roles that completed assessments, only 71% (1,607 out of 2,255) of individuals attained a result equal to or above the optimal standard for their role. This meant that 29% of staff were below achieving the optimal level of fitness. The Volunteer Duty System staff group had the lowest level of performance.
99. The fitness standard can be achieved without the need for gym access or specialist equipment. The test can be conducted using available operational equipment, measured against agreed standards. Therefore we feel the SFRS should consider more frequent testing and assessment.
100. As part of this inspection we analysed the data relating to accidents and injuries. Manual handling/body movements (Musculoskeletal (MSK)) injuries account for 36% (77 out of 212) of the total events reported. And 38% (29 out of 77) of all manual handling/body movement injury occurs during training.
101. We understand that a MSK working group exists within the SFRS with the intent of reducing MSK risk and injuries. The membership of this working group is not clear and those role holders within SDA areas responsible for H&S were unsure of the priorities of the group. MSK events are significant and lead to staff absence and cost to the organisation.
102. Disappointingly, we were advised by managers that the MSK working group had not met for 12-15 months. This is at odds with what we originally heard from more strategic staff and would indicate a disconnect across the organisation. However, we understand the support systems for staff who suffer a MSK injury have been recently reviewed with a Scotland-wide approach now in place to provide external physiotherapy support services to all staff if required.

Area for Consideration 11 – The MSK working group should be reinvigorated to address and reduce the number of MSK injuries among operational staff. Operational staff should also be made aware of the membership, remit and outcomes of this group.

103. The Service has high levels of reported accidents and injuries occurring during training, 35% (69 out of 195) in 2019/20; although this is 5% lower than the previous reporting period. The number of injuries and particularly the similarity of injuries should be of concern to the Service. The sustainability of the organisation to learn from previous events is important. When we spoke with the OA team about these figures they were not fully aware but stated ‘they have no formal arrangements to audit training’. The lack of any internal arrangements should not be a barrier to any audit

11 [hsw_annual_report_2018_19.pdf \(firescotland.gov.uk\)](#)

function taking place. Responding to trends will assist understanding and investigation of the causes of such events, and will assist in lowering the likely occurrence and the impact on staff.

Area for Consideration 12 – Many H&S events are similar or reoccur to those previously investigated. The Service needs to be assured that actions previously identified from the event investigation process are addressed and followed through within appropriate timescales.

Welfare of Staff at Operational Incidents

104. In an operational context the SFRS exists to respond to emergency events and has limited control over the demand profile for its services. The country's geography and the demographic disposition of the population adds to this complexity. Some incidents, such as wildfires or other large or protracted events, can require a large amount of physical resources. We are advised that at some incidents, staff have had little rest before being re-committed to the incident. Welfare facilities for rest and replenishment (food and hydration) have been described by some members of staff as 'insufficient' or 'inadequate' in some areas.
105. During our fieldwork, staff commented negatively about the frequency and adequacy of the welfare arrangements available, particularly the use of Welfare Pods. Many suggested the previous legacy arrangements were better. Some staff suggested that welfare arrangements should be triggered as part of the mobilising arrangements but were reluctant to escalate this suggestion due to their belief that little would be done.

Area for Consideration 13 – The SFRS should consider the suitability, use, provision and deployment of welfare arrangements, particularly regarding the availability and use of Welfare Pods.

106. Throughout our fieldwork staff were not only raising concerns but providing solutions that appeared reasonable. There was, however, a sense of frustration that the collective experience of station-based staff wasn't being fully utilised to resolve local issues.
107. This was a re-occurring theme from staff at fire stations: they either felt that they didn't have contact with FDOs to raise these issues or were unwilling to escalate issues themselves as they felt nothing would be done. We understand that there are other opportunities for staff to raise and discuss concerns and issues, however, these arrangements are either not trusted or not utilised.

Area for Consideration 14 – The SFRS should seek to understand why staff are unwilling to report and escalate H&S related issues appropriately and why they perceive that there is a lack of feedback. The Service should also utilise the collective creative capacity of the workforce to stimulate innovation and ideas.

108. We have also been made aware that some FDOs are required to travel significant distances prior to taking command roles at operational incidents, then, once relieved, are expected to travel back to their office or home address without any risk assessment being recorded to ensure they are able to do so in a safe manner. This should be addressed. However, we found no specific evidence to show that welfare arrangements had a direct impact on the number of H&S related events.

Area for Consideration 15 – The SFRS should ensure that FDOs comply with the Occupational Road Risk Management Arrangement (ORRMA) policy and carry out a risk assessment (recorded) post operational incidents, prior to travelling back to home address, where they may have travelled a significant distance, to ensure their fitness to travel. The expectations placed on FDOs at incidents should take into account the need for fitness to travel.

Organisational Risks

109. The Service has a duty under the Fire (Scotland) Act 2005 (Chapter 2 sections 9 (subsection 2 (d)), 10 (subsection 2 (d) and 11 (subsection 3 (c) (iv)) to make arrangements for obtaining information to discharge its duties.
110. The SFRS has a strategic risk register that is regularly updated and reviewed and shared with the SFRS Board. LSOs are responsible for Local Fire and Rescue Plans and these are shared and agreed at local authority level with partners.
111. We are not aware of any significant specific H&S issues contained in any of these documents, albeit that generic risk relating to H&S is addressed. However, we are aware that as part of the SFRS 'Service Improvement' work there is significant work being undertaken in developing the Community Risk Index Model (CRIM). The CRIM is expected to identify the risks and resources needed to deal with current and future risks. This project will potentially have significant impact on location and resource models for the Service and will no doubt impact on the management of H&S at both fire station and community level and how the Service responds to emergency incidents in the future. Until this project achieves its first milestone in March 2023, we are unable to comment upon the impact this piece of work will have on Operational H&S.
112. When we discussed with staff the key operational risks faced by the SFRS, the response was generally consistent. Staff identified Breathing Apparatus (BA) in compartment fires, Incident Command, Marauding Terrorist Attacks (MTA) and Water as the highest levels of risk faced by firefighters. We acknowledge that the current areas of priority for the Service includes dealing with MTA incidents and the links to national terms and conditions of employment. Although the MTA risk exists, it is seen as a low risk outside major city areas, and the reason MTA was quoted so often was perhaps due to the recent focus and local arrangements that were put in place for the COP 26 event. As mentioned elsewhere in this report, attrition rates, reduced experience and knowledge are ongoing issues. Ensuring staff are trained to deal with current and future risks is of primary importance so that safety is kept as a high priority.

Community Risks

113. Fire station-based personnel understand and train for risks in their area and also train for large scale national events. The operational risk information which is collected and then made available to staff is a significant contributor to managing H&S. This information is stored on an electronic tablet (GETAC) that is mounted on front line fire appliances (but can be removed and used on the incident ground) and gives crew access to information. We were made aware that the GETAC tablets that hold this information on fire appliances were not always functioning as expected. Staff were concerned with the need for security passwords that were required to be changed frequently, and this was seen as a barrier to accessing the tablet at incidents. HMFSI appreciates that, due to the sensitive nature of some of the information contained on the device, there is a need for password protection.
114. We were given examples where the GETAC tablets were being charged off the appliance using station power sockets, which would then need to be taken on to appliances if mobilised. Information on the tablet is updated using Wi-Fi connection, we were advised that some GETAC tablets need to be moved to a certain location within the station curtilage to enable them to be updated. Staff also raised concerns that the devices lack certain types of information, for example, the lack of crash and safety system data.
115. Issues relating to the GETAC tablet have been highlighted previously in the HMFSI report on the SFRS's arrangements for the provision of operational risk information¹².
116. We raised these issues with managers during our fieldwork and were advised that the Service was aware of these concerns. This supports our suggestion that those making decisions are at times unclear or unaware on individual or corporate accountability, as mentioned previously within this report.

Recommendation 3 – The SFRS should ensure that risk critical information provided to crews via the GETAC tablet is easily accessible when required, up-to-date and the information available suitable for all foreseeable incident types.

117 Staff within the SEBS are knowledgeable about the risks within their area this is

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- A dramatic night scene showing a firefighter in a bucket reaching into a massive fire. The fire is intense, with bright orange and yellow flames and thick black smoke billowing upwards. The firefighter is silhouetted against the bright light of the fire, holding a hose. The bucket is extended high into the air, and the firefighter is positioned near the top of the bucket. The overall atmosphere is one of intense action and bravery.

Welfare and Wellbeing Culture

119. Staff interviewed as part of this inspection were complimentary of the positive way that senior leaders had addressed welfare issues related to Covid-19, and how mental health wellbeing was now being discussed and recognised at all levels.

Good Practice 6 – SFRS senior managers are viewed positively by staff in promoting a strong H&S culture throughout the organisation, with a strong focus on mental health and wellbeing.

120. The Post Incident Support Policy (PISP) was mentioned by many as a positive way to actively support staff. The policy is designed to support operational staff by providing external psychological support services where required, after a traumatic incident. The process is initiated by the watch management teams of personnel who have attended such an incident.
121. A number of FDOs stated that PISP was a positive contributor to welfare, however, they were not always given informal welfare support by their line manager if they had been the most senior officer at an incident, and would be expected to trigger the PISP themselves. This self-referral process creates a gap in the support available to some Incident Commanders.

Recommendation 4 – The SFRS should ensure that the Post Incident Support Policy and Procedure is amended so that triggers are in place and are activated automatically to support all levels of operational staff attending relevant incidents.

122. Generally, staff think that the Service has moved away from operating a culture of blame by hindsight. The current management approach, driven by a ‘no blame’ culture, is well received by staff, although there still remains some suspicion, among those interviewed, that ‘someone will be chasing you’.
123. We were told by some operational staff that new entrant and trainee firefighters were not encouraged to think for themselves, that their previous life experience was not valued. Some felt that they were not trusted to make decisions without seeking permission. Failure to use the collective knowledge of all the workforce may be a reason for some reporting concerns and cultural issues which we refer to within this report.

Area for Consideration 16 – The SFRS core value of ‘Teamwork’ could be embedded further throughout the organisational processes to ensure new entrants are encouraged to utilise personal skills and experiences. Ensuring people can be themselves, will encourage broader diversity.

124. Some of the FDOs interviewed advised us that they had on occasion felt a moral obligation to remain on duty, even if they were tired or exhausted. This was due to an awareness of officer fire cover availability, where taking time off would impose an increased burden on their colleagues who were on duty. This was particularly emphasised in the North SDA. The number of FDOs, working hours and duty system may be a contributing factor to wellbeing issues. We were not told of any organisational monitoring of individual working hours to ensure managers have appropriate rest periods. These issues could increase H&S risks to this staff group.
125. There is acknowledgement from very senior managers that the workload of some managers are very demanding, and can lead to potential welfare and wellbeing issues. Whilst this is a difficult issue to discern, the Service should consider what work could 'stop' or be delivered differently.

Area for Consideration 17 – Working hours and rest periods are covered by primary legislation and should be actively monitored to ensure all operational staff have adequate rest periods.

Impact of Covid-19

126. HMFSI recognises the impact Covid-19 has had on the way the SFRS has been able to deliver against its statutory duties. Inspectors undertook a review of the SFRS's planning and preparedness for Covid-19¹⁴ in December 2020 and reported the findings to the Scottish Government.
127. The impact of Covid-19 is well understood by Inspectors and we recognise that it will have had an effect on a number of issues covered by this report and will have added delay and slippage to progressing work.
128. Covid-19 is likely to be a factor in planning going forward and the SFRS should identify areas of business that have been impacted and put in plans to remediate any concerns.

¹⁴ [Update on the Scottish Fire and Rescue Service's planning and preparedness for COVID-19 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/updates/2020/12/20201220-scottish-fire-and-rescue-service-planning-and-preparedness-for-covid-19/pages/2/)

Check – Monitoring and Reporting

Monitoring Arrangements

129. Significant time is spent by managers in SDAs following up action plans related to H&S matters. Whilst this pro-active monitoring is good to see, we think that there is much duplication of effort, with too many monitoring systems being developed and used locally. We found examples of managers having their own ‘local action plan’ monitoring systems.
130. While the monitoring arrangements of action plans is contained within management structures and the reporting mechanisms throughout the Service, we found that actions within plans were not always understood. This was attributed to a lack of early engagement, and the language used was blamed for adding delay, confusion or misunderstanding.
131. Whilst the TSA Directorate assured us that one to one discussion is offered, and provided, and that all action plans are agreed with the risk owner via the SASG and NSAB, some managers stated they did not ask for clarity in case they were seen as incompetent. This is their perception of negative cultural issues that are linked to issues across the Service regarding escalation and challenge.
132. There is recognition that the TSA Directorate is working positively to manage H&S issues that are identified. Actions within plans can be delayed if there is disagreement on the level of evidence provided by the end user, and this can at times lead to all parties becoming frustrated. The challenge for all is to ensure that evidence is suitable, proportionate and adequate and that issues are not seen as a box-ticking exercise.
133. The SFRS communications team plays a part in the construction, content, distribution and monitoring of some documentation. It has good oversight and understanding of how those communications are received and reviewed by staff. The team does not control or see all communications from departments so understanding is not complete.
134. We were told how the communications team view the SFRS ‘weekly brief’, which is circulated on the intranet, as a key Service document and how communications materials can also be accessed using personal devices.
135. It is vitally important that staff involved in the delivery of key messages, particularly in relation to H&S specific matters, have a full understanding of the working patterns and limitations associated with all duty groups. Our inspection fieldwork led us to believe that some confusion existed among some communications team members over the difference between the VDS and the RDS. Failure to understand the needs of any specific staff group will mean that communications cannot be directed and tailored to their specific needs.

Performance Systems

136. The TASS event recording system has replaced the RIVO software system. Both systems record safety events and investigations. System users indicate that the new system performs better than the RIVO system, although there is limited practical experience of the TASS system by the users we engaged with during our fieldwork.
137. We understand that following the rollout of TASS there were concerns about the access levels to events reported on the system, this led to the system being restricted e.g. access to reports. We have been advised that the ICT team are close to resolving those issues and the expectation is that access will return to the level originally planned. The management decision to restrict use of the system to certain roles, is understandable and we recognise this decision is a contributory factor with regard to the limited use. A number of members of staff suggested that if they needed to use the system they would refer this to their H&S lead, this clearly could add to the workload of those role holders. The H&S team acknowledge that there is a lack of user understanding of the system and intend to produce a flow chart to assist and support staff.
138. We witnessed significant use of data throughout the H&S working groups at all levels and saw data graphics displayed on a number of H&S noticeboards at fire stations, which was very encouraging. Data was also incorporated within documents with many managers using this as evidence of improved performance.

Good Practice 7 – The positive use of data and visibility of up-to-date H&S information at fire station level raises awareness and embeds a positive H&S culture.

139. When we asked managers about the activities that were contributing to improve H&S performance, there appeared to be a lack of understanding among some staff interviewed. We accept that the current reported trends and data indicate that H&S measures are moving in a positive direction, this is welcomed. The SFRS must, however, understand what it is doing to cause the improvement to allow it to continue investing in those activities that are making a positive change.

Area for Consideration 18 – The use of data to support decision making should be complemented by understanding ‘why’ and ‘how’ the data was used to make the decision.

Area for Consideration 19 – The Service should take steps to ensure that staff fully understand the relationship between the activities they undertake and the improvements made in performance.

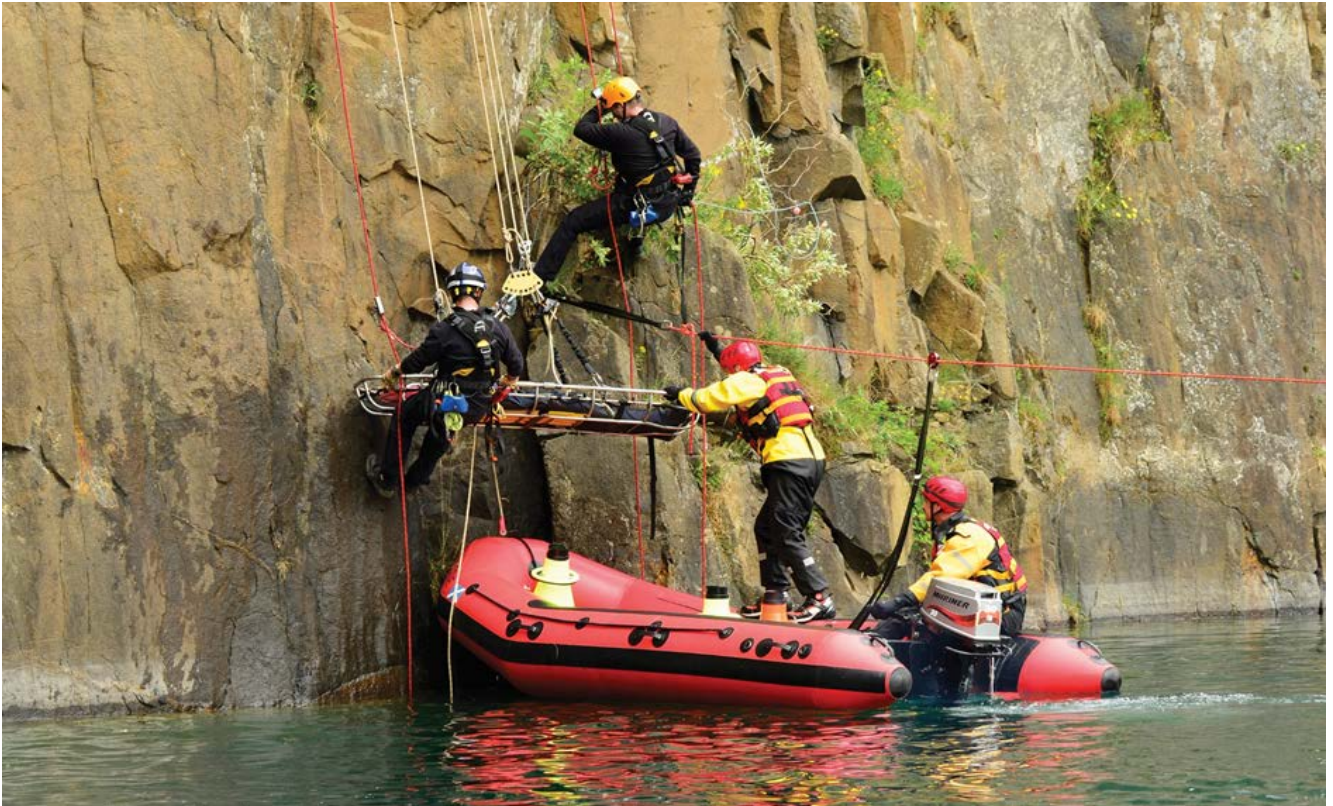


Image courtesy of SFRS Corporate Communications

Recording and Reporting of Incidents Including ‘Near Miss’

140. As stated above, many of the staff we interviewed had little exposure to the TASS H&S event recording system. Those that had some experience of the new system found that it was an improvement from the previous RIVO system. We were made aware that since going live the system is still being adapted to provide different levels of access for managers, and resolve some other technical issues that have been identified.

Good Practice 8 – The event recording system (TASS) is seen by staff that utilise it, as an improvement on the previous system being more user friendly and with increased functionality and access to data.

141. When we discussed the understanding of the term ‘near miss’ and how this should be reported, we found in most areas of the Service that this was well understood. We then asked, when was the last time anyone reported a ‘near miss’? We found that these types of event were rarely reported. In fact no one we interviewed could recall reporting a ‘near miss’ in the past year.
142. Exploring the reasons for this, staff suggested that reporting events would add significant work for supervisory managers and there would be additional work/administration for all parties. There was also a belief among some that this could result in blame being apportioned and action taken. Another common reason given was that the reporting process itself is too complex and is restricted to supervisory managers and above.

143. While managers recognise the importance of 'near miss' reporting and accept that the low levels of reporting 'near misses' was not ideal, the gap in the organisation's understanding of these issues is not being captured. The reason for low reporting is a weakness and should be addressed.

Recommendation 5 – The SFRS should identify the cultural barriers that prevent staff reporting 'near misses'. The 'near miss' recording systems, should be accessible to staff and encourage ease of use to improve and encourage reporting across the organisation.

144. We are pleased to note that in the H&S Annual Report 2019/20, 'near miss' reporting continues to increase across the three SDA areas. We note that 'Operational near misses' accounted for 36% (71 out of 199), 'non-operational activities' accounted for 30% (59 out of 199) and 'training activities' accounted for 35% (69 out of 199) of the total events reported.
145. The most common reported 'near miss' events involve BA related training, 40% (28 out of 69) with 71% (20 out of 28) occurring during SDA led training.

Event Investigations

146. The SFRS has detailed policies, procedures and management arrangements for the investigation of H&S incidents. The investigations are categorised in line with policy and investigated by a person of suitable role. Reports that are categorised as Level 3 or 4 incidents have recommendations quality controlled and scrutinised by the Safety and Assurance Sub Group, and then presented to the NSAB for approval and monitoring.
147. Whilst there are timescales for events to be investigated, and controls are in place, there can be a significant delay in reports being presented to NSAB, some up to 18 months after the occurrence. This can be due to the investigating officers balancing competing work demands on the time available. The delay in progressing these reports and their actions could place others at risk and high priority learning should be identified and shared to reduce harm to staff.

Area for Consideration 20 – The SFRS policy on event investigations should be amended to allow completion of investigations within agreed and achievable timescales with the necessary resources allocated to complete.

148. Inspectors are aware that the SFRS uses safety notices to raise awareness of specific H&S risks, however, we are concerned that the overall level of information received at fire stations may in some way diminish the perceived level of importance of notices.
149. In the H&S Annual Report 2019/20 the Service is aware that only 42% (15 out of 36) of Level 2 to Level 4 incident investigations were complete. This should be of concern to the SFRS. We are aware, that the H&S Directorate are looking to provide dedicated resources for completing Level 3 and 4 investigations.

Training and Recording

150. Since, the first Covid-19 lockdown in March 2020, the SFRS has reduced the exposure of its workforce to personal harm and contact by reducing training sessions. This was part of a number of control measures put in place and reviewed in line with the continually evolving government guidance.
151. RVDS staff were allowed to train in smaller groups to aid resilience. However, we found that there were examples of staff coming on to station to train without appropriate levels of supervision and management. The impact of these changes and the effect to the knowledge and understanding of staff has not been assessed. We understand this was due to vacancies in supervisory roles within some RDS stations.

Area for Consideration 21 – The SFRS should carry out an evaluation exercise that considers the impact of the pandemic with regard to RVDS staff training in small groups, with limited supervision and support. The SFRS should develop a plan that prioritises any training slippage for RVDS staff caused by Covid-19.

152. We were given assurance during our interviews that the SFRS had prioritised a number of critical training areas including Incident Command (IC). When we engaged with the Incident Command team we were advised that command competence had been managed effectively and that the Incident Command Level 1 (ICL1) plan 2020/21 had been effectively delivered.
153. The IC team was able to show the level of ICL1 training from April 2020 to March 2021 was:
- 12 courses run
 - Total capacity 120 delegates
 - Total attendees 115
 - This is a 95.83% attendance achieved during Covid-19 which is very positive.
154. The Service is reliant on PDRPro (personal development records for staff) to monitor competency and compliance of its Operational staff. We were told by RVDS staff, that during 'business as usual' there is insufficient time to complete all the training required.
155. We heard repeatedly from senior managers that staff had a lack of experience responding to complex incidents and that training for safety-critical events was, and will be, hugely important in individual development. There is concern that a lack of realistic training and little developed understanding of risk and hazard perception could lead to a future organisational risk. This should be of real concern given the recent and future attrition rates.
156. Training should be blended to include a balance of both practical and theoretical elements to prevent knowledge voids appearing which in turn may lead to increased levels of injury and events.

Competence of Staff

157. The loss of skills and experience at all levels is an increasing issue throughout the fire sector in the UK and its impact is significant to the SFRS. HMICFRS in England identify in their report 'State of Fire and Rescue 2021' that many services in England are failing to establish adequate succession plans for future leadership. This included; a lack of workforce planning, planning for future leaders and a lack of development opportunities for RDS (On-Call). SFRS has similar issues to address.
158. Evidence generated from our data analysis and fieldwork, indicates that there are numerous operational staff requiring basic H&S training beyond that provided on the initial trainee firefighter course (we understand 45 minutes is dedicated to H&S).
159. The data supplied to us in June 2021 suggests a reduction in the number of staff who have qualifications or training issued, or accredited by, the Institution of Occupational Safety and Health (IOSH) or National Examination Board in Occupational Safety and Health (NEBOSH). Many staff who have qualifications have not been re-accredited or updated since the qualification was originally gained. We contacted IOSH and received the following advice, 'with IOSH Managing Safely, there is no expiry date on the qualification however it is recommended to take the refresher course within three years of the original'. The information supplied to us indicates the SFRS has a desire to follow this recommendation as they include a renewal date for qualification within the data provided.
160. The number of staff with H&S qualifications;

	Number qualified	Number within 3 years	% not re-accredited
IOSH (Managing Safely)	1347	308	77.1%
NEBOSH (General Certificate)	125	2	98.4%

Table 2 IOSH and NEBOSH qualifications

Area for Consideration 22 – H&S training and qualifications are integral to firefighters understanding of H&S and to service delivery. There needs to be a suitable continuous professional development program in place to maintain competence and ensure alignment to the good practice suggested by IOSH.

161. The Learning Content Management System (LCMS) contains a number of specific H&S packages. The general content of the LCMS system was described by some station-based staff and FDOs as too long and not suited to the end user. The content owners of these packages have detailed knowledge of their subject matter, however, they seem unable to always deliver the key messages to staff, especially those staff that have limited time available for training in the workplace. Inspectors reviewed

Competence¹⁶

‘Truly effective health and safety management requires competency across every facet of an organisation and through every level of the workforce.’

The health and safety of Great Britain: Be part of the solution
(www.hse.gov.uk/strategy/document.htm)

Resilience

166. All organisations have finite resources, a limited number of staff with the required knowledge, skills and understanding to deliver their work. The SFRS is no exception, however with such a large number of staff employed to deliver its response capability, it should be sufficiently resourced to ensure any deficiency in the service delivery model is minimalised.
167. There are a number of key roles within the SFRS that have responsibility for the day-to-day delivery of many of the legislative H&S expectations of the Service. FDOs and operational supervisory managers are key to monitoring and maintaining standards and expectations.



Image courtesy of SFRS Corporate Communications

168. The difficulty faced by SFRS however, is that a great number of its fire stations are crewed by RVDS staff and are located in remote, rural and island communities across a large geographical area. This makes it very challenging for the Service to assure itself that the appropriate level of managerial and supervisory staff are experienced, adequately trained and available to respond when required to do so.

¹⁶ [Managing for health and safety \(HSG65\) \(hse.gov.uk\)](http://www.hse.gov.uk/strategy/document.htm)

169. We have seen data that shows significant appliance non-availability at RVDS stations in rural areas and understand this has been consistent since the formation of the single service. This was perceived as a ‘risk to firefighter safety’ by station-based operational personnel during our interviews.
170. Recruitment and retention of RVDS staff is a UK-wide issue and impacts upon the SFRS significantly due to the large numbers of staff employed on these duty systems.
171. The differences between the role of a firefighter and station-based supervisory managers within RVDS stations is significant, due to a number of factors such as increased responsibility and administration. This can be a barrier in attracting suitable staff willing to undertake these positions. Without regular support and supervision, there is an increased risk of issues going unnoticed which may increase the risks to staff and those they serve.
172. Many staff, particularly at RVDS stations, report that they do not see or engage with FDOs routinely enough and that they do not feel able or willing to escalate issues and influence outcomes. This lack of visibility of FDOs is a H&S risk for the Service and staff. Risks include an inability to check the knowledge and competency of staff in regards to areas of operational risk, and an inability to ensure important information has been received and understood. This lack of visibility could be a reason for the inconsistencies in the H&S knowledge of some crews, both Wholetime Duty System (WDS) and RVDS that was witnessed during our fieldwork.
173. Where there are gaps in station-based RVDS supervisory management this places greater dependency and expectation on some supervisory FDOs who may have a significant number of RVDS stations to manage. Add to this the geographical distances which may be encountered, and the high attrition and recruitment rates at some stations, and it shows the problem and risks are potentially significant and should be risk assessed.
174. FDOs we spoke with appeared committed to visiting fire stations and supporting RVDS staff, however they have spoken about difficulties in balancing competing demands and it appears RVDS station visits routinely suffer as a consequence. We have seen the increased use of virtual meetings as a way to increase capacity, but this is not always possible, desirable or effective, and should not be seen as a replacement for face-to-face team engagement.
175. The increase in the number of rural RVDS Watch Commander support roles (now numbering 54) has helped staff at some stations to manage routine work, however these staff are not employed to manage or monitor other station-based supervisory managers and their staff.
176. The SDA DACOs and LSOs generally acknowledge the issues associated with RVDS staff and FDOs. However, we were not provided with significant assurance that any immediate plans are in place to deal with these issues. Other associated vacancy management issues, including the development, recruitment and training of staff to address these gaps are known, but finding a resolution without them further impacting

upon other areas of business is not clear. We note and welcome the SFRS future focus on Mental Health as stated in its H&S Annual Report 2019/20.

177. Attrition rates at all levels in the SFRS are high: vacancy management, and personnel development will be an ongoing challenge for the SFRS to manage effectively. In our opinion the loss of experience, skills and knowledge are a contributory factor in many H&S related issues. This includes reporting, investigating and accident prevention.

Recommendation 6 – RVDS staff should be provided with effective middle management supervision and support to ensure that knowledge and information is shared and staff assessed to the required standards.

Reducing Vehicle Movements and Vehicle Accidents

178. As part of a presentation delivered to the HMFSI team on Automatic Fire Alarms (AFA), we were advised that the SFRS continues to attend a large number of AFA incidents with 97% recorded as unwanted fire alarms signals (UFAS). These events represent over 31% of the total incidents the Service attends. UFAS necessitate approximately 57,000 unnecessary blue light journeys that impact upon firefighter and public safety. In April 2021, the SFRS adjusted its response model to this type of incident due to Covid-19 and has reduced blue light journeys by 21% in that period. It is anticipated that sustained change following the public consultation on the SFRS' future UFAS policy may reduce vehicle accidents by up to 29%.
179. A significant amount of time and cost is recorded against vehicle accidents. These are monitored and reported at all SDA H&S meetings and discussed ultimately at NSAB. Analysis from the H&S Annual Report 2019/20 reported that 56% (140 out of 249) of vehicle accidents occurred during operational activities, 33% (83 out of 249) occurred during non-operational activities, and 11% (26 out of 249) occurred during training, representing a 4% increase.
180. The 2019/20 H&S Annual Report stated that, the most common cause of vehicle accidents across the SFRS continues to be 'hit something fixed or stationary', accounting for 61% (152 out of 249) of the total reported, compared to 74% (178 of 241) when considering the previous reporting year.
181. A significant number of the reported vehicle accidents occurred at slow speed, with 80% (44 of 55) occurring while the vehicle was travelling forward. The SFRS has introduced fire station traffic management plans and promoted the use of driving assistants when manoeuvring vehicles. The trend and costs associated with these events is significant and more importantly these incidents could lead to personal injury.
182. The pressures to train adequate numbers of Blue Light Vehicle Drivers, Incident Commanders and other specialists is understood within TSA. We have not seen detailed plans which would address the potential organisational risk that exist and, therefore cannot comment on the suitability of any plans or proposals.

Provision of Equipment, Training and Documentation

183. During our visits we witnessed, and were informed of, equipment arriving on fire stations without the appropriate documentation. In some areas equipment would arrive or be left on site with no records of delivery. This equipment did not have the required technical information notes or periodic inspection and testing sheets. In other areas equipment would arrive with all associated documentation and training materials. The impact of this inconsistency is difficult to measure, with equipment often left unused and/or untested for some time. There is a risk that station staff could use equipment inappropriately and could potentially lead to personal injury or damage to the equipment.
184. We understand that when a product is to be procured, a Provision and Use of Work Equipment Regulations 1998 (PUWER) assessment is undertaken which determines how the product is rolled out and an implementation plan developed. The established process does not deliver the reliability needed and implementation is not always achieved. The inconsistencies should be resolved to reduce any future risk of personal injury or damage to equipment.

Area for Consideration 25 – The process for determining how new equipment is rolled out and implemented needs to be applied consistently to ensure it is delivered as expected.

185. We heard that staff think their new structural fire kit (PPE) was an improvement over its predecessor, and we understand that work is being undertaken to look at a fire tunic more suited for non-compartment fires and other related incidents. Securing a fire tunic for this purpose will be welcomed by operational staff and will be an aid to reducing fatigue and the potential for injury and heat stress, especially dealing with wildfires.
186. The storage of PPE on fire stations varies due to available space, however, there are still examples of PPE stored in appliance bays exposed to vehicle fumes. In general, however, the storage of PPE is positively managed. We were encouraged to hear staff describing a desire to reduce potential cross contamination by regular cleaning of their kit or separating it when returning to station away from the crew cab. This positive and proactive approach should be encouraged to activities beyond PPE.
187. The reliance on a paper-based system of standard test records is a risk to the organisation and is a weakness in the current testing and maintenance arrangements.

Recommendation 7 – The SFRS should consider introduction of an electronic asset management and testing solution, which would reduce reliance on paper records and limit organisational exposure and risk.

Organisational Learning

188. Elsewhere in this report we identify that there is little evidence of H&S data being used to support decision making at local levels. This may be linked to the decision making authority and accountability issues we previously identified. We have, however, seen significant effort by the SFRS to raise staff awareness to operational risk and hazards. As previously discussed, the Service uses a number of different documents to pass information to staff including; Awareness Briefings, Safety Notices, Frontline Updates and Urgent Instruction. The use of Frontline Updates demonstrates the benefits of the work of the OA team, the debrief processes and a real commitment to organisational learning. This was recognised by station-based Operational staff during our fieldwork.
189. There are some common accident themes that continue to require investigation such as low speed manoeuvring and the trapping of limbs whilst carrying out BA exercises. The ability for the organisation to learn from these events should be questioned and addressed. The use of data across the functional areas and in departments should assist identifying where improvements should be made. HMFSI discussed the level of events particularly within the training environment and were advised that the OA team has no auditing role for support functions due to no formal arrangements being in place. We were informed that the OA function would assist any department to understand and improve if requested or a need is identified through monitoring.
190. Senior managers interviewed were able to give examples of where evidence had been used to support H&S decisions. We found that lower level managers were unable to provide evidence or examples of where and how data has been used to effect change. This may explain why there are lower levels of recording and reporting in all SDAs areas as with the reporting of 'near misses'. If staff can see that evidence is utilised to make improvements they may be more inclined to record events.

Recommendation 8 – The SFRS should ensure that information related to Operational risk and safety-critical hazards is clearly prioritised with key messages identified and information targeted to the intended recipient rather than to general staff groups.

Worker consultation and involvement;

'I find it hard to imagine how one could ever put in place an effective workplace health and safety system that did not include real participation and engagement of the workforce.'¹⁷

Judith Hackitt, HSE Chair

¹⁷ [Managing for health and safety \(HSG65\) \(hse.gov.uk\)](#)

Joint and National Organisational Learning

191. The SFRS is committed to learning from emergency incidents and events it attends, from significant incidents reported throughout the fire sector, and from other blue light responding agencies. The debrief process allows for internal learning locally and for it to be shared across the country. The OA team monitor many systems to ensure shared learning is reviewed and distributed. National events impacting upon the sector are routinely shared and we are pleased to see recent sharing of both national and local learning across the Service.
192. We were given examples of how multi-agency learning was being shared both from and with partners; events included wildfires, flooding and a recent train derailment. Lessons learned from these case studies is also being used by the incident command team in their work with all levels of incident command training.

Good Practice 9 – The sharing of Service and fire sector incident debriefs ensures operational staff are able to learn from ‘real’ incidents and improve firefighter safety.

193. We observed how combined learning from Joint Organisational Learning (JOL)/ National Organisational Learning (NOL)/ National Operational Guidance (NOG) is managed within the SFRS. The governance arrangements within the Service appear robust and effective. The Service should also ensure that all lessons identified through national multi-agency training and exercising are captured and considered in line with its desire for continuous improvement.
194. We were advised that the dissemination of some learning has been delayed, over concerns that there are outstanding legal matters that may need to be resolved. It is our view that there should be no unnecessary delay in sharing learning that will reduce risk to operational staff. Those responsible for delays should understand and be accountable for information not being shared.
195. Staff from the OC function feel that they are often excluded from participating in the sharing of information. We understand that staff within the Operations function are addressing some of these concerns. Other departments should be encouraged to take the same approach. OC staff are an integral part of the incident resolution process and part of the management of H&S across the SFRS.

Act – Review of Health and Safety Performance

Evaluation

196. We found little evidence to suggest that the SFRS evaluates the effectiveness of its H&S policy and procedures. This may be due to the sheer volume of work that the policies and procedures cause to managerial staff and support teams. Evaluation could be linked to the ‘check’ part of the HSG 65 model and may bring broader organisational benefits.
197. Failing to routinely evaluate policy and procedure could lead to inefficient and unproductive work being carried out by some staff groups. Ensuring policy and procedures have positive outcomes on objectives will assist in the effective utilisation of the resources available.
198. We discussed the UFAS proposals with managers and acknowledge that any changes to the current response methodology would likely reduce vehicle accidents and injuries. The additional time gained from unnecessary vehicle movements will permit station-based staff more time to undertake priority work.
199. We have previously mentioned the document, Conversion Project within this report and were originally led to believe that this project would assist in the streamlining and reduction of a range of documents across the SFRS. However our original understanding is incorrect and the project is limited to the suite of documents within the Operations function. From our interviews with leaders within the Operations team we believe that the project has reduced the volume of documents in that department. We would expect the evaluation of the project’s success to lead to the principles of the project being considered for extension across all functions of the Service.
200. We believe that information overload and the lack of up-to-date and timely information could be a contributor to future risks for all operational staff.

Resources

201. The allocation of teams within the H&S headquarters function, SDA and LSO areas with specialist and multi-disciplinary functions is based on legacy Service arrangements with resources distributed unequally. While the SDA DACO can share or request additional resources to support their needs, we were not shown how resources are allocated based upon need. Neither could we see evidence of resources being regularly allocated or re-distributed due to a specific business case or an identified need.

202. There is a potential imbalance or inefficient use of resources in some parts of the SFRS, and this is possibly linked to issues that were identified to us with regards to actual and perceived workloads/priorities. We understand the SFRS has a project to look at risk and resources allocation using the Community Risk Information Model. This work may influence future resource distribution and address some of the issues raised. Using data to enhance decision making could be improved with active feedback to prevent misunderstanding or frustration from those raising issues relating to legitimate local priorities.
203. A number of the H&S related documents contain an element of audit that have not been achieved. This includes 'Health and Safety Audits Management Arrangements - Level 1 audits of the Senior Leadership Team. We recognise the impact that the Covid-19 pandemic has had on the Service's ability to undertake this work since March 2020, however we found that prior to the pandemic this audit had not been achieved as per policy. By stating a specific audit frequency there is an expectation of completing them as stated; if these frequencies are unrealistic the policy should be amended or resources identified.
204. We were made aware that additional 'new' resources were being introduced, or were to be introduced, to a number of departments, including H&S, Training and other teams. We were told that this was facilitated by an increase in the organisational establishment through utilising and redistribution of existing staff. We found little clarity to what this organisational growth would look like and where any other resources would be deployed. We also acknowledge that the SFRS has increased the number of WCs supporting the RVDS in the past few years by 54 people. Continuing to increase the establishment of course places increased pressure on the resource budget.

H&S Annual Report and Publications

205. An Annual Report on the SFRS H&S performance is presented to the SFRS Board. The report presents the quantitative data on the performance of the Service in a number of key H&S areas, the report also gives a commentary against previous and current performance. The last published report covers the period 2019/20, we expect the new H&S report for 2020/21 will be published soon.
206. Published reports are available on the SFRS website¹⁸.

18 [Scottish Fire & Rescue Service \(firescotland.gov.uk\)](https://www.firescotland.gov.uk)

Conclusion

- 207. The SFRS has a good understanding of its duties relating to H&S, with good structures in place for developing H&S related plans and monitoring activities and investigating events.
- 208. H&S is positively promoted across the Service by senior leaders and through our fieldwork we have been able to identify areas that staff feel are good practice.
- 209. We believe that if the SFRS give appropriate attention to areas we identify for consideration and positively address our recommendations, this will further promote a positive H&S culture reducing risk to staff and the communities they serve.

Summary of Recommendations, Areas for Consideration and Good Practice

Recommendations

- **Recommendation 1** – The outcomes of the Document Conversion Project currently being carried out in the Operations function, should be evaluated and the benefits extended to other SFRS Directorates, including Training Safety and Assurance (TSA).
- **Recommendation 2** – The SFRS should revise and amend the LCMS packages on ARA and DRA to ensure that they focus on how and why to complete the documentation, ensuring the content is suitable for all Operational staff.
- **Recommendation 3** – The SFRS should ensure that risk critical information provided to crews via the GETAC tablet is easily accessible when required, up-to-date and the information available suitable for all foreseeable incident types.
- **Recommendation 4** – The SFRS should ensure that the Post Incident Support Policy and Procedure is amended so that triggers are in place and are activated automatically to support all levels of operational staff attending incidents.
- **Recommendation 5** – The SFRS should identify the cultural barriers that prevent staff reporting 'near misses'. The 'near miss' recording systems, should be accessible to staff and encourage ease of use to improve and encourage reporting across the organisation.
- **Recommendation 6** – RVDS staff should be provided with effective middle management supervision and support to ensure that knowledge and information is shared and staff assessed to the required standards.
- **Recommendation 7** – The SFRS should consider introduction of an electronic asset management and testing solution, which would reduce reliance on paper records and limit organisational exposure and risk.
- **Recommendation 8** – The SFRS should ensure that information related to Operational risk and safety-critical hazards is clearly prioritised with key messages identified, and information targeted to the intended recipient rather than to general staff groups.

Areas for Consideration

- **Area for Consideration 1** – The SFRS core values including ‘Safety’ could be embedded further into organisational processes such as promotion, selection and appraisals.
- **Area for Consideration 2** – The SFRS should consider establishing a designated SFRS Board member as H&S lead or champion.
- **Area for Consideration 3** – The SFRS should introduce clarity on the accountability and decision making authority of all levels of managerial staff to improve H&S management and delivery.
- **Area for Consideration 4** – The SFRS should ensure there is early engagement with relevant internal stakeholders to ensure their priorities and ideas are considered within future H&S plans.
- **Area for Consideration 5** – The SFRS should ensure that staff understand the roles and the functions of specialist teams; such as OA and H&S, particularly those working within the RVDS staff groups.
- **Area for Consideration 6** – The SFRS should ensure that H&S Policies and Procedures are designed, developed and tested in conjunction with all duty systems prior to issue.
- **Area for Consideration 7** – Documents that contain safety-critical information should be readily identifiable to the relevant staff. There is a lack of clarity on document types and their importance relative to each other, this and the volume of documentation leads to information overload and could place staff and the organisation at risk.
- **Area for Consideration 8** – The SFRS should take steps to ensure that the frequency of H&S and OA audit and review stated in policy, is aligned to available resources and capacity.
- **Area for Consideration 9** – Incident Command training should include the development of the understanding of individual and organisational risk appetite and the implications of its application at operational incidents.
- **Area for Consideration 10** – The SFRS should ensure a consistent level of understanding of the ‘Firefighter Safety Maxim’ and how it links to the organisations risk appetite.
- **Area for Consideration 11** – The MSK working group should be reinvigorated to address and reduce the number of MSK injuries among operational staff. Operational staff should also be made aware of the membership, remit and outcomes of this group.
- **Area for Consideration 12** – Many H&S events reoccur similar to those previously investigated. The Service needs to be assured that actions previously identified from the event investigation process are addressed and followed through within appropriate timescales.
- **Area for Consideration 13** – The SFRS should consider the suitability, use, provision and deployment of welfare arrangements, particularly regarding the availability and use of Welfare Pods.
- **Area for Consideration 14** – The SFRS should seek to understand why staff are unwilling to report and escalate H&S related issues appropriately and why they perceive that there

is a lack of feedback. The Service should also utilise the collective creative capacity of the workforce to stimulate innovation and ideas.

- **Area for Consideration 15** – The SFRS should ensure that FDOs comply with the Occupational Road Risk Management Arrangement (ORRMA) policy and carry out a risk assessment (recorded) post operational incidents, prior to travelling back to home address, where they may have travelled a significant distance, to ensure their fitness to travel. The expectations placed on FDOs at incidents should take into account the need for fitness to travel.
- **Area for Consideration 16** – The SFRS core value of ‘*Teamwork*’ could be embedded further throughout the organisational processes to ensure new entrants are encouraged to utilise personal skills and experiences. Ensuring people can be themselves, will encourage broader diversity.
- **Area for Consideration 17** – Working hours and rest periods are covered by primary legislation and should be actively monitored to ensure all operational staff have adequate rest periods.
- **Area for Consideration 18** – The use of data to support decision making should be complemented by understanding ‘why’ and ‘how’ the data was used to make the decision.
- **Area for Consideration 19** – The Service should take steps to ensure that staff fully understand the relationship between the activities they undertake and the improvements made in performance.
- **Area for Consideration 20** – The SFRS policy on event investigations should be amended to allow completion of investigations within agreed and achievable timescales with the necessary resources allocated to complete.
- **Area for Consideration 21** – The SFRS should carry out an evaluation exercise, which considers the impact of the pandemic with regard to RVDS staff training in small groups, with limited supervision and support. The SFRS should develop a plan that prioritises any training slippage for RVDS staff caused by Covid-19.
- **Area for Consideration 22** – H&S training and qualifications are integral to firefighters understanding of H&S and to service delivery. There needs to be suitable continuous professional development program in place to maintain competence and ensure alignment to the good practice suggested by IOSH.
- **Area for Consideration 23** – The SFRS should ensure that all training records are an accurate reflection of the work completed and any system ‘workarounds’ should be eliminated.
- **Area for Consideration 24** – The LCMS system is a comprehensive library of learning material. However, it needs to be designed to meet the needs of all end users, adjusted sufficiently to realistically utilise the time available, and identify and prioritise safety-critical risks.
- **Area for Consideration 25** – The process for determining how new equipment is rolled out and implemented needs to be applied consistently to ensure it is delivered as expected.

Good Practice

- **Good Practice 1** – A number of the SFRS H&S policies and procedures align with the principles within HSG 65 and other HSE guidance documents, utilising the Plan, Do, Check, Act methodology.
- **Good Practice 2** – The restructure of H&S into the Training, Safety and Assurance Directorate is seen as positive across the organisation, streamlining governance and reporting, with H&S as a standing agenda item in relevant management meetings across the Service.
- **Good Practice 3** – H&S teams across the SFRS pro-actively follow up and report progress on improvement/action plans which ensures an organisational focus on the importance of H&S.
- **Good Practice 4** – At strategic level the SFRS has a good understanding of its duties, with regard to H & S and has a comprehensive suite of documentation to support its H&S objectives.
- **Good Practice 5** – The adoption and provision of a dedicated Firefighter Safety Resource to certain incidents, enhances Firefighter safety throughout Scotland. The SFRS should consider sharing information regarding these arrangements across the UK via the NFCC.
- **Good Practice 6** – SFRS senior managers are viewed positively by staff in promoting a strong H&S culture throughout the organisation, with a strong focus on mental health and wellbeing.
- **Good Practice 7** – The positive use of data and visibility of up-to-date H&S information at fire station level raises awareness and embeds a positive H&S culture.
- **Good Practice 8** – The event recording system (TASS) is seen by staff that utilise it, as an improvement on the previous system being more user friendly and with increased functionality and access to data.
- **Good Practice 9** – The sharing of Service and fire sector incident debriefs ensures operational staff are able to learn from ‘real’ incidents and improve firefighter safety.

Glossary and Abbreviations

An explanation of abbreviations used can be found in the table below.

The glossary below includes the up-to-date role names.

AC	Area Commander
ACO	Assistant Chief Officer
ARA	Analytical Risk Assessment
BA	Breathing Apparatus
CC	Crew Commander
DACO	Deputy Assistant Chief Officer
DRA	Dynamic Risk Assessment
FBU	Fire Brigades Union
FDO	Flexi Duty Officer
FRS	Fire and Rescue Service
HMFSI	Her Majesty's Fire Service Inspectorate
H&S	Health and Safety
HSE	Health and Safety Executive
HSWA	Health and Safety at Work etc. Act 1974
IC	Incident Commander
LAI	Local Area Inspection
LCMS	Learning Content Management System
LSO	Local Senior Officer
NFCC	National Fire Chiefs Council – is a professional body that drives collective improvement and development throughout the UK FRSs.
NSAB	National Safety and Assurance Board
OA	Operational Assurance
OC	Operations Control
OD	Operational Discretion

PDA	Pre-Determined Attendance
PISP	Post Incident Support Policy and Procedure
PPE	Personal Protective Equipment
PUWER	Provision and Use of Work Equipment Regulations 1998
RIVO	Previous H&S event recording system
RVDS	Retained Volunteer Duty System (this includes Retained duty system and Volunteer duty system)
SALO	Safety and Assurance Liaison Officer
SC	Station Commander
SD	Service Delivery
SDA	Service Delivery Area
SFRS	Scottish Fire and Rescue Service
SG	Scottish Government
SLT	Strategic Leadership Team
SMARTEU	Scottish Multi-Agency Resilience Training and Exercise Unit
SOP	Standard Operating Procedure
TASS	Think Act Stay Safe – new SFRS event recording system
TSA	Training, Safety and Assurance
TTM	Task and Task Management
UIG	User Intelligence Group
WC	Watch Commander
2005 Act	The Fire (Scotland) Act 2005

Appendix 1 - About HM Fire Service Inspectorate

Her Majesty's Fire Service Inspectorate in Scotland (HMFSI) is a body that operates within, but independently of, the Scottish Government (SG). Inspectors have the scrutiny powers specified in section 43B of the Act. These include inquiring into the state and efficiency of the SFRS, its compliance with Best Value, and the manner in which it is carrying out its functions.

HMFSI Inspectors may, in carrying out inspections, assess whether the SFRS is complying with its duty to secure Best Value and continuous improvement. If necessary, Inspectors can be directed by Scottish Ministers to look into anything relating to the SFRS as they consider appropriate.

We also have an established role in providing professional advice and guidance on the emergency response, legislation and education in relation to the Fire and Rescue Service in Scotland.

Our powers give latitude to investigate areas we consider necessary or expedient for the purposes of, or in connection with, the carrying out of our functions:

The SFRS must provide us with such assistance and co-operation as we may require to enable us to carry out our functions.

When we publish a report, the SFRS must also have regard to what we have found and take such measures, if any, as it thinks fit.

Where our report identifies that the SFRS is not efficient or effective (or Best Value not secured), or will, unless remedial measures are taken, cease to be efficient or effective, Scottish Ministers may direct the Scottish Fire and Rescue Service to take such measures as may be required. The SFRS must comply with any direction given.

We work with other inspectorates and agencies across the public sector and co-ordinate our activities to reduce the burden of inspection and avoid unnecessary duplication.

We aim to add value and strengthen public confidence in the SFRS and do this through independent scrutiny and evidence-led reporting about what we find. Where we make recommendations in a report, we will follow them up to assess the level of progress. We will aim to identify and promote good practice that can be applied across Scotland.

Our approach is to support the SFRS to deliver services that are high quality, continually improving, effective and responsive to local and national needs. The terms of reference for inspections are consulted upon and agreed with parties that the Chief Inspector deems relevant.



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