



Health and Safety Executive		Sector Information Minute	
Public Services		SIM 07/2001/16	
Cancellation Date	16/04/2005	Open Government Status	Fully Open
Version No & Date	1: 16/04/2001	Author Unit/Section	Defence, Fire and Police Unit

Target Audience:
AFQ Inspectors
SG Inspectors

INVESTIGATION OF SELECTED DANGEROUS OCCURRENCES

This SIM provides inspectors with background information and supporting arrangements in support of a Services Sector Objective for 2001/02 for the investigation of dangerous occurrences involving fire service breathing apparatus.

INTRODUCTION

1 This objective is linked with HSC/E Strategic Theme 2: To improve health and safety performance in key risk areas. It also supports HSC/E's Continuing aims:

- to secure compliance with the law..... on a risk related basis (No 2);
- to improve the knowledge and understanding of health and safety through the provision of appropriate information and advice (No 3); and
- to promote risk assessment (No 4).

STATEMENT OF THE PROBLEM

2 The [Incident Selection Procedure](#) (ISP) sets out the selection criteria for the investigation of RIDDOR reports. Dangerous occurrences (DOs) involving breathing apparatus (BA) fall outside the criteria in ISP Work Instruction 1 Appendix 1 Section (A) but will in most cases meet the criterion set out in Section (B)7. This SIM is to remind inspectors of the importance of investigating these events and provide guidance.

3 Certain types of BA failure are reportable as DOs under RIDDOR, (Schedule 2 Pt I Para 9) which updated earlier reporting requirements. Investigation of such incidents is important to HSE because in many firefighting and rescue situations, there are few reasonably practicable precautions which can be taken to protect firefighters, other than 'software' measures, PPE and RPE. Breathing apparatus is safety critical equipment which is worn routinely by firefighters and on which their lives will often depend.

4 The number of reportable BA DOs is difficult to predict since the fire units experience is that fire services have been slow to recognise and respond to the change in reporting requirements following the introduction of RIDDOR.

AGREED OBJECTIVE

5 To carry out investigations of BA DOs reported to HSE by public fire services in accordance with the decision tree and other guidance set out in SIM 7/1999/05 *Fire Service Breathing Apparatus failures reported under RIDDOR; Guidance on Investigation* and SIM 7/1999/06 *Fire Service Breathing Apparatus failures reported under RIDDOR; Guidance to PI Suppliers*.

ENFORCEMENT GUIDANCE

6 Enforcement decisions must be consistent with the HSC/HSE enforcement policy and follow the liaison arrangements that have been agreed with HM Fire Service Inspectorate. The Defence, Fire and Police Unit (DFP Unit) should be consulted prior to taking any formal enforcement action.

REPORTING REQUIREMENTS

7 Investigations should be entered onto FOCUS (and SAPID) records in the usual way. Even where HSE chooses not to investigate, all BA DOs are likely to be investigated by the users and relevant information from their investigation should be entered onto the FOCUS system. In this way HSE's intelligence on BA failures can be significantly enhanced. The DFP Unit recommends that a FOCUS investigation record be created for reportable BA failures even where HSL is not involved.

8 Inspectors should request a copy of the brigade's investigation report, including any manufacturer's reports, and using this a FOCUS record should be created. Paragraph 9 suggests the information which should be included in such reports, to allow PI supplier, DFP Unit and others to make best use of the information stored on FOCUS.

9 The following information, as a minimum, should be included in the FOCUS report of investigation of a BA DO. (See also the guidance on investigation reports in the FOCUS data handbook.)

- manufacturer's name;
- set type/model;
- who carried out technical investigation, eg brigade, manufacturer, HSL. Names of individuals if known;
- part which failed; as specific as possible, eg not just "O-ring" but "O-ring between cylinder and pillar valve" or "O-ring in Regulator";
- reason for failure, eg design flaw; lack of maintenance; incorrect part; operator error;

- further action, and by whom; eg SAPID raised, HSL to carry out further work, brigade to review BA maintenance procedures.

The reportability flag and the process code on the FOCUS DO record should also be checked by the inspector, to ensure they are correct.

COMPLETION DATES

10 Visits and reports should be completed by the end of March 2002.

COMPETENCIES/TRAINING/BRIEFING NEEDS

11 Inspectors taking the lead in investigations should have participated in a CFP NIG conversion course, conference or a Fire technical seminar. They need to understand the sensitivities of the sector, the potential for national implications of local action, the role of the Fire Service Inspectorate and representative bodies.

12 Before investigating a BA DO, inspectors should read the following documents.

- NIGM 7/B/1997/07;
- SIM 7/1999/06;
- Technical Bulletin 1/97 (subject file 334);
- OC 237/5 Supp 1;
- [OC 282/14](#).

OTHER SOURCES OF INFORMATION

13 The following documents provide further information:

- *FOD Guide to the inspection of health and safety management*
- CFP NIG Conversion course manual 1995;
- CFP NIG Conference manual 1996;
- Fire Unit Technical Seminar papers 1997, 1998 and 2000;
- Current NIGMs/SIMs;
- Fire Service Guide Vol 4 *Dynamic Management of risk at operational incidents* (subject file 334).

NAME OF SECTOR CONTACT

14 Nina Judkins, Basingstoke. VPN 502 4033.

Date first issued: 16 April 2001