Highlight Report

Name and Role	Joanne Hellen Head of Health and Safety

Period covered:

Date from:	**01/04/2024**	**Date to:**	**30/06/2024**

Highlights / achievements this period

Departmental Work - *Prevention, Protection and Response, Develop and broaden the roles and range of activities undertaken by the Service, make best use of our resources, Collaborate with our partners.*

Issued Toolbox Talks:

Toolbox Talk 68: Appliance Movements, 10-Apr'24

During attendance at an operational incident, the driver was asked to reposition the pump supplying water from its tank, the manoeuvre was carried out without first checking the delivery hose had been disconnected. This resulted in the delivery outlet sheering from the pump, injuring a Firefighter (FF), and causing damage to the appliance.

Toolbox Talk 68 was issued to remind personnel that clear communication should take place when moving appliances on the incident ground. A 360 check of the appliance and associated equipment should be undertaken by the driver to ensure safety of vehicle movements.

Toolbox Talk 69: Bump Cards, published 17-Jun'24

During the Q4 Occupational Road Risk Group (ORRG) meeting, questions were raised surrounding the use of the Fire and Rescue Indemnity Company (FRIC) report cards, known as "Bump Cards", which should be available on all service vehicles in case of a collision with a third party. An action was raised to enquire as to how we order replacement cards and send out communication to operational and support staff. Once an order of Bump Cards had been received from FRIC, Toolbox Talk 70 was issued to explain what the cards are for and how they should be used. Colleagues were also informed that replacement and spare cards can be requested from the Health and Safety Mailbox and will be sent out in internal post.

Following the issue of the Toolbox Talk, the Front of House team at Kelvedon Park were provided with Bump Cards for pool cars and a box of cards were delivered to Service Workshops. Over a dozen packs of cards were requested and either sent to stations or collected by colleagues who had recently read the Toolbox Talk.

Toolbox Talk 70: Guidance for the storage of Water Rescue Bags, published 21-Jun'24

Following manual handling and safety concerns raised by Equipment Shop team members, when testing karabiners stored in water storage rescue bags, Toolbox Talk 70 was issued to request that all personnel store the karabiners externally. This is to reduce the risk of an injury, requires less manual handling and allows for increased efficiency when caring out testing. It was

noted that a team member had been injured by an unsheathed knife, causing a laceration when completing inspections previously.

Issued Safety Flashes:

Safety Flash 34: Textile Sling Defacing, published 22-May'24

Following a discussion with Technical Services, Health and Safety were made aware of crews using permanent marker to mark the textile slings attached to service equipment such as the Paratech supports. It was noted that the permanent ink can cause the material to degrade and break down. It may also hide any defects. Safety Flash 34 was issued to remind crews that this is in breach of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) and would not pass an inspection.

Ongoing Significant/Serious Accident Investigation Boards (SAIB):

INC-000134 SAIB Orsett Bulk Foam Module Ladder - Fall from height when ascending the access ladder to carry out inventory checks on the Bulk Foam Module (BFM), 14-May'23.

A total of 8 board meetings have taken place following the Orsett Bulk Foam Module Ladder accident. The most recent meeting took place 08-May'24 to review evidence and confirm sign off of the closed recommendations. A total of 7 recommendations out of the original 19 were identified as requiring further evidence to sign off. These were included in an action plan which will be managed by the Health, Safety and Welfare Strategic Group (HSWSG) alongside their quarterly meetings. The next meeting taking place in August 2025 (Q2). Following this decision, the SAIB was closed, and the attendees were thanked for their support throughout the accident investigation process.

INC-000092 SAIB Orsett Bay Appliance Cab Fire - Thermal Imaging Camera battery fault, 13-Jul'23

The Orsett Bay Fire SAIB was closed in Q4, and the action plan was sent for review by the Organisational Assurance department. Following the review, any recommendations will be forwarded to the HSWSG to progress.

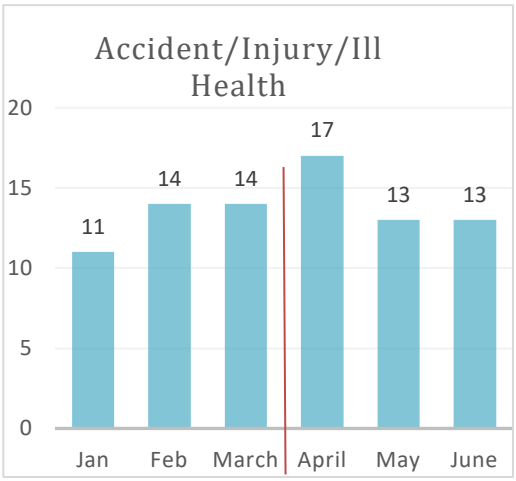
INC-000338 SAIB Chelmsford Training Centre - BA Training finger injury, 08-Aug'23

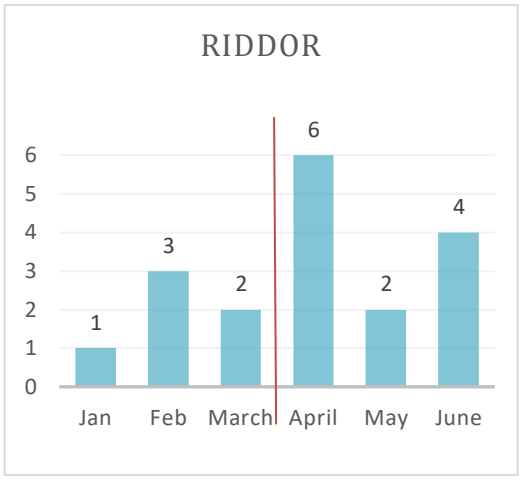
Following the finger injury during BA training, 11 recommendations were identified and closed with the action plan signed off by the board. The action plan has been sent for review by the Organisational Assurance department who will focus on recommendations to review BA training closed door procedures. Any actions following the review will be forwarded to the HSWSG to progress.

Safety Event Figures Q1 2024/25 April, May, June and Q4 2023/24 January, February, March - *Prevention, Protection and Response, promote a positive culture in the workplace, Be transparent, open, and accessible.*

The graphs below show Q1 (24-25) safety event data in comparison with Q4 (23-24).

Accidents and RIDDOR





Accidents/Injury/Ill Health - There were 43 accident/injury/ill health reports submitted in Q1 against 39 in Q4. Local accident investigations have taken place to ensure learning opportunities are captured to mitigate the risk of similar events reoccurring. Below is a breakdown of the Q1 reports by month.

April 2024
Of the 17 accident/ill health reports received in April, 1 related to an operational incident which was a late report from February where the injured person (IP) injured their back after deploying a dam off the water bowser. The IP did not inform anyone of the injury, but it was raised later when their Crew Manager (CM) witnessed them struggling to get out of a chair on station.

5 reports were during training, 1 of which was a manual handling injury where the IP experienced knee pain during their Breathing Apparatus (BA) basic course. There was a report where the IP struck their back on a block at Lee Valley and the other 3 reports were of IP's feeling unwell: 1 during water rescue training after experiencing a severe leak in their dry suit, 1 recruit feeling unwell due to stomach cramps, causing them to faint, and 1 report of an IP feeling unwell during a casualty care course and being taken to hospital for tests which came back clear.

9 reports were from events on Station; 3 reports were of illness suspected to be from hot water issues on station, 1 twinged knee during a charity car wash, 1 report of chest pains whilst at the station, leading to a hospital visit where they were diagnosed with pleurisy and told to rest, 1 twinge in back getting Holmatro from locker, 1 pop in rib cage getting down from the appliance following BA tests, 1 twisted knee getting in to the appliance and 1 report of arm pain pulling a BA set out of the cradle on the pump.

Other reports included a flexi officer experiencing a heart attack whilst on duty at home and a cleaning contractor trapping their finger in a spray bottle, bursting a blood vessel and feeling unwell.

May 2024
Of the 13 accident/ill health reports in May, 6 related to Operational Training, 2 at Service Training Centre (STC); IP hit their head whilst walking down the stairs at STC, causing a cut to their eyebrow and a report of a FF losing grip and falling to the ground twisting their ankle when climbing down the jacobs ladder. 3 reports were during Water Rescue Training; 1 report of a stiff back and pain following water rescue training and 2 reports of IPs hitting blocks at Lee Valley, 1 causing pain and swelling in their knee and the other was complaints of a stiff back which was reported late following training in March. The other report during training was of the IP experiencing hot skin during a live fire exercise at Wethersfield Training Centre (WTC).

There was one report in May during fitness tests where the IP twisted their knee

Other reports received in May include an on call FF colliding with a car responding to pager on their bike, IP fell down two steps in property when carrying out safety visit, glass shattering in hands when unloading the dishwasher on station causing two lacerations, driver twinged their calf dismounting the appliance on return from an operational incident, 1 report of cleaning products entering the IPs eye when cleaning the animal rescue unit and a report of the volunteers knee giving way at an event, causing them to slip from the appliance and experiencing muscular pain and brusiing down one side of their back and rib cage.

June 2024
Of the 13 accident/ill health reports submitted in June 3 were during operational training; 1 FF swallowed water during training at Lee Valley and 2 reports of injuries to instructors; 1 twisted knee and 1 report of an instructor striking their ankle and knee on block on the course.

2 reports related to operational incidents where a FF felt unwell after BA and the other was of a CM slipping down a gulley, injuring their knee.

There was 1 report relating to physical training where an IP was lifting dumbbells in the station gym when their shoulder dislocated.

3 were reports of injuries to non ECFRS staff; contractors leg gave way when checking the roof at Chelmsford above the BA training shower areas, a member of the public tripping on a change of level outside the rear of the bay causing a cut and bruising to their knee and a report of a fire cadet rolling their ankle walking up a steep hill during the Silver Duke of Edinburgh Award.

Other reports included an IP walking down the back stairs when they fell from near the top to the bottom of the first flight down, IP cutting a cable tie when they slipped causing the blade of the knife to penetrate their thigh, technician reaching into water rescue bag to perform LOLER duties on the karabiner when an unsheathed knife cut their finger (see TBT 70) and a report of an IP being hit by the hose when removing it from the appliance causing their wrist to swell.

RIDDOR - There were 12 RIDDORs submitted to the HSE in Q1 all of which were due to over 7 day absences with 3 affecting on call personnel and the other 9 affecting wholetime.

There were 3 RIDDORS submitted from incidents in Q4 of which one of these was a late report due to the IP not making colleagues aware that an injury occurred which was later recognised by their CM when they were struggling to get out of their chair. This was reported in Apil following the injury in February where the IP felt their back go after deploying a dam off the water bowser.

The other late report was from an incident in Q3 23/24 where the IP caught their ankle and achilles tendon on an external door on a BA chamber which slammed closed. The door had been reduced to allow fire hose to be pulled through but has since been deemed to be defective due to an ineffective self-closing device. The injury progressively got worse, and the IP booked sick from December with the report being submitted to Assure at the end of March. The RIDDOR was submitted beginning of April, and a survey was carried out on the door by an external company to rectify the issue.

A breakdown by month is as follows:

April
Of the 6 RIDDORS submitted in April, there was 1 report where the IP tripped over hose and used their hand to steady themselves in the gap of the appliance door which then shut as they fell forward, trapping their index finger causing damage to the nail bed, 1 twinged knee during charity car wash on station, 1 report of back twinge/pain at an operational incident (late report February'24), 1 pop in rib cage when dismounting the appliance following BA tests, 1 report of an IP striking their back on a block at Lee Valley and 1 report of the IPs ankle being caught on the external door of a BA chamber during an exercise, damaging their Achilles tendon (late report from November'23).

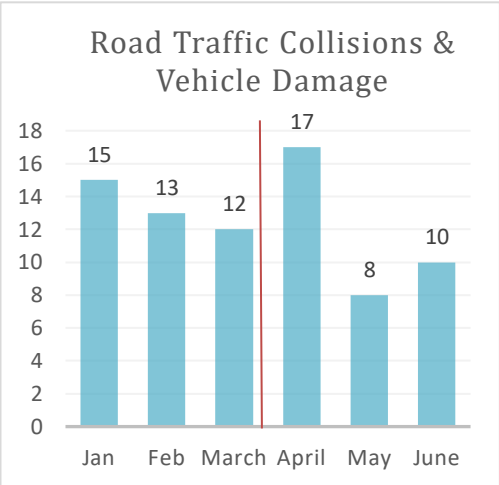
May
Of the 2 over 7-day RIDDORS submitted in May, there was 1 report of a FF experiencing a twinge in their calf when dismounting the appliance on return from an incident and the other was a report of a twisted knee during fitness tests at Kelvedon Park.

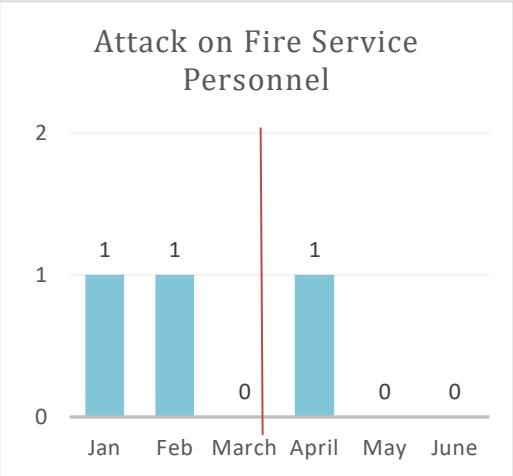
June
There were 4 RIDDORS submitted to the HSE in April of which there was 1 report of arm pain pulling a BA set out of the cradle, 1 report of a twisted knee during water rescue training, 1 report of a dislocated shoulder whilst lifting dumbbells in the gym on station and a report of an IP slipping when cutting a cable tie, cutting their thigh,

An ongoing trend in terms of RIDDOR and injuries is due to manual handling causing strains and sprains. The department have been in touch with the fitness team and have included a slide in the Roadshow to focus on prevention of these type of injuries, long and short term. It has also been discussed with Operational Training to ensure that a reminder of manual handling techniques using Task, Individual, Load, Environment, Other (TILEO) as a guide is delivered at the beginning of each training course.

With the development of a new JavaScript Object Notation (JSON) RIDDOR tracker, which links directly to Assure, the department can review the incident date against the date the report is submitted to the HSE. This will aid in our own KPI's for 'on time' reporting and provide the department with the data to support in educating colleagues of the importance of reporting before the end of shift and to managers, encouraging the review of incidents within the 7-day goal.

Road Traffic Collisions and Attacks on Fire Service Personnel (FSP)





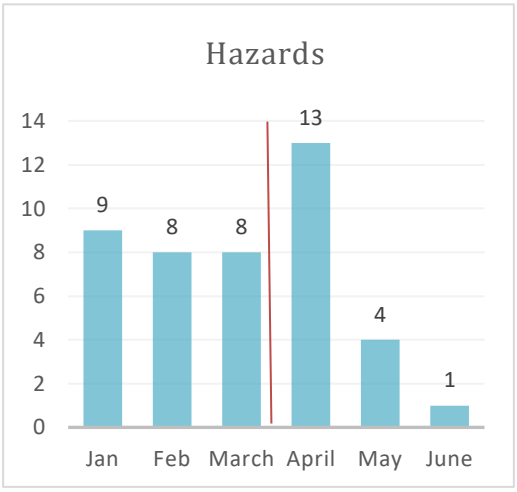
Road Traffic Collisions (RTC) /Vehicle Damage – There were 35 RTC/vehicle damage events reported during Q1, a decrease from 40 in Q4.

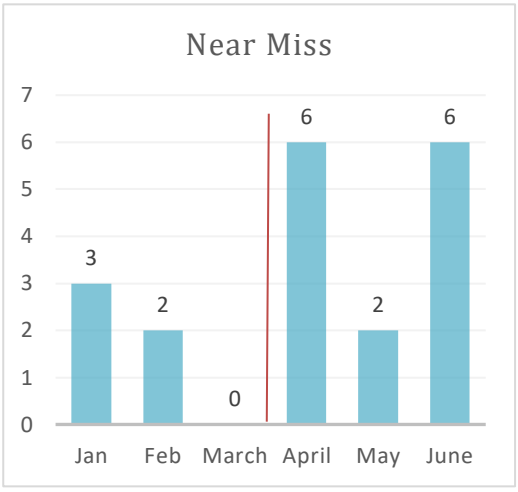
Our highest category of RTC/Vehicle damage reported relates to forwards operational vehicle movements. This is a continual trend with the most common journey purpose relating to travelling on route to operational incidents.

The Assure vehicle incident module has been reconfigured to allow for more accurate reporting and data scrutiny to identify trends sooner for action to be taken. The data will feed into the Occupational Road Risk Group for members to discuss control measures to mitigate risk of reoccurrence.

Attacks on Fire Service Personnel – There was single reported attack on Fire Service Personnel during Q1 compared with 2 in the previous quarter. The incident took place in April when a FF stopped to assist the Police following an RTC when travelling to work. The FF identified himself and assisted by carrying out casualty care when the driver involved in the collision got aggressive and threw him to the ground. The Police took the FF's details, and the Station Manager has contacted the Police to ensure the incident is reported and a crime reference number is provided.

Hazards and Near Misses





Hazards – 18 hazards were reported during Q1 compared with 25 hazards in the previous quarter. We encourage all hazards to be reported to ensure measures are taken to avoid them developing into accidents. Below is a breakdown of the reports received this quarter and brief details of the remedial action taken.

Premises:

- Fire alarm system does not automatically close fire doors when tested throughout the station - Reported to Property Services
- Possible vapours/gas present in work area - reported to Property Services
- Uneven concrete in ground of Kelvedon Park - reported to Property Services and the defect has been raised on the quarterly premises inspection.
- Fire exit leading from the mess room has been unsafe now for 6 weeks and is still blocked off - Area is cordoned off, raised with Property Services on the hazards and defects sheet and quarterly inspection.
- Small holes in path leading to the barn – individual covered the holes and ensured colleagues were aware of the issue which was also raised with Property Services.
- Smell of sewerage on station when taps and showers are run - reported to line manager and raised with Property Services.

- 3 reports of carpet lifted between the mess room and the rear back door lobby - raised on quarterly inspection and with Property Services.

All of the above have been raised with Property Services and included on the Health and Safety hazards and defects tracker which encompasses defects reported via Assure and the quarterly premises inspections. The purpose of the tracker is to ensure outstanding defects are appropriately resolved with ongoing hazards escalated to the Health, Safety and Welfare Functional Forum for discussion and progression as required.

Personal Protective Equipment (PPE):

- PPE returned from Bristol in an unsuitable condition - The tunic was bagged up to be sent to Technical Services.
- FFs witnessed on the incident ground in the risk area without correct PPE - Their Officer in Charge (OIC) arranged for another OIC to collect PPE from the station and delivered it to the incident ground.

Equipment:

- No Hero wipes or cleaning wipes for the fire appliances, unable to clean PPE or personnel from fire effluents - raised with Technical Services.
- Lanyard assembly of thermal imaging camera became detached from the handle - raised with Technical Services.
- Front windscreen blue lights on flexi-duty response vehicle reflecting off the front windscreen and dashboard causing impaired vision at night - raised with Service Workshops who have carried out a temporary fix by sticking foam tape on the windscreen below the light.
- No webbing on the new heavy rescue machines for storage of the BA masks – raised with Service Workshops.

Routine Activities:

- Service Control crewing inadequate - Raised with Service Control. Work is ongoing surrounding staffing issues and the Control Business Continuity Plan.
- No personal gas monitoring could be carried out due to no equipment during fire investigation in a hazardous environment - Briefing included a reminder to notify colleagues if any signs or symptoms of illness were experienced and to withdraw away from the scene. Welfare checks on those present was carried out 30 minutes after leaving the scene.
- Mobilising issue where the nearest available station was not mobilised to an incident - raised with control.

Near Misses - 14 near misses were reported during Q1, against 5 in the previous quarter. Local accident investigations have taken place to ensure learning opportunities are captured to mitigate the risk of similar events reoccurring. Below is a breakdown of the reports received in the quarter:

Equipment:

- Carabiners on harnesses were working loose during a charity event- A group email to all USAR & Technical Rescue members was sent to remind individuals to keep regular checks on all attachments to their harness.
- Godiva Prima Pump failed during training at Wethersfield Training Centre, the PTO was engaged, water was being supplied to the branch and when the revs increased the rear of the appliance started spraying water from behind the pressure gauges - This was immediately reported as an urgent defect and the appliance was taken to Service

Workshops to be inspected and subsequently taken off the run due to a hole in the pump casing.

- Oxygen cylinder would only open to 3lts and the connection spins round and jammed into place where mask could not be attached – It was removed from use and ambulance oxygen cylinder used instead 40 minutes later, the Station Manager (SM) has referred the incident to Technical Services to investigate.
- Burst hose during pumping drills – the damaged length was removed, booked and labelled with the hose reel branch fitted to length two. A service message was sent, and defect reported with the crew informed of the defect and actions taken.
- Head harness strap snapped on the BA face mask - another BA set was utilised, and crews made aware to be vigilant when testing.
- Crew attempted to connect the 19mm hose to the second pump in attendance 22mm hose when they came apart under pressure - Crews were briefed that the two different hoses cannot be connected together, and Operations issued Bulletin 148.
- Matting in floor of K9 kennel is loose and dog chewing – Fleet Workshops were informed and fitted additional sheeting on top of the matting to make access more difficult as an interim measure.
- Escape hood fell off due to poor quality karabiner during BA training - Technical Services have purchased new lock gate karabiners and will be issuing them to all operational fire hoods.
- Appliance went over a speed bump on route to an incident, pinning the OIC back in their seat and would not release – reported to Fleet Workshops.

Premises:

- Steel door fell from its top hinge while demonstrating a closed door procedure in a BA chamber - The crew were told to avoid the area and an assessment of the area was arranged with an external company.
- Youths reported climbing on the top of a fire station - Property Services informed and investigating signage and anti-climb measures/deterrent to apply to the roof.

PPE/RPE:

- PPE looked worn on delivery to Wethersfield. On closer inspection, the tunic shoulder had ripped – photographs and the barcode were noted and sent to Technical Services to query with the supplier.
- Whilst attending a car fire, a FF pulled the rubber spider straps of the BA mask tight when 2 of the rubber strap tabs snaped, this resulted in the mask falling from his face, and rendering the mask unusable - Another set was used at the incident. On return to station, the set was handed over to the oncoming watch, and bagged up for stores collection, labelled as defective.

Other:

- Member of public pulled out in front of appliance on route to operational incident causing driver to mount the embankment. - No collision or damage occurred, and the appliance continued to proceed to the incident.

Key Risks (problems and opportunities predicted, not occurring)	Mitigating actions – how prevent a problem or develop an opportunity

Key issues (problems occurring now – needing action)	Actions required e.g., decisions needed