Rosepark Care Home
An Examination of the Facts

Strathclyde Fire & Rescue

Based on the findings of the
Fatal Accident Inquiry
by
Sheriff Principal Brian Lockhart

20th April 2011

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Chief Officer's Foreword

On 31st January 2004, I attended the incident at Rosepark Care Home and immediately understood the magnitude of what had occurred; a disaster in which fourteen lives were tragically lost. At that time, I expressed my sincere condolences to all those who were affected by this terrible incident and today I offer these very same sentiments; it is my genuine hope that in sharing this experience and learning from the incident, we can ensure that this tragedy will never be repeated.

Some seven years after the event we now have an opportunity to review Sheriff Principal Brian Lockhart's determination in which he notes that the Fatal Accident Inquiry (FAI) is an exercise in "applying the wisdom of hindsight." In so doing, he considers fourteen unique points in respect to the Rosepark Care Home fire and, offers these so as to ensure that measures are now taken to avoid any future loss of life . These fourteen points serve us well and, provide a means to review matters relating to building design, fire protection, prevention, regulation, inspection and the training of care home employees. We are also provided with recommendations concerning the type of information and intelligence gathered by the Fire and Rescue Service and, the way in which this may be used so as to enhance operational deployments.

Whilst the findings present the Fire community with a valuable opportunity to review our current procedures, I am assured that almost directly following the incident, my own Service took early steps to initiate some procedural changes which added immediate value and, as such these were noted by the Sheriff Principal. In publishing this report, I intend to share the full details of those specific actions which were recognised but, will also summarise the determination's key findings as they relate to the main aspects of service delivery. This will include comment on those areas where additional work is required together with details on how this should be taken forward.

I remain in no doubt that this was one of the most difficult incidents in our Service's history; one which has called on the professionalism of a number of colleagues who either attended the care home or later provided evidence at the FAI. I am most grateful to all those who contributed and whose involvement helped to shape the Sheriff Principal's determination. I commend this report to you and trust that it will go some way to providing the means by which we can all learn from the Rosepark Care Home Tragedy. We can and must ensure that these lessons will never require to be learned again.

Brian P. Sweeney QFSM, D. Univ, MA
Chief Officer, Strathclyde Fire & Rescue

1. Introduction

1.1 The fatal incident which took place at the Rosepark Care Home, Uddingston on January 31, 2004 presented the largest loss of life in a fire within a residential care facility in Scotland. A Fatal Accident Inquiry (FAI) in terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976[i] (FASUDI) into the circumstances surrounding the tragedy was deemed to be in the public interest, and the Inquiry was conducted between 2009 and 2010. The Sheriff Principal's Determination from the FAI[ii] was published on 20 April 2011, and contains the following definition of the purpose of the determinations of the FAI: "The purpose of the conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with hindsight, the evidence led at the inquiry, and the determination of the inquiry, may be persuaded to take steps to prevent any recurrence of such a death in future" (Lockhart 2008 Chapter 1 Paragraph 8). This paper is designed to summarise the events of, and corresponding responses to, the incident, consider the Sheriff Principal's findings and to consolidate interim developments with those findings, in order to document the lessons learned by Strathclyde Fire & Rescue (SFR). This paper is split into 5 constituent parts:

1.1.1 **The events occurring on the night of the tragedy.** It is considered vital to revisit the events which occurred on the night in question, in order to inform the remainder of the document.

1.1.2 **The immediate responses.** Certain actions, reviews and amended procedures were implemented in the immediate aftermath of the incident. These actions will be discussed in terms of the three business streams involved:

- Operations:
- Training: and
- Fire Safety.

1.1.3 **Intermediate developments.** An intervening period of some five years occurred between the incident itself and the convening of the FAI due to matters outwith the control of SFR. However, within SFR, the process of consideration and review of the Rosepark incident continued during that time. In addition, the enactment of the Fire (Scotland) Act 2005[iii] (FSA) and, in particular, Part 3 of that Act and the Fire Safety (Scotland) Regulations 2006[iv] (FSSR), radically changed the operation of the Fire Safety business stream. This part will consider developments pursued by SFR in that timeframe.

1.1.4 **The Determination.** The Inquiry heard evidence from 212 witnesses over 141 days between 16 November 2009 and 12 August 2010. Written submissions from interested parties were lodged on 7 February 2011 with a public hearing to finalise submissions taking place in Hamilton Sheriff Court on 17 February 2011. Sheriff Principal Lockhart published his final determination on 20 April 2011, which contains 7 main findings in terms of reasonable precautions which could have been expected (Section 6(1)(c) FASUDI), 5 main findings regarding failings of systems of work (Section 6(1)(d) FASUDI) and 11 findings in relation to other factors relevant to the circumstances of the deaths (Section 6(1)(e) FASUDI). This part of the paper is intended to summarise the findings and to consolidate interim developments with those findings.

1.1.5 **Gap analysis**. This part of the paper will consider the Inquiry's findings and assess the consequences presented to SFR and other interested parties.

2. The events occurring on the night

2.1 Rosepark Care Home is situated in Uddingston with access from New Edinburgh Road (the postal address) and Rosepark Avenue (the main access point and car park) via Fallside Avenue, as shown in Figure 1.

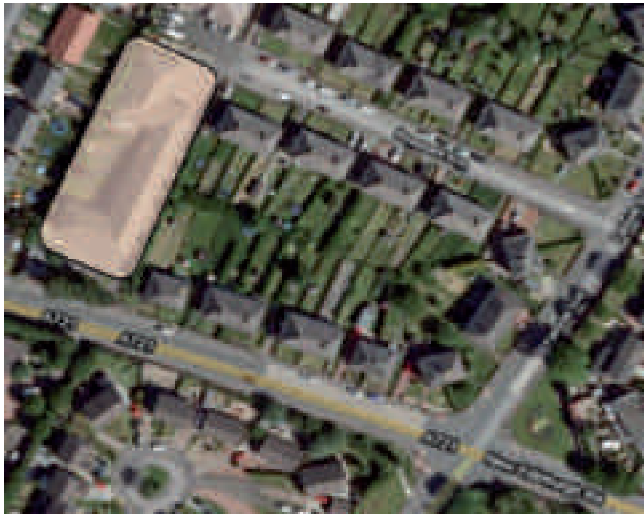

Figure 1 - Location of Rosepark Care Home (highlighted)

2.2 Rosepark Care Home is built on two floors. Because the site slopes generally from New Edinburgh Road up to Rosepark Avenue, the main entrance of the Home is in fact on the upper floor at Rosepark Avenue. At that end of the building, the Home is single-storey building, comprising only the upper floor (Figure 2), whereas at the New Edinburgh Road end, the building is two storeys in height (Figure 3).

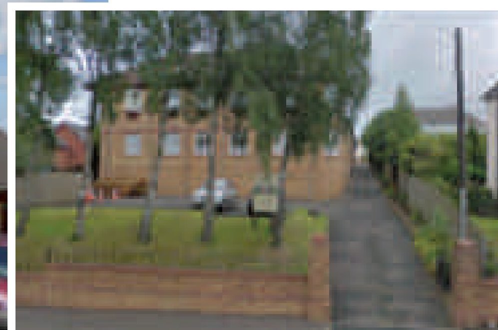

Figure 3- New Edinburgh Road

Figure 2- Rosepark Avenue main entrance

2.3 The schematic diagram in Figure 4, below, shows how the two storeys are oriented with each other. There are two stairwells connecting the upper and lower floors: a central stairwell (Stair 1), which includes a lift shaft; and a secondary stairwell (stair 2) at the south west corner of the building.

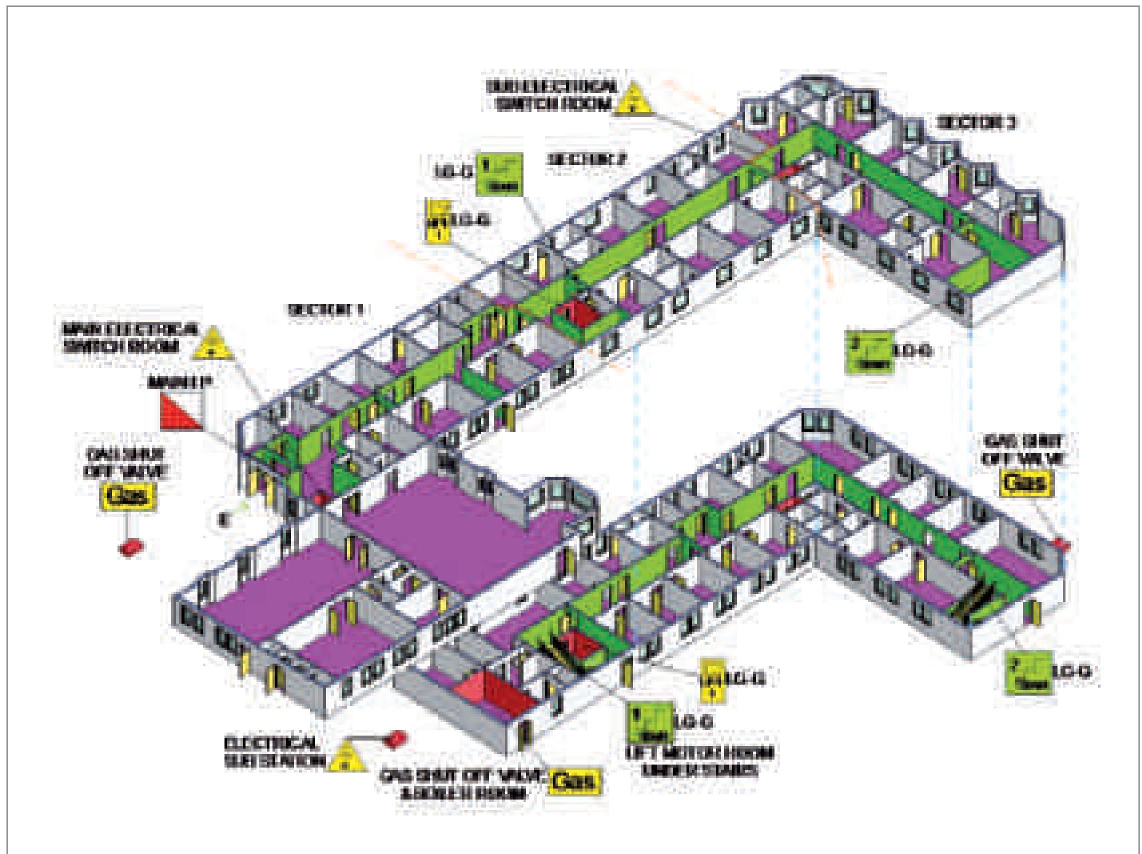

Figure 4 - Schematic Layout of Rosepark Care Home

2.4 The construction of the building was solely supervised by the owner who had no experience of managing a project which involved structural fire precautions of the sort required at Rosepark. As a consequence, *inter alia*, there were inadequacies in the fire protection of the ventilation system and the main electrical system as installed.

2.5 The building was completed in 1992 and registered with Lanarkshire Health Board[v] (LHB) as a Nursing Home on 17 February 1992. The initial registration was for 30 beds only and related to the provision of care for the frail elderly, the elderly with mild mental impairment, the young physically disabled and terminally ill. On 13 April, a further Certificate was issued registering the Home for 42 beds.

2.6 The ongoing enforcement of fire safety matters in nursing homes remained with the Health Board until the advent of the Care Commission (CC) in 2001, however neither of these organisations employed fire safety professionals within the inspection teams. Indeed, due to a lack of clarity in the legislation, both LHB and CC believed, incorrectly, that nursing homes within Strathclyde were routinely inspected by SFR.

2.7 The premises had been subject to inspection by an SFR Fire Safety Officer (FSO) prior to the provision of a "letter of comfort" relating to physical fire precautions within the building, from SFR to LHB as part of the initial registration process. Prior to the "letter of comfort" being issued, the FSO required the provision of overhead self closing devices on all bedroom doors. For a variety of reasons, by the time of the tragedy the majority of these devices had been disconnected. Due to the misunderstanding about enforcement responsibility for fire safety matters mentioned above, the regular inspections of Rosepark by LHB and CC staff failed to identify the lack of self closing devices as a risk.

2.8 The fire started at or about 04.25 hrs on 31 January 2004 in a cupboard on the upper level of the premises which contained an electrical distribution board and combustible materials, including a number of aerosol sprays. This circumstance led to a very fast developing fire of short duration, which, according to expert opinion and detailed reconstruction of the incident, would normally have self extinguished before the Fire & Rescue Service (FRS) was called or certainly before they arrived. However, the following factors contributed to a protracted incident during which the majority of the upper floor was smoke logged (Figure 5):

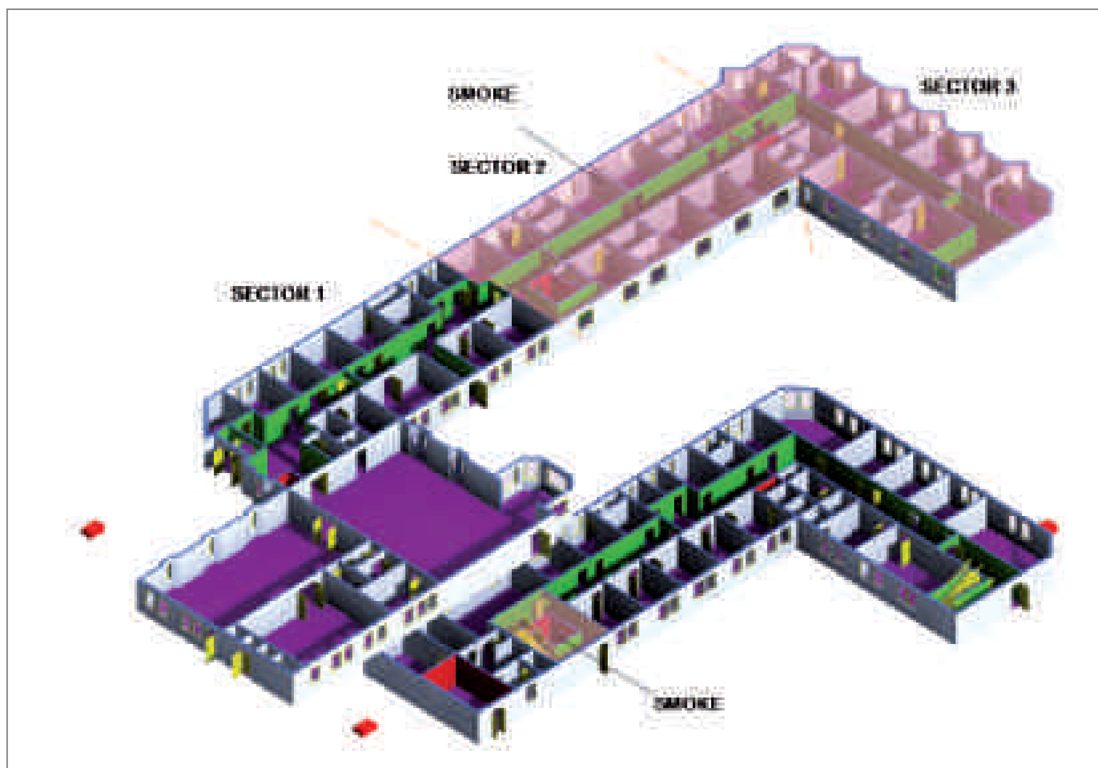

Figure 5 - Extent of Smoke Logging

- Fire dampers had been omitted from the ventilation system allowing smoke to move from one fire compartment to another, and in particular from the corridor adjacent to the room of fire origin to the upper lift shaft area.
- There was no fire stopping of service entry points between fire compartments.
- There was no effective compartmentation in the attic area and the presence of an open vent in the lift shaft area allowed smoke from the upper corridor, adjacent to the room of fire origin, to penetrate via the roof void to the upper lift shaft area.
- Bedroom doors were routinely left open over night.

2.9 The fire alarm sounded shortly before 04.28 hours. However, due to the following factors, the immediate actions of the staff on duty were inappropriate in response to the incident:

- There was no effective staff training in fire procedures and the staff on duty on the night of the fire had never participated in a fire drill.
- There was no evacuation plan committed to writing, and in the event no adequate evacuation plan existed for the premises.
- Alarm zones overlapped physical fire compartments within the building and the prose descriptions of the physical locations of the alarm zones, provided at the fire alarm panel, were ambiguous and confusing.
- The alarm panel was changed several days before the fire without staff being informed or trained on its use and staff had no idea how to interpret the information provided by the fire alarm.

2.10 The only coherent procedure followed on the night of the fire (albeit inappropriate), was an ineffective attempt to identify that a fire had indeed broken out prior to calling SFR, resulting in a delay of nine minutes. The call to SFR was made only after staff had reset the alarm system which immediately re-actuated due to the operating smoke detector in the compartment of fire origin.

2.11 The call to the SFR Operations Control (OC) at Johnstone was received at 04.37 hours and an initial Pre Determined Attendance (PDA), consisting of two appliances, one apiece from Bellshill and Hamilton Fire Stations, was mobilised at 04.38 hours.

2.12 The first appliance arrived at 04.42 hours, however the postal address was not the appropriate vehicular entrance to the Home and a lack of familiarity with the location and layout of the premises caused the first two attending appliances to enter via New Edinburgh Road, the more appropriate entrance being via Rosepark Avenue. This led to firefighters accessing the main entrance located at Rosepark Avenue by climbing locked security gates positioned in the lane to the side of the premises. The appliances were subsequently relocated from Rosepark Avenue and additional appliances were informed of the correct Rendezvous Point (RVP).

2.13 Upon arrival of SFR, the staff had misinterpreted information from the alarm and advised the Officer in Charge (OIC) that the fire was in the lift shaft area at the lower level of the premises. The OIC had no reason to doubt that information as it was consistent with the information gathered from his own observations (wisps of smoke in a room adjacent to the lift shaft area on the lower ground floor as he approached the building and the presence of smoke in the lift shaft area at the upper level when he arrived at the building). In addition, the OIC was advised that the residents on the lower floor were unaccounted for and that two members of staff had gone down to evacuate them; there had been no communication from them and that their current status was unknown; and the residents on the upper floor were still in their rooms and had not been evacuated.

2.14 A "persons reported" message was sent at 04.50 hours however an assistance message "make pumps 3" was not sent until 04.55 hours. The OIC had no reason to doubt the effectiveness of the fire compartmentation in the building or that bedroom doors would be closed; being unfamiliar with the layout of the premises, the requirement for additional resources was not immediately apparent. At that time the OIC was aware that there was smoke in the upper corridor beyond the central stairway, but he took the view that he was dealing with a fire in the lift shaft on the lower floor.

2.15 A Breathing Apparatus (BA) team was committed to the lower floor, where fire was suspected in the lift shaft, via the central stairway. The team quickly located the 14 residents who had been roused by the 2 staff members and mustered in the corridor. The BA team then assisted their evacuation by way of an exit direct to open air.

2.16 The BA team did not encounter fire conditions on the lower floor corridor, but discovered that the second stairway was compromised by heavy smoke logging at approximately 05.04 hours. The OIC, following receipt of communication of this information from the lower floor, sent a further assistance message "make pumps 4" at 05.06 hours acknowledging that the extent of the fire spread and the potential number of residents affected were beyond the capabilities of the resources in attendance.

2.17 A further BA Team was committed to the corridor at the upper level beyond the central stairway at 04.53 hours where six casualties were found and removed from the upper corridor by 05.06 hours. Additional BA teams (to a final total of five teams involving 11 personnel) were committed as further resources arrived. These additional teams discovered further casualties on the upper floor.

2.18 The OIC sent a final assistance message "make pumps 6, several possible fatalities, send on fire investigation and audio visual" at 05.25 hours as it was considered prudent to request additional resources for the relief of existing personnel, fire investigation and damping down procedures.

2.19 The small pockets/embers of fire remaining in the cupboard of origin were finally extinguished at approximately 05.25 hours, therefore personnel from the appliances which completed the six pump attendance took no active part in fire fighting or search and rescue operations

2.20 During the incident, crews were committed to the risk area in order to locate and extinguish the seat of the fire. Furthermore, it became clearly apparant that a number of rescues were required. These demanded a dynamic response to what was an extraordinary set of circumstances, and called on firefighters to deploy to the limits of operational procedures and doctrine. In so doing, the attending crews rescued 24 casualties of which 20 survived the incident.

2.21 In total, 14 casualties were discovered in the upper corridor, ten of whom were later confirmed to be fatalities at the scene and an additional 4 casualties were rescued alive only to tragically expire later in hospital.

2.22 The Sheriff Principal opined, following toxicology reports and expert witness statements, that the 10 residents who were pronounced dead at the incident had succumbed to the toxic fire products by 04.39 hours, before the attendance of the first appliance.

3. Immediate responses

3.1 A statement was made in the Holyrood Parliament by the incumbent Justice Minister, Cathy Jamieson MSP, on 4 February 2004, that, in order to provide reassurance to all concerned,

> *"...we have decided that the 1,800 or so care homes in Scotland should be visited to confirm that there are no obvious deficiencies in the fire safety measures in those homes[vi]".*

These visits were to be carried out by Fire Services (FRS) and undertaken outwith

> *"normal daytime hours to offer reassurance and any necessary advice at a time when residents and staff might feel most vulnerable[v]".*

Figure 6- Scottish Parliament in 2004

3.2 These visits were facilitated by means of letters sent to all care providers in Scotland from the incumbent Regulatory Authority (CC) as the extant fire safety legislation[vii] gave no statutory powers to Fire Authorities to routinely enter and inspect registered care facilities. These letters were sent to the providers.

Operations

3.3 It was intended within SFR that these "Reassurance visits" would be carried out by operational personnel where possible, in order to facilitate the provision of advice and reassurance to residents and staff members in addition to providing opportunities for crew familiarisation with the individual premises.

3.4 The visits were unannounced and carried out between 21:00 hrs and 04:00 hrs.

3.5 All operational officers had received training in technical fire safety as part of their role in re-inspecting premises holding a fire certificate under the Fire Precautions Act 1971 (FPA).

3.6 The programme began on 8 March 2004 and was completed by June 2004.

3.7 In Strathclyde this involved 701 premises of which 667 were care homes (the remainder consisted of independent hospitals including hospices, school care accommodation services and secure accommodation).

Community Safety

3.8 It was identified that in rural areas in Strathclyde, where fire cover was provided by Retained Duty System (RDS) and Volunteer personnel, there was insufficient knowledge and experience in technical fire safety available within those personnel to carry out the reassurance element of the visits, therefore a blend of Flexible Duty Officers (FDS) and Fire Safety Officers (FSO) were employed in this regard.

3.9 All the visits were facilitated by the production of a book containing pre-printed No Carbon Required (NCR) checklists designed and provided at Corporate Level within SFR. Each form was completed in triplicate utilising the NCR facility allowing a copy to be left with the care provider, one copy to be returned to the Care Commission for information and subsequent action and the final copy to be retained by SFR for record purposes. Additional guidance on completion of the checklist was designed and promulgated for use by officers conducting the visits.

3.10 The checklists consisted of 18 questions which acted as a prompt for personnel undertaking the visits and ensured a consistency of approach across SFR.

- Does the premises have a current fire risk assessment?
- Records of fire/evacuation drills carried out in the previous 12 months are available?
- Records are available of training of all staff in the previous 12 months?
- Staff are aware of action to be taken in the event of fire, or a fire alarm actuation?
- Staff are familiar with evacuation procedure in the event of fire?
- Records are available of emergency lighting tests carried out in the previous 12 months?
- Records are available of the fire, automatic detection system being tested in the previous 12 months?
- Records are available of the means of giving warning in the event of fire has being tested in the previous 12 months?
- The means of fighting fire is readily available, and has been tested in the previous 12 months?
- All bedroom doors are fitted with an automatic self-closing device, in good working order?
- All final exits are unobstructed and open freely?
- Means of escape corridors are kept free from obstructions?

3.11 The existing Fire Safety Database was adapted to record the details of the visits carried out by all staff and to produce the returns requested by the Scottish Executive Justice Department (SEJD).

3.12 All completed checklists were passed to local FSO, who were responsible for checking that no major issues had been noted and collating the relevant copies for delivery to CC. Premises causing undue concern in terms of fire safety matters were also subject to an "exception report" to the SEJD and CC.

3.13 FSO began a programme of visiting care services in May 2004 to explain items contained in the Reassurance Visits reports and to assist providers in formulating their action plans required by CC. These visits especially highlighted the requirement to carry out a Fire Risk Assessment.

4. Intermediate developments

4.1 Legal deliberations (external to and outwith the control of SFR) related to the Rosepark incident led to a period of some six years passing before the Fatal Accident Inquiry began in 2010. However, this interval did not delay the development of responses to the Rosepark tragedy. All business streams within SFR undertook development in relation to safety in Care Homes, whether in response to internal or external stimuli.

Operations

4.2 An additional tranche of reassurance visits were instituted in 2007, with particular emphasis on the number of staff on duty during the night and their knowledge and understanding of evacuation procedures within the premises.

4.3 Operational Technical Note (OT Note) A.124 "Procedures for responding to incidents in residential care homes" was formulated and promulgated in 2008. This Note introduced detailed procedures relating to operational intelligence gathering, familiarisation visits for each watch, liaison with FSO and care home managers. In addition, OT Note A.124 encouraged the preparation and dissemination of a bespoke response plan for each care premises.

4.4 OT Note A.124 also ensured that the enhanced operational intelligence gathering methodologies contained in OT Note A.83 "Operational Risk Information" were extended to residential care facilities, in particular the production of 3 dimensional plans stored on Vehicle Mounted Data System terminals (VMDS) provided in each appliance.

4.4 The PDA was increased to 3 appliances for Care Homes across SFR.

Fire Safety

4.6 Changes to building standards legislation in Scotland (BSA)[viii, ix], were implemented in 2005. The new functional standards produced by this legislation provided *inter alia* for the installation of automatic life safety fire suppression systems within new "residential care" buildings, including nursing homes.

4.7 The legislation also provided for statutory consultation between Building Standards Officers (BSO) and FSO in defined circumstances and the inclusion of a specific chapter within the technical guidance[x] relating to the detailed fire safety measures required in residential care buildings.

4.8 A formal Memorandum of Understanding (MOU) between FRS and CC in relation to fire safety in care services was signed by representatives of both parties in 2005.

4.9 The purpose of the MOU was to clarify the relationship between the parties, when the Fire Services would inspect care services or give opinions on fire safety in care homes, and to ensure that there was close cooperation and mutual understanding between the parties on fire safety matters.

4.10 The principle effect of the MOU was that, in respect of applications for new registration, SFR undertook to inspect the premises and report on their findings both to the applicant and to the Care Commission. An FSO would be required to comment on the care service's fire risk assessment. The standards of physical fire precautions within premises were benchmarked against SHTM84[xi] during the inspection process.

4.11 SFR also agreed to undertake fire safety inspections in all care home services, the regularity being determined by a process of risk assessment of each service. The inspection process was not limited to services in respect of which concerns had been raised by the Care Commission. It was a new programme of proactive inspection with the permission, and at the invitation, of theCare Commission.

4.12 The enactment of the FSA, in particular the introduction of Part 3: Fire Safety and the FSSR in October 2006, produced a sea change in the enforcement of fire safety legislation in Scotland, with the responsibility for the enforcement of fire safety in non-domestic premises (in the main) being placed firmly upon FRS.

4.13 An immediate priority for formal Audit in terms of FSA in Strathclyde was care facilities, in particular nursing homes, which were subject to Audit within the first year of operation of FSA.

4.14 The formal Audit process uses a pro-forma, consistent across Scottish FRS, in order to comprehensively assess the compliance of fire safety management and measures provided in the relevant premises in the following areas:

Has the process of fire safety risk assessment been carried out for the premises?

Areas of consideration:

- Fire safety risk assessment process undertaken, completed and records available;
- Assessment covers all risks which may affect those who may be at risk from fire;
- Evidence confirming the assessment is reviewed on a regular basis;
- Where young persons are employed, particular account is taken; and
- Where appropriate, dangerous substances, both new and existing, have been taken into account.

Have reasonable measures been taken to reduce the risk of fire?

Areas of consideration:
- Standard of housekeeping;
- Storage;
- Control of flammable and combustible material;
- Security against fire raising;
- Fittings and contents;
- Use of equipment and processes; and
- Electrical systems subject to appropriate testing.

Have reasonable measures been taken to reduce the spread of fire?

Fire spread potential has been considered and where appropriate, measures taken in terms of:
- Compartmentation;
- Separation;
- Internal linings;
- Cavities; and
- Fire spread on external walls.

Are there appropriate fire safety arrangements?

Areas of consideration:
- Effective management attitude to fire safety;
- Planning, organisation, control, monitoring and review of fire safety measures in place; and
- Are arrangements recorded (where applicable).

Are arrangements in place to manage the elimination or reduction of risks from dangerous substances?

Areas of consideration:
- Controls to eliminate or reduce risk;
- Replace dangerous with non dangerous substance;
- Adequate controls;
- Control of ignition sources;
- Mitigate detrimental effects;
- Safe handling, storage & transportation; and
- Ensuring that conditions necessary for the elimination or reduction of risks are maintained.

Are there suitable additional emergency measures provided to safeguard all relevant persons from an accident, incident or emergency related to dangerous substances in or on the premises?

Areas of consideration:

- Information on emergency arrangements is available;
- Suitable warning and other communication systems are established to support response, remedial actions and rescue operations;
- Where it is considered necessary, escape facilities are provided and maintained;
- Information provided to accident and emergency services available and displayed at the premises;
- Plans are in place for immediate steps to be taken in the event of an incident occurring, which include steps to mitigate the effects of fire, restore the situation to normal, informing relevant persons who may be affected; and
- Personal protective equipment, clothing, specialised equipment and plant provided and available in case of an incident occurring (where necessary).

Are effective fire warning arrangements provided?

Areas of consideration:

- Appropriate system for the risk;
- Audibility levels;
- Appropriate levels of detection;
- Management of unwanted fire alarm signals; and
- Commissioning / Installation certificates available.

Are effective means for fire fighting provided?

Areas of consideration:

- Appropriate levels and standard of FFE;
- FFE suitably positioned;
- Suitable signage for FFE provided;
- Nominated persons sufficiently trained in the FFE provided; and
- Contacts with emergency services regards fire-fighting and rescue work.

Is effective means of escape provided and maintained?

Areas of consideration:

- Emergency routes and exits;
- Safe and quick evacuation;
- Number and distribution of emergency routes and exits;
- Direction of door openings;

- Correct use of sliding/revolving doors;Suitable door fastenings;
- Signage; and
- Emergency lighting.

Are there appropriate procedures for serious and imminent danger from fire and for danger areas?

Areas of consideration:
- Appropriate procedures in place for evacuation in case of fire;
- Safety drills carried out;
- Sufficient number of competent persons to manage evacuation;
- Prevention procedures to restrict exposure of relevant persons to risk, unless trained; and
- Information and instruction to non employees to restrict exposure to risk.

Are fire safety measures being maintained?

Areas of consideration:
- Relevant premises maintained in good repair;
- Fire systems and equipment subject to suitable systems of maintenance;
- Regular testing by competent persons; and
- Records being maintained.

Are there an adequate number of competent persons and arrangements in place to assist the dutyholder in undertaking measures to comply with Chapter 1 duties?

Areas of consideration:
- Sufficient number of competent persons appointed;
- Sufficient training given to competent persons;
- Co-operation between appointed persons;
- Information given to appointed persons who are non-employees;
- Information about other employees/persons at risk; and
- Co-operation between competent persons.

Is provision made to provide comprehensible and relevant information to employees?

Areas of consideration:
- Significant findings of fire risk assessment provided;
- Details of fire safety measures taken provided;
- Appropriate procedures to be taken in the event of an emergency;

- Details of appointed competent persons;
- Young person's controls;
- Information on dangerous substances provided; and
- Reviewed periodically.

Is comprehensible and relevant information provided to employers and employees from outside undertakings?

Areas of consideration:

- Information provided to employers of any employees from outside undertakings with regard to risks to those employees and fire safety measures undertaken;
- Employees from outside undertakings provided with appropriate instructions and information regarding risks; and
- Employers and employees from outside undertakings are given information with regard to evacuation procedures within the relevant premises.

Are employees given adequate fire safety training?

Areas of consideration:

- Induction training;
- On transfer or working with new or changed risks;
- New equipment or change of existing;
- Introduction of new technology;
- New systems of work;
- Emergency procedures;
- Competent persons to secure evacuation;
- Reviewed periodically;
- Adapted to take account of change;
- Training being delivered by competent persons; and
- Evidence of training available;

Is there co-operation and co-ordination between dutyholders where there are two or more sharing responsibilities or have duties in respect of premises?

Areas of consideration:

- Co-operation to enable compliance with requirements and prohibitions imposed by or under the Act;
- Reasonable steps taken to enable compliance with requirements and prohibitions imposed by or under the Act;

- Reasonable steps taken to inform other duty holders with regard to risk; and
- In case of explosive atmospheres the person with overall responsibility for the premises has taken steps to co-ordinate the implementation of all relevant measures to protect relevant persons;

Are employees carrying out their general duties while at work?

Areas of consideration:

- Reasonable care being taken by employees to prevent harm to others who may be affected by their acts or omissions at work;
- Employees co-operate with their employer to enable compliance with any duty or requirement; and
- Hazards identified by the employee reported to the employer or other employees with specific responsibility for safety.

Are suitable arrangements in place to ensure that facilities, equipment and devices for use by or the protection of fire fighters are maintained in an efficient state, in efficient working order and in good repair?

Areas of consideration:

- Testing and maintenance records available and up to date;
- Fire fighting shafts;
- Dry/wet risers;
- Measures in place to ensure co-operation between occupiers for the maintenance of facilities;
- Fireman's switch;
- Smoke ventilation systems; and
- Common areas of private dwellings.

4.15 Additional guidance and information capture was developed and provided for operational crews engaged in the secondary tranche of reassurance visits in 2007.

Training and Operational Review

4.16 A review of SFR's Incident Command (IC) system was initiated, which led to a comprehensive programme of incident command training being provided for all operational commanders.

4.17 A formal programme of Assessment of Incident Command Competence (AICC) for all incident commanders was introduced for all levels of the organisation, from the aspirational fire fighter to the Chief Officer.

4.18 Residential care homes are used within AICC scenarios to specifically assess the ability of commanders to deal with this specific type of risk.

4.19 SFR have devised, designed and implemented command training courses at Gold Silver and Bronze levels which are attended by all 8 FRS in Scotland.

4.20 A process of operational review of Incident Command has been implemented. Monitoring officers are mobilised to incidents to observe and provide hot strike feedback on IC during operational incidents, which in turn feeds back into the wider IC process.

4.21 It has been recognised nationally[xii] that more than 3 strands of control in a dynamic operational situation will overwhelm the individual. Enhanced support has therefore been provided for the Incident Commander by the introduction of search co-ordinators and roll call officers.

4.22 The Maintenance Phase Development Plan (MPDP) was devised and implemented. This is a structured, Service-wide training programme which addresses the individual's core skills, in particular preparation for incidents in all sleeping risks.

4.23 A programme of BA refresher training was devised, initiated and delivered to all operational personnel.

5. The determination

5.1. Sheriff Principal Lockhart includes 7 main findings in terms of reasonable precautions which could have been expected, 5 main findings regarding failings of systems of work and 11 findings in relation to other factors relevant to the circumstances of the deaths. SFR welcome the Sheriff Principal's findings and will actively address them.

5.2 Several of these findings, particularly in terms of other factors such as the actions of the health board and inspections by CC staff in relation to fire safety measures have been superseded in the intervening years. This section will, therefore, concentrate on the elements of the findings which require a response from SFR and other parties.

Reasonable precautions

Inspection and Testing of the Electrical Installation

It would have been a reasonable precaution for the distribution board to have been inspected and tested in accordance with the IEE Regulations at least on the following occasions:-

a) On completion of the electrical installation at Rosepark in 1992;

b) When the system was modified; and

c) Not later than the fifth and tenth anniversaries of the completion of the electrical installation.

5.3 Evidence is actively sought during Audits that reasonable precautions are being taken to reduce the risk of fire. This includes evidence that the mains electrical installation is subject to a suitable regime of inspection and testing by a competent person.

Protection of the Means of Escape

Cupboard doors

It would have been a reasonable precaution for the doors to the cupboard which was the location of the fire to have been kept locked shut or at least securely closed.

It would have been a reasonable precaution to have fitted fire-resisting doors to the cupboard which was the location of the fire.

5.4 The sector specific guidance (the guide) issued by the Scottish Ministers in respect of care homes[xiii] includes recommendations in line with these precautions, therefore assessment of these measures forms part of the Audit process.

Closed bedroom doors

It would have been a reasonable precaution for all bedroom doors to have been closed in the event that a fire alarm sounded. In particular it would have been a reasonable precaution for the management of Rosepark to have fitted devices to ensure that bedroom doors were closed automatically in the event that the fire alarm sounded.

5.5 Again, the requirement for bedroom doors to be closed in the event of fire is contained in the guide and forms part of the Audit process.

Fitting Smoke Seals to Bedroom Doors

It would have been a reasonable precaution to have fitted smoke seals to bedroom doors.

5.6 The current standard accepted by SFR for bedroom doors, within existing care facilities, is FD30S, i.e. providing short duration (30 minutes) resistance to fire complete with ambient temperature smoke seals and intumescent strips located in the edges and top of the door.

Storage of combustible materials

It would have been a reasonable precaution to minimise the storage of combustible materials in the cupboard which was the location of the fire. In particular, it would have been a reasonable precaution not to store a quantity of aerosols within the cupboard which was the location of the fire.

5.7 Current Audit procedures include an assessment of storage facilities for combustible materials within the premises. In addition, storage of combustible materials within cupboards containing electrical distribution equipment has been actively discouraged in all premises types since the tragedy.

To subdivide the corridor substantially involved in the fire
The number of persons accommodated in the corridor substantially involved in the fire, namely 14, were too many for an effective evacuation. It would have been a reasonable precaution in these circumstances to subdivide that corridor.

Other reasonable precautions open to management to deal with this obvious concern would have been:
a) as an interim measure, they could simply have decided to take fewer residents;
b) they could have moved highly dependent residents to other locations;
c) they could have installed a sprinkler system;
d) they could have employed additional staff on the night shift.

5.8 A major area of assessment during the Audit process is whether there is a sufficient number of competent persons to secure the evacuation of the relevant premises. In the case of residential care premises, that assessment takes account of the ratio of staff available to the number of residents in the compartment of fire origin.

The Sheriff Principal's reasonable precautions at a) to d) above have all been considered and proposed in specific cases within SFR following Audit.

Fire Dampers
The installation of fire dampers would have been a reasonable precaution.

5.9 The level of compartmentation and sub-compartmentation is assessed during the Audit process, in which the provision of fire dampers in ventilation systems passing through fire resisting barriers is included. If there is doubt as to the existence of the necessary compartmentation, the dutyholder would be requested to provide evidence to confirm that the compartmentation exists.

Prompt and Effective action by Staff

Information at the Alarm
It would have been a reasonable precaution to have provided clear information at the fire alarm panel (and, in particular, a diagrammatic representation) such as would enable staff to identify quickly and accurately the location of the detector which had been activated.

5.10 The provision of such a facility is not currently an explicit element for assessment within the Audit process. See Part 6 "Gap Analysis".

Training and Drills

It would have been a reasonable precaution for staff to have been provided with adequate training and drills in the action required of them in an emergency.

It is necessary that:

a) training be delivered not only at the start of a staff member's employment but also regularly thereafter;
b) training be related to the particular workplace;
c) training includes the communication of information about the way fires may behave in enclosed spaces, which is outside ordinary experience;
d) training be delivered by a knowledgeable and credible individual;
e) any members of staff who may be required to undertake emergency fire fighting, to be given sufficient training in the use of fire extinguishers to enable those staff members to engage confidently in emergency fire fighting;
f) staff who are expected, in an emergency, to undertake particular responsibilities, such as nurse in charge particularly on night shift, to be given appropriate and adequate training in those responsibilities, including evacuation procedure;
g) there is confirmation of competence which is an important output of training. It is essential to check that staff have taken on board the key elements of training;
h) all staff be subject to drills - not only to test that training has been effective, but to give staff practical experience at times of particular risk such as at night.

5.12 All of these points are required by Regulations contained within FSSR and, as such, compliance is subject to assessment during the Audit process.

Instruction of the nurse in charge in relation to the new Fire Alarm

It would have been a reasonable precaution for the nurse in charge to have been given instruction in relation to the new fire alarm panel which was installed some days before the fire.

It should be noted this would have involved:

a) drawing the new panel to the attention of any nurse who was to be a nurse in charge;
b) explaining to the nurse in charge that, although the panel had changed, the zoning arrangements had not changed;
c) giving the nurse in charge sufficient information to enable them to interpret the indications on the panel accurately;

giving the nurse in charge sufficient information to enable them to carry out the basic operations at the panel - silencing and re-setting - correctly.

5.13 The provision of such a facility is not currently an explicit element for assessment within the Audit process. See Part 6 "Gap Analysis".

The Events of the Night - Early involvement of the Fire Service

The following would have been reasonable precautions:

An immediate call to the Fire Service when the fire alarm sounded and, to that end:-
An Emergency Procedure which provided for an immediate call to the Fire Service; and an automatic transmission of a signal to the Fire Service in the event that the fire alarm was activated.

5.14 Assessment of the emergency procedures in place in any relevant premises form part of the Audit process.

5.15 The requirement for the provision of facilities for an automatic transmission of a signal to FRS on actuation of the fire warning system in existing buildings is not currently SFR policy. See Part 6 "Gap Analysis".

The exhibition, on prominent display in Matron's office, of a laminated sheet specifying clearly what information should be given to the Control Operator by the member of staff who calls the Fire Service;

5.16 The provision of such a facility is not currently an explicit element for assessment within the Audit process. See Part 6 "Gap Analysis".

To have had the callout slip received by fire fighters at the local fire station display the access address of the premises which is the subject of the emergency call at the top of the callout slip.

5.17 The enhanced operation intelligence contained within the premises specific response plan and the annual familiarisation visit by each watch to each care facility, required by OT Note A.124 will ensure that operational crews are aware of the appropriate vehicle access points and attend accordingly.

Classification by SFR of Rosepark Care Home as "special risk" under Operational Technical Note (OT Note) Index No A6 such that each watch at the local fire station visited it annually;

5.18 Residential care facilities are not classified as "special risks" by SFR in terms of OT Note A.6, however the application of OT Note A.124 ensures that these premises are visited by each watch annually, in addition to an enhanced PDA of three appliances to those premises ensure a similar level of response to premises formally categorised as "special risk".

For responding appliances to have attended at Rosepark Avenue instead of New Edinburgh Road.

5.19 Firefighters were called to the postal address in New Edinburgh Road. The enhanced operational intelligence contained within the premises specific response plan and the annual familiarisation visit by each watch to each care facility, required by OT Note A.124 will ensure that operational crews are aware of the appropriate vehicle access points and attend accordingly.

Suitable and Sufficient Risk Assessment

It would have been a reasonable precaution for the management of Rosepark to have undertaken a suitable and sufficient risk assessment.

5.20 The requirement for the dutyholder to carry out an assessment of the workplace for the purpose of identifying any risks to the safety of relevant persons in respect of harm caused by fire in the workplace lies at the core of the fire safety provisions of FSA.

5.21 Ultimately, the purpose of the entire Audit process undertaken by SFR is to assess the adequacy of the risk assessment carried out by the dutyholder, and then to require the rectification of any shortcomings identified.

Early and Sufficient Resourcing of the Incident by the Fire Service

For the officer in charge to have examined the fire alarm panel and zone card in order to verify the information he had obtained from staff about the possible whereabouts of the fire;

5.22 Consideration of the OIC's actions on arrival at incidents involving care homes is clearly stated in OT Note A.124, and forms part of the Incident Command training regime. Scenarios involving care homes form part of the Assessment of Incident Command Competence mentioned above and these actions are actively assessed during that process.

For the officer in charge to have treated the residents of the upper level bedrooms beyond the main stairwell as unaccounted for, until the position was established otherwise.

5.23 As 5.22 above.

For the officer in charge to have confirmed with the staff of Rosepark whether the doors to the bedrooms beyond the main stairwell were open or closed;

5.24 This recommendation is not currently explicitly stipulated in OT Note A.124. However, SFR accept the legitimacy of the point and OT Note A.124 will be reviewed to ensure that the Sheriff Principal's recommendations are fully implemented within it.

For the officer in charge to have instructed the message "make pumps 6" at 0450 hours when the persons reported message was sent;

5.25 SFR has introduced a system of mobilising appliances and supporting resources consisting of a series of "levels". This will ensure that there are adequate resources provided to ensure efficient and effective management of the incident command system.

The defects of any system of working

Maintenance of the Electrical Installation

The system of maintenance of the electrical installation at Rosepark before the fire was defective

It is to be noted that an adequate system of maintenance would have involved:

a) regular visual inspections and

b) periodic inspections and testing in accordance with IEE Regulations.

5.26 Evidence is actively sought during Audits that reasonable precautions are being taken to reduce the risk of fire. This includes evidence that the mains electrical installation is subject to a suitable regime of inspection and testing by a competent person.

5.27 The ethos of Audit in terms of FSA is "risk appropriate", rather than "prescriptive", therefore testing in strict accordance with IEE Regulations is not currently an explicit element for assessment within the Audit process. See Part 6 "Gap Analysis".

Inadequate Training and Drills

The system of work in respect of fire safety training and drilling of staff at Rosepark was defective.

5.28 Evidence is actively sought during Audits that staff are provided with fire safety training appropriate to role on induction and at regular intervals thereafter. This includes evidence that the mains electrical installation is subject to a suitable regime of inspection and testing by a competent person.

5.29 An explicit assessment of the confirmation of staff competence i.e. evidence that staff have understood the key elements of training is not currently an explicit element for assessment within the Audit process. See Part 6 "Gap Analysis".

System of Management of Fire Safety
The management of fire safety at Rosepark was systematically and seriously defective.

5.30 There is a specific requirement within FSSR (Regulation 10) that a dutyholder must make the necessary arrangement for the management of fire safety, including arrangements for the effective planning, organisation, control, monitoring and review of fire safety measures within the relevant premises. These arrangements should be recorded, where necessary.

5.31 The active verification of management systems forms an explicit area for assessment during Audits.

Other Factors

Certificate of Completion: The Position of the Architect and Building Control Authority
It is a fact relevant to the circumstances of these deaths that a certificate of completion was issued in circumstances where there had been a serious failure to comply with the Building Regulations in respect of the omission of fire dampers.

I (the Sheriff Principal) recommend that Scottish Ministers give careful consideration to the following proposals:

(1) Whether, when an architect signs an application for a completion certificate on behalf of a client, he should declare:
(a) the basis on which he was employed in respect of the project; and
(b) the steps he has taken to ascertain the building has been completed in accordance with the Building Regulations and the terms of the warrant; and

(2) Whether there should be a more prescriptive regime of the steps required to be taken by Building Standards before pronouncing themselves satisfied that a building has been completed in accordance with the conditions on which the relevant warrant was granted.

5.32 Whilst these proposals relate directly to consideration by Scottish Ministers, as FRS are statutory consultees in defined instances in terms of building standards legislation, and changes to methods used by BSO to verify compliance with the functional standards prior to accepting a completion certificate may have a bearing on that consultation. See Part 6 Gap Analysis.

Checking of Documentation in respect of Inspection and Testing of an Electrical Installation and a Ventilation System

It is a fact relevant to the circumstances of these deaths that there had been no external check for documentation vouching: (a) the testing and inspection of the electrical installation; or (b) the testing and inspection of the ventilation system.

I recommend
That there should be such an external check by a regulator.

There should be clarity between the potential regulators namely Health & Safety Executive (HSE), Fire and Rescue Service and the successor to the Care Commission (SCSWIS) as to who should carry out this task; and

The relevant inspectors should have instructions as to the nature of the documentation which they would expect to see.

Consideration should be given to the proposal of SFR that the smoke and fire integrity of compartments (which would include but would not be limited to the presence and effectiveness of dampers, if so fitted) be subject to expert certification in the same way as the electrical installation is certified.

5.33 SFR stand ready to assist in any negotiations with HSE and SCSWIS to determine which agency should take the lead in relation to ensuring suitable oversight of the testing and inspection of electrical installations and ventilation systems. See Part 6 Gap Analysis.

5.34 It is considered that, especially in terms of ventilation systems due to their installation within the fabric of the building precluding extensive inspection after installation, that additional reassurance regarding the standards of design and installation of such a system would be provided by third party certification.

Assurance as to the Competence of Fire Risk Assessors

It is a fact relevant to the circumstances of the deaths that there was at the time of the fire no statutory requirement as regards the qualifications of persons who provide services in connection with the risk assessment of care homes.

1. *The circumstances of this inquiry illustrate that in the specific context of fire risk assessments of residential care homes, there may be a case for a more prescriptive approach to be taken to the question of the qualification of persons who are engaged by duty-holders to assist. This could be justified: (a) by the particular difficulties attendant on fire risk assessment of such premises; and (b) the legitimate public aim of protecting vulnerable residents.*

2. *An alternative approach, short of statutory regulation, would be the use of third party accreditation schemes, with appropriate support being given to the importance of using accredited assessors in non-statutory guidance to those responsible for running Care Homes and in the actions of regulators The inquiry heard evidence that there are now registration or accreditation schemes for fire risk assessors run by four bodies (all but one of them post-dating the fire at Rosepark), and that the industry is actively engaged in developing third party certification schemes.*

3. *A similar point might be made about those who provide, install and maintain key protection systems such as fire alarm systems. There are already available third party certification schemes for such providers.*

5.35 SFR consider that some form of assurance of competence of persons undertaking fire risk assessments is critical in providing reassurance to dutyholder and regulators alike. It is understood that the Fire Risk Assessment Competency Council, a broad group of fire industry and business sector stakeholders, is preparing a competency standard for persons who carry out fire risk assessments on a commercial basis. It is anticipated that this will be published by the end of 2011[xiv] .

It is noted that the Sheriff Principal considers that a more prescriptive approach to the competence of fire risk assessors is justified in the case of care homes due, in the main, to the nature of the residents. SFR considers that any future prescriptive approach should be extended, as a minimum, to assessors who offer services in any sector providing sleeping accommodation, due to the higher risk presented by those premises.

SFR stand ready to assist in any future consultation on these matters. See Part 6 Gap Analysis.

Current Attitude of Care Commission to Issues of Fire Safety and the Fire (Scotland) Act 2005
I recommend if the guidance ("Fire Safety Guidance for 24 hour Services" issued by Scottish Ministers to Care Commission dated April 2007) is to remain in force, it ought to be amended to reflect as accurately as possible, the approach taken by the Care Commission, as evidenced by Ronald Hill and Jacqueline Roberts, to their statutory responsibilities under the 2001 Act and 2002 Regulations.

5.38 Whilst this is a matter for SCSWIS, SFR consider that, whilst SCSWIS inspectors are NOT responsible for the enforcement of fire safety in care services, the sharing of information, in particular evident concern experienced by an individual inspector in terms of a fire safety issue, is vital in maintaining fire safety standards.

5.39 SFR will act on complaints/concerns raised by any competent authority in relation to fire safety in relevant premises. As a minimum, any premises subject to a substantiated complaint will be audited within 2 working days.

Future Developments in the Regulatory Field

I recommend:

(a) early attention to be given by Scottish Ministers to place on a formal footing the relationship between SCSWIS, the Fire and Rescue Authorities and the Health & Safety Executive. How they are to operate together in the care service sphere is not just desirable but essential.

5.40 SFR have already entered into discussions with SCSWIS in relation to a replacement for the MOU jointly agreed with CC in 2007. In addition, CFOAS have agreed an interim MOU with SCSWIS. As above, SFR stand ready to enter any discussions required to ensure effective regulation of residential care facilities.

(b) the same applies to the relationship between SCSWIS and other regulators operating outwith the sphere of fire safety.

Colin Todd

Colin Todd, a renowned expert in the field of fire safety, produced a report setting out a number of suggestions and recommendations arising from his understanding of the circumstances of this Inquiry. He identified in that report matters which properly arise from the subject matter of this Inquiry and which it is appropriate that those charged with policy in relation to fire safety should consider.

I do not consider it appropriate that I make recommendations as to what actions should be taken by Scottish Ministers in respect of each and every one of these recommendations. I recognise that, in taking any decision, they will be advised by a body of expert opinion. The recommendations were not the subject of detailed evidence from other experts. No doubt Scottish Ministers will carry out a consultation exercise with interested parties. I think it is sufficient that I commend the report and the evidence thereon to Scottish Ministers for their careful consideration.

5.41 SFR have no adverse comment to make on the detailed proposals for inclusion in amended guidance documents by Mr. Todd. Indeed, on the contrary, they are considered to be worthy of our active support. Specifically, SFR do not currently and will not in the future utilise call challenging procedures in relation to calls from residential care facilities.

5.42 However, the inclusion of the individual recommendations within the documents maintained by Scottish Ministers viz. sector specific guidance for fire safety matters and technical handbooks in relation to building standards; and British Standards Institution (BSI) i.e. BS 5839: Part 1, in relation to fire detection and alarm systems, may not have the results that the Sheriff Principal intended.

5.43 As mentioned above, the enforcement of FSA is intended to be risk based as opposed to prescriptive. The status of the sector specific guides is clearly defined within each guide in the following terms "Where possible, this guide does not set down prescriptive standards, but provides recommendations regarding the fire safety risk assessment process, the reduction of risk and guidance on fire safety measures that can be implemented to mitigate risk. It is not necessary to follow the recommendations of this guide if other fire safety risk assessment methods, or fire safety measures which achieve the same end, are used. This means there is no obligation to adopt any particular solution in this guide if the outcomes of a fire safety risk assessment can be met in some other way."

5.44 In terms of enforcement, each guide states "Enforcing authorities are required to take into account the content of this guide to assist in determining whether enforcement action may be necessary but in doing so they should have a flexible approach to enforcement and should not use the benchmarks in the Technical Annexes as prescriptive standards. This would be a misinterpretation, as the objective is to use the relevant benchmarks when assessing the existing fire safety measures and the guidance provided in the Technical Annexes may be a method of assisting with the reduction of the risk."

5.45 This view is reinforced in Scottish Fire and Rescue Service Circular 17/2007[xv] (at paragraph 7) "All personnel involved in the enforcement of Part 3 of the Fire (Scotland) Act 2005 and the Fire Safety (Scotland) Regulations 2006 should be aware that the benchmarks in the sector specific guides are not designed to be used as prescriptive standards.".

5.46 The Technical Handbooks relating to building standards are also non-prescriptive guidance documents, indicating one method of compliance with the legislation. This is reinforced at Section 5 BSA "Failure to comply with a guidance document does not render a person liable to civil or criminal proceedings. But proof of compliance with such a document may be relied on in any proceedings (whether civil or criminal) as tending to negative liability for an alleged contravention of building regulations."

5.47

British Standards are also non-statutory guidance documents. Harmonisation of all existing National Standards across Europe is actively underway in line with the Construction Products Directive (CPD) [xvi.] Any changes to a British Standard which are not mirrored in the equivalent European Standard would, therefore, result in a robust implementation of the recommendation. Indeed, a prescriptive specification of a British Standard in a formal notice by SFR would probably be illegal in terms of the CPD.

5.48 It can be seen, therefore, that the inclusion of Mr. Todd's recommendations in the relevant guidance documents will not result in their automatic implementation. The Scottish Ministers would have to explicitly endorse the prescriptive implementation of those recommendations before the Sheriff Principal's direction would be achieved. SFR stand ready to assist in any consultation in relation to this point.

6. Gap analysis

Prompt and Effective action by Staff

Information at the Alarm
It would have been a reasonable precaution to have provided clear information at the fire alarm panel (and, in particular, a diagrammatic representation) such as would enable staff to identify quickly and accurately the location of the detector which had been activated.

6.1 The provision of such a facility is not currently an explicit element for assessment within the Audit process. However, SFR undertake to amend the current Audit form to reflect the need to actively assess this element and this will be reinforced with FSO by additional training.

Instruction of the nurse in charge in relation to the new Fire Alarm
It would have been a reasonable precaution for the nurse in charge to have been given instruction in relation to the new fire alarm panel which was installed some days before the fire.

6.2 Again, the provision of such a facility is not currently an explicit element for assessment within the Audit process. However, SFR undertake to amend the current Audit form to reflect the need to actively assess this element and this will be reinforced with FSO by additional training.

An immediate call to the Fire Service when the fire alarm sounded and, to that end:-
An automatic transmission of a signal to the Fire Service in the event that the fire alarm was activated.

6.3 The requirement for the provision of facilities for an automatic transmission of a signal to FRS on actuation of the fire warning system in existing buildings is not currently SFR policy which is influenced by national policy decided by the Chief Fire Officers Association (Scotland) (CFOAS). SFR will actively progress this recommendation with CFOAS.

The exhibition, on prominent display in Matron's office, of a laminated sheet specifying clearly what information should be given to the Control Operator by the member of staff who calls the Fire Service;

6.4 The provision of such a facility is not currently an explicit element for assessment within the Audit process. However, SFR undertake to amend the current Audit form to reflect the need to actively assess this element and this will be reinforced with FSO by additional training.

Maintenance of the Electrical Installation

The system of maintenance of the electrical installation at Rosepark before the fire was defective

It is to be noted that an adequate system of maintenance would have involved:
a) regular visual inspections and
b) periodic inspections and testing in accordance with IEE Regulations.

6.5 The ethos of Audit in terms of FSA is "risk appropriate", rather than "prescriptive", therefore testing in strict accordance with IEE Regulations is not currently an explicit element for assessment within the Audit process. SFR will actively progress this recommendation in consultation with CFOAS and Scottish Minsters.

Training and Drills
It would have been a reasonable precaution for staff to have been provided with adequate training and drills in the action required of them in an emergency.

6.6 The confirmation of staff competence i.e. evidence that staff have understood the key elements of training is not currently an explicit element for assessment within the Audit process. However, SFR undertake to amend the current Audit form to reflect the need to actively assess this element and this will be reinforced with FSO by additional training.

Certificate of Completion: The Position of the Architect and Building Control Authority

Whether there should be a more prescriptive regime of the steps required to be taken by Building Standards before pronouncing themselves satisfied that a building has been completed in accordance with the conditions on which the relevant warrant was granted.

6.7 Whilst these proposals relate directly to consideration by Scottish Ministers, as FRS are statutory consultees in defined instances in terms of building standards legislation, and changes to methods used by BSO to verify compliance with the functional standards prior to accepting a completion certificate may have a bearing on that consultation. SFR stand ready to assist in any consultations in relation to this recommendation.

Checking of Documentation in respect of Inspection and Testing of an Electrical Installation and a Ventilation System

It is a fact relevant to the circumstances of these deaths that there had been no external check for documentation vouching: (a) the testing and inspection of the electrical installation; or (b) the testing and inspection of the ventilation system.

6.8 SFR stand ready to assist in any process of consultation with HSE and SCSWIS to determine which agency should take the lead in relation to ensuring suitable oversight of the testing and inspection of electrical installations and ventilation systems.

Assurance as to the Competence of Fire Risk Assessors

It is a fact relevant to the circumstances of the deaths that there was at the time of the fire no statutory requirement as regards the qualifications of persons who provide services in connection with the risk assessment of care homes.

6.9 SFR stand ready to assist in any future consultation on these matters.

Colin Todd produced a report setting out a number of suggestions and recommendations arising from his understanding of the circumstances of this Inquiry. He identified, in that report, matters which properly arise from the subject matter of this Inquiry and which it is appropriate that those charged with policy in relation to fire safety should consider.

6.10 It can be seen that the inclusion of Mr. Todd's recommendations in the relevant guidance documents will not result in their automatic implementation. The Scottish Ministers would have to explicitly endorse the prescriptive implementation of those recommendations before the Sheriff Principal's direction would be achieved. SFR stand ready to assist in any consultation in relation to this point.

Glossary

AICC	Assessment of Incident Command Competence
BA	Breathing Apparatus
BSA	Building (Scotland) Act 2003
BSI	British Standards Institution
BSO	Building Standards Officers
CC	Care Commission
CFOAS	Chief Fire Officers Association (Scotland)
CPD	Construction Products Directive
FAI	Fatal Accident Inquiry
FASUDI	Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976
FDS	Flexible Duty Officers
FPA	Fire Precautions Act 1971
FRS	Fire & Rescue Service
FSA	Fire (Scotland) Act 2005
FSO	Fire Safety Officers
FSSR	Fire Safety (Scotland) Regulations 2006
HSE	Health & Safety Executive
IC	Incident Command
LHB	Lanarkshire Health Board
MOU	Memorandum of Understanding
MPDP	Maintenance Phase Development Plan
NCR	No Carbon Required
OC	Operations Control
OIC	Officer in Charge
OT Note	Operational Technical Note
PDA	Pre Determined Attendance
RDS	Retained Duty System
RVP	Rendezvous Point
SCSWIS	Social Care and Social Work Improvement Scotland
SEJD	Scottish Executive Justice Department
SFR	Strathclyde Fire & Rescue
VMDS	Vehicle Mounted Data System

References

[i] Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act c. 14 1976

[ii] Inquiry under the Fatal Accidents and Inquiries (Scotland) Act 1976 into the sudden deaths at the Rosepark Nursing Home. 20 April 2011, Sheriff Principal Brian A Lockhart: http://www.scotcourts.gov.uk/opinions/2011FAI18.html

[iii] Fire (Scotland) Act asp. 8 2005

[iv] Fire Safety (Scotland) Regulations SSI. 2006 No. 456

[v] Nursing Homes Registration (Scotland) Act c. 73 1938

[vi] The Official Bulletin of the Scottish Parliament. Second Session. 4 February 2004. Column 5449

[vii] Fire Precautions Act c. 40 1971

[viii] Building (Scotland) Act asp. 8 2003

[ix] Building (Scotland) Regulations SSI. 2004 No. 406

[x] The Scottish Building Standards Technical Handbook- Non-domestic Annex 2A.

[xi] Scottish Health Technical Memorandum 84: Fire risk assessment in residential care premises (SHTM 84)

[xii] Fire and Rescue Service Manual Volume 2: Fire Service Operations- Incident Command.

[xiii] Practical Fire Safety Guidance for Care Homes. Police & Community Safety Directorate, Scottish Government; HM Fire Service Inspectorate for Scotland; Scottish Building Standards Agency; Health and Safety Executive. February 2008

[xiv] Fire safety in purpose-built blocks of flats. Draft 18 April 2011. Local Government Association.

[xv] Scottish Fire and Rescue Service Circular 17/2007. Fire and Civil Contingencies Division. 25 October 2007

[xvi] The Council of the European Communities. Council Directive on the approximation of laws, regulations and administrative provisions of the Member States relating to construction products . Council Directive 89/106/EEC, Brussels.

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