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CRISIS RESPONSE
VOL:8 ISSUE:1
WWW.CRISIS-RESPONSE.COM JOURNAL
We need global disaster codes ................................. 63
Ed Blakely presents a strong argument for the introduction of international human settlement codes of practice, similar to today’s building codes, in order to encourage safer communities and to discourage building in unsuitable areas.

Space mapping ......................................................... 48
Alois A Hirschmugl describes how new technology was tested during the response to floods in Pakistan in 2010.

Social hazard resources ........................................... 50
Communication devices and multiple platform streams can be harnessed to act as force multipliers in crisis response, say Silas W Smith, Matthew Williams and Ian Portelli.

The role of public health .......................................... 54
Raphael M Barishansky and Audrey Mazurek describe how public health emergency preparedness has developed in the last decade.

The times they are a changin’ ..................................... 56
Mike Hall shares his thoughts on how and why today’s Fire Service is evolving, and what outside pressures are shaping these changes.

Spreading information .............................................. 58
In the wake of the London Metropolitan Police Service report into the 2011 riots, Anna Averkiou looks at how social media is changing the way crises are managed.

Training for transport emergencies ............................. 60
Training available for people who prepare for, and respond to, passenger transport emergency incidents is discussed by Willie Baker.

Communication plans .............................................. 62
Regina Phelps outlines how to ensure effective communication in an emergency.

Protocols are crucial to maintain the existing services provided to the public, but are one of the most important factors that affect their ability to operate effectively, says Gore & Associates (UK) Ltd.

Cover story: Strategy rethink

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Comment

Mastering the figures, not the facts; the compliance, not the meaning.” He says individuals at all levels are discouraged from using their creative judgement or from questioning core beliefs; and those who dare to do so are denounced. Constant and immediate scrutiny have led to the adoption of: “The most rapidly visible approach.”

Baumard’s theories are expressed in universal terms, but seem to be backed up by specific examples in this issue. On p56 Mike Hall questions how the safety domain is affecting the Fire Service, saying health and safety legislation, coroners’ inquests and official inquiries are: “Blessed with the religious clarity of hindsight,” and have little regard for the realities and pressures of emergency management.

On p10 Michael Eburn casts a legal eye over a recent high-profile fatal incident, concluding that the incident commanders in question operated correctly and complied with their employers’ stated policy. But, he says: “If we want rescuers to exercise imagination, flexibility and adaptability, then the training and doctrine of the organisation has to empower and authorise them to assess outcomes and, if necessary, depart from policy.”

Let’s be clear: the examples highlighted in this issue are drawn from the UK, but the problem is a global one; we are not questioning the constant need to improve safety and standards, nor the wisdom of learning from past incidents.

But unintended consequences are snaring first responders, who sometimes appear hamstrung, stilled by this universal strategic void and confounded by an abundance of restrictive edicts, unclear legislation, contradictory directives, media scrutiny and an enthusiastic litigious system. If this were a classic Gordian knot, we could slice through the red tape. Reality may prove more challenging.

Emily Hough
Editor in Chief
contents

News ............................................................... 4

Comment

Business and resilient cities ................... 8
Peter Gruetter says it is essential for the private sector to engage with the United Nations to reduce disaster risks

Health and safety law .............................. 10
Michael Eburn casts a legal eye over recent incidents that highlight the difficulties faced by fire commanders

Preventing state failure ........................ 14
Dave Sloggett investigates how targeting overseas aid can help to avert state failure and its associated crises

Incident analysis

Restoring power ................................... 16
Emily Hough speaks to the Manager of the Vasilikos Power Station in Cyprus, which suffered extensive damage when a nearby munitions depot exploded in July

Congo munitions blast ......................... 20
Two hundred people were killed and up to 6,000 buildings were damaged or destroyed in Brazzaville in a munitions storage explosion in March, writes Emily Hough

Learning from Turkey’s experience ....... 22
Cem Behar and Zeynep Gül Unal provide valuable lessons learnt from the two quakes that struck Turkey in 2011

Reviewing earthquake response ............ 26
Mike Hall presents findings from the Fire Service review into last year’s earthquakes in New Zealand

Interviews

What next for USAR? ...................... 28
Professor Elraim Kramer tells Hilary Phillips it is time to review the optimal delivery of cross-border urban search and rescue

Collective intelligence ....................... 30
Emily Hough talks to Bruno Maestracci, Head of France’s Operational Centre for Crisis Management, COGIC

Profiles

Heavy lifters ...................................... 32
Dave Sloggett highlights the use of C-17 aircraft in British Royal Air Force humanitarian activities overseas

Civil protection ............................... 34
To mark its 40th Anniversary, Alexander Kuvshinov charts the history of the International Civil Defence Organisation

Features

Securing London 2012 ....................... 36
Michael Fuller describes his design and implementation of the National Olympic Security Co-ordination centre that will be used in London this summer

Preparing for Sochi ......................... 40
Lina Kolesnikova scrutinises preparations for the 2014 Winter Olympic Games, in Sochi, Russia

Moving out of the classroom ............... 46
Alex Lopez Carresi argues that the only way to provide aid workers with the skills to deal with difficult situations in the field is to train them under realistic conditions
I n 2011, Sheriff Desmond J Leslie, holding a Fatal Accidents Inquiry (FAI) into the death of Alison Hume in Scotland was critical of the actions of several incident commanders from the Strathclyde Fire and Rescue Service (FRS). The incident commanders had vetoed plans by firefighters to attempt a difficult rescue from a disused coal mine. Although the victim’s injuries were said to be ‘survivable’ the local police and fire authorities took five-and-a-half hours to bring her to the surface. As a consequence of the delay, she died.

This article will review the findings of the FAI and the relevant UK law to demonstrate the difficulties facing commanders in the emergency services context. It will then consider, given recent developments in workplace health and safety law, how this situation might be governed in Australia.

In the Strathclyde incident, the victim had been walking home at night on July 25, 2008. When she failed to arrive home, her family searched and heard her calling from the bottom of a disused mine shaft.

The FRS received the emergency call at 02:12hrs. On arrival, a firefighter was lowered down the shaft using equipment provided for safe working at height and arrangements were being made to lower a paramedic, who was untrained in rope techniques. A senior officer arrived, took on the role of incident commander, and ordered the firefighters and paramedic to withdraw. The FRS had specifically ordered that safe working at height equipment was not suitable for rescue. Where rope rescue was required, the Strathclyde Mountain Rescue Team was to be called.

More senior officers came to the scene and took over the role of incident commander and each affirmed the decision that the FRS would not attempt a rescue. The Mountain Rescue Team arrived at 05:50hrs. At 07:42hrs, as the victim was being brought to the surface, the effects of hypothermia and her chest injuries caused a cardiac arrest. She was pronounced dead at 09:30hrs on July 26. Her injuries were described as: “Survivable, had prompt action had been taken to rescue her.”

**Legislative requirements**

Under the UK 1974 Health and Safety at Work etc Act, the incident commanders were obliged ‘to take reasonable care for the health and safety of … persons who may be affected by (their) … acts or omissions’. That duty was owed both to the firefighters and the victim awaiting rescue. Regardless of whether the decision to veto rescue is called an act or an omission, it was a decision that affected the victim, so the risk posed to her needed to be considered.

The matter was further complicated by corporate manslaughter law. The UK 2007 Corporate Homicide and Corporate Manslaughter Act says a corporation commits the offence of corporate manslaughter if the management of a corporation’s activities represents a breach of a legal duty and causes death. The UK police and emergency services are largely exempt from the Act’s provisions, save for duties owed to staff. The result is the FRS could have been prosecuted for corporate manslaughter if one of the firefighters had died, but not for the death of the victim herself.

The offence of corporate manslaughter is committed only by the organisation, so the incident commanders, as individuals, could not be charged with that offence. The incident commanders, however, could be charged with the offence of negligent manslaughter. This is established where the defendant owes a duty of care to the victim, there is a breach of duty in circumstances that can be described as gross negligence and the breach causes, or substantially contributes, towards the death of the victim.

In describing gross negligence Lord Aitken said: “For purposes of the criminal law there are degrees of negligence, and a very high degree of negligence is required to be proved before the felony is established. Probably of all the epithets that can be applied ‘reckless’ most nearly covers the case.”

Negligent manslaughter is an offence created by the common (or judge-made) law rather than having been enacted by Parliament. It follows that the Strathclyde incident commanders could have been charged with negligent manslaughter if anyone died and there were allegations of gross negligence. The FRS, on the other hand, could only be charged if one of the firefighters was killed.

The Sheriff noted that experienced firefighters had conducted their own risk assessment and were willing to modify their equipment and practices to attempt a rescue. Regrettably, had the firefighters proceeded and been killed or injured, their consent would have been no defence to proceedings for manslaughter or for breach of the Health and Safety at Work etc Act.

Said Sheriff Leslie at the FAI: “For a rescue to be achieved, some imagination, flexibility, and adaptability were necessary. There was clearly a balance to be struck between the interests and safety of the rescuers, and those of the casualty they were there to rescue. The core consideration of a risk assessment is a question of whether or not the risks to be taken are proportionate to the benefits gained.”

A proper risk assessment should have considered the risk to the victim as well as the risks to firefighters, but it had to be done within the confines of the law. The Sheriff did not expressly consider the provisions or obligations in the Health and Safety at Work etc Act.
If we want rescuers to exercise imagination, flexibility and adaptability, then the training and doctrine of the organisation has to empower and authorise them to assess outcomes and, if necessary, depart from policy.
When reviewing these events, incident commanders deserve to be judged on the basis of the information available at the time the decision was made and not with the distorting effects of hindsight bias...
committed if a corporation or a senior officer recklessly or negligently causes the death of a ‘worker’. If the Strathclyde incident had occurred in the ACT, both the FRS and the incident commander could be charged with industrial manslaughter if a firefighter died, but not for the death of the victim. In this jurisdiction, the legislation gives further weight to the claim that the duty to protect staff takes priority over the duty to others.

Notwithstanding our emotional reaction to the Strathclyde event, and our wish or desire that firefighters be permitted to act as heroes and do whatever is required to ensure a rescue, from a legal point of view, the Strathclyde commanders took the appropriate action.

Other incidents
The outcome at Strathclyde can be compared with the outcome following the deaths of four firefighters at a warehouse fire in 2007 at Atherstone-on-Stour, also in the UK. The exact circumstances of the deaths have not been reported, but three senior fire officers, who had acted as incident commander before, during or after the deaths, have been charged with manslaughter.4 If convicted, it will be the incident commanders, not the FRS, who will face punishment, which may include imprisonment. The Strathclyde incident commanders may have been subject to criticism but they have not been charged with any offence. The family of the victim may want to sue but it will be the FRS that is vicariously liable for any negligence.

With hindsight we know that a firefighter did descend into the shaft without complications, the land did not slip and the delay caused the victim’s death. To expect the incident commander to do anything other than apply their training in the context of their employer’s stated policy would be to ask them to substitute their judgement for that of the FRS, to disobey the express directions of their employer and to fail to co-operate with the FRS’s attempts to comply with its legal obligations, as outlined in the UK’s Health and Safety at Work etc Act.

An inherent problem in the application of work health and safety law is the use of restrictive edicts such as the one applied at Strathclyde. The direction that the safe working at heights equipment was not to be used for rescue constrained the commanders. Employees must follow the directions of their employers and this direction imposed a clear restriction on the available choices. Had they chosen to use the equipment or to act contrary to policy, and a firefighter had died, the incident commanders would have been in front of a different fatal accident inquiry having to explain why they took action that the service had expressly determined should not be taken and they, and the FRS, could be facing manslaughter charges. In the face of that clear direction, it would not be reasonable to expect the incident commanders to respond other than they did, whether they were responding in the U.K. 2007 or Australia in 2012.

If we want rescuers to exercise imagination, flexibility and adaptability, then the training and doctrine of the organisation has to empower and authorise them to assess outcomes and, if necessary, depart from policy. As the Fire Services Inspectorate said in its Report into the Galston Mine Incident: “… given the broad and ultimately un-definable range of incidents which the service might be called on to respond to, the best operational policies are ones which set out what can and cannot reasonably be done but which allow for intelligent and informed decision-making on the incident ground.”

Policy, training and law have to be flexible and identify factors to be considered and how to balance different risks, and then empower commanders to make the final judgement. The modern Australian law, with its focus on what is reasonably practicable and its express direction on the factors to be considered, could incorporate such flexibility. A FRS could move away from edicts and stringent standard operating procedures, but that would require a significant amount of trust in its staff and a willingness, still, to accept that there would be consequences that the community would not like – people will still be allowed to die when the assessed risk to rescuers exceeds the likely benefit, and firefighters will die when a rescue is considered ‘worth the risk’, but an unlikely, worst case residual risk occurs.

In either case, when reviewing these events, incident commanders deserve to be judged on the basis of the information available at the time the decision was made (including standing orders and service doctrine) and not with the distorting effects of ‘hindsight bias’.10

These real situations demonstrate the very real dilemmas facing incident commanders and the problems of applying work health and safety laws in the context of the emergency services. The law requires everyone, including firefighters, to do what is ‘reasonable’, but that gives little guidance. Many people are in positions where they have to balance competing objectives and considerations but, unlike emergency service incident commanders, they don’t have to do it in a dynamic environment where, whatever they decide, lives hang in the balance.

Regardless of the decision-making process, if someone dies, incident commanders are going to be required to answer questions and justify their decision.

This paper summarises the outcome of a Scottish Fatal Accident Inquiry and the law in both the UK and Australia. It cannot take the place of legal advice and necessarily skims over many issues that are relevant to the application of law to particular facts. Anything contained in here should not be relied upon to determine any action or legal position. If legal advice is required, readers should contact an appropriately licensed lawyer in their jurisdiction.

Sources
3- Andrews v DPP (1937) 2 All ER 552, 556 (Lord Atkin);
4- Steven Torrie, A Report to Scottish Ministers – The 2008 Galston Mine Incident (Her Majesty’s Fire Service Inspectorate, London, 2012);
6- See, for example, the State Emergency and Rescue Management Act 1989 (NSW) and the supporting disaster plans;
7- Crimes Act 1900 (ACT) ss 49C and 49D;
8- As the matter is still before the court as Crisis Response Journal went to press, the exact circumstances of the deaths have not been reported, but see article by Claire Elliott (March 1, 2011): Three brigade bosses to be charged with manslaughter over deaths of four firefighters in warehouse blaze, www.dailymail.co.uk/news/article-1361454/Fire-brigade-bosses-charged-manslaughter-warehouse-blaze; and the article by Steve Hayes (November 28, 2011), Atherstone fire charges could be dropped, www.learningonobserver.co.uk/2011/12/05/story-Atherstone-fire-charges-could-be-dropped-24000