Highlight Report

Name and Role	Joanne Hellen T/Health and Safety Manager

Period covered:

Date from:	**01/10/21**	**Date to:**	**31/12/21**

Highlights / achievements this period

COVID-19 Department Work – *Prevention, Protection and Response, develop and broaden the roles and range of activities undertaken by the Service, Collaborate with our partners.*

- **Government Guidelines for COVID-19**
  During the last quarter the Health and Safety department reviewed the COVID-19 workplace risk assessment in line with changes to Government guidance which in turn prompted a review of all sites COVID-19 workplace assessments. The department conducted the reviews at Fleet Workshops, BA Workshops and Stores and contacted other managers to request a review of their relevant workplace risk assessments. This is ongoing and will be completed for all sites by the end of January 2022.

Non-related COVID-19 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:

- **No 48 – "Guidance – COVID-19 Additional Control Measures"** was issued due to the rapid increase in transmission rates across the Service. In anticipation of a 10% absence trigger previous control measures were reintroduced to ensure our operational response, prevention and protection activities and wider risk critical business could continue with safe procedures in place to protect our staff and the public we serve.
- **No 49 – "Guidance – COVID-19 Changes to Self-Isolation Periods"** was issued in line with changes announced by the Government to reduce self-isolation periods from 10 to 7 days following two negative lateral flow tests taken 24 hours apart.

Issued Safety Flashes:

- **No 23 – "URGENT Seatbelts"** was issued following numerous seatbelt stalk failures on front-line appliances. Workshop Technicians were sent to visit all stations and remove the plastic coverings to check the integrity of the internal metal components.
- **No 24 – "Operation and use of Oxygen Cylinders**" was issued following notification of a fatal fire from the Ambulance Service which occurred when the valve of an oxygen cylinder was opened.
- **No 25 – "Fire Hydrant Outlet Extensions"** was issued for use with any fire hydrants fitted with an outlet extension when hydrants are particularly deep within the pit. The information contained in the safety flash ensures that deep pit hydrants are not rendered unusable.

Policy Reviews:

- The Health and Safety Policy was reviewed and updated following managerial changes within the Health and Safety department.

Eastern Regional Meeting

The department attended the Eastern Regional Health and Safety Practitioners Forum in December where all Services gave a COVID-19 update and reported increased absences due to the OMICRON variant.

The National Health and Safety committee met in October but did not issue any changes to COVID-19 guidance as the OMICRON variant had not yet taken hold.

Significant Accident Investigations

OSHENS IN009702 Contractor fall at Coggeshall Fire Station – Following an accident involving a sub-contractor who fell whilst working on the training tower at Coggeshall fire station, and an accident investigation by the on-call Health and Safety Advisor, a serious accident investigation board (SAIB) was arranged. The sub-contractor was working on the second floor of the tower when he fell against the scaffolding resulting in several broken ribs.

The board was chaired by a Group Manager who invited the relevant departments to attend and create an action plan so any issues identified by the accident investigation report could be addressed. The board looked at how Property Services issue working at height permits, the attendance by Station Managers at prestart meetings to ensure site specific risk assessments are completed, and the contractor's handbook. Six action points were created, and a follow up board meeting was booked to track progress of the action points and ensure completion. Following the meetings, we now have a process in place for spot checks on sub-contractors on Service premises, the system for issuing working at height permits has been reviewed and updated, all Station Managers have been reminded that they must either attend prestart meetings themselves or send a deputy and ensure that site specific risk assessments are completed, and Property Services will review and update the contractor's handbook accordingly. The contractor involved in the incident has now been removed from the Service's approved list of contractors due to in sufficient control measures and good working practices in place.

OSHENS IN009899 / 9933 – Seatbelts in Service Vehicles - Over the past few years, the Service has had several incidents of seat belt stalks breaking which prompted a significant accident investigation board (SAIB) to be arranged. Failures had occurred where the seat belt stalk had been forced under the BA kit and fastened to stop the audible alarms sounding. On several previous occasions we had released toolbox talks and safety flashes on the correct wearing and stowing of seat belts, as well as initiated full inspections of all front-line appliance seatbelts by the Station Managers and Watch Managers, but it became evident that a more in-depth inspection was required to ensure the safety of all personnel. The action plan identified 15 points to be addressed of which the main one was for Technicians from Fleet Workshops to visit all stations to inspect every seatbelt stalk by removing the outer covers to check the integrity of the internal works.

This was completed swiftly with 32 stalks completely replaced. The Health and Safety department re-released previous Toolbox Talks and worked with Corporate Communications and the Road Safety team to initiate a Service wide campaign for re-education on the wearing and stowage of seat belts. The work of the SAIB was shared at Station Managers and Managers Briefing meetings to ensure dissemination through the Service and the Training department were involved to ensure inclusion in all Driver Training. Operational Assurance will now include seat belt checks in their inspections and the Trade Union Rep bodies involved in the SAIB ensured the message was relayed to all their members. The Management of Road Risk policy was also reviewed to ensure it covered the wearing of seat belts.

RSM Risk Assurance Services Audit

RSM Risk Assurance Services carried out a follow up external audit on several departments, including the Health and Safety department, in May 2021. Action point 2 remains outstanding with partial assurance given.

Action point 2 *– "The Service will ensure that all new starters carry out the Health and Safety Premises Induction on their first day. To support this, a monitoring mechanism will be introduced, with non-compliance being escalated accordingly. We will make the Working Safely training a mandatory requirement for all staff, with this training being refreshed on a periodic basis".*
We received partial assurance on this action, and an induction and onboarding working group has been established involving the relevant heads of departments to ensure this action is completed and provides full assurance going forward. A Power App has been created to facilitate the onboarding process which is now being piloted before wider roll out across the Service.

OSHENS Replacement

Using a suitable health and safety management system will allow the Service to monitor, audit and review safety events in line with HSG65 Managing for Health and Safety to meet our statutory requirements. A new system is required that meets the Service needs now and in the future as OSHENS will be phased out by the provider over the next 3 years.

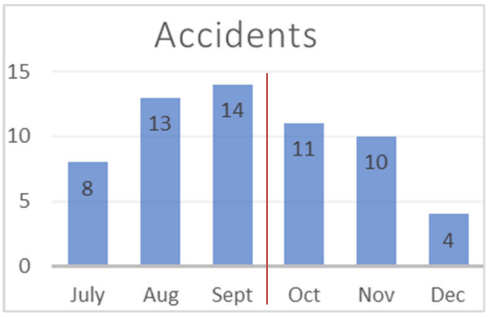
The OSHENS replacement PID will be taken to the Digital and Data Programme Board on 26th January 2021 for formal sign off.

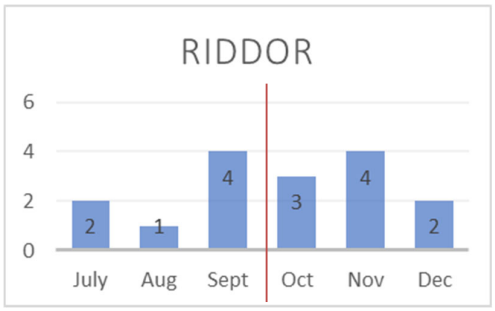
Safety Event Figures Q2 July, August, September and Q3 October, November, December

- *Prevention, Protection and Response, promote a positive culture in the workplace, Be transparent, open, and accessible.*

The graphs below show a comparison of Q2 safety event data with Q3 safety event data.

Accidents and RIDDOR





Accidents – There were 25 accidents reported in Q3 of this financial year, against 35 in the previous quarter. 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 previous quarter's accidents month by month:

- **October 2021**- Of the 11 accidents reported this month, **3 were related to Operational incidents**: 1 complaint of back pain (this injury was an over 7 day absence and RIDDOR reportable), 1 report of debris going underneath a visor and entering FF's eye, and 1 knee injury after ascending a ladder. **1 injury relating to responding** where a FF slipped in the bay while making their way to the appliance. **6 relating to Operational training**: 1 back pain during ladder drills, 1 rolled ankle whilst jogging back to the appliance, 1 shoulder discomfort during ladder drills, 1 experienced pain in their back after an RTC training exercise (this was an over 7 day injury and RIDDOR reportable) and 1 jarred back during a hose reel test. **1 relating to Physical training** where a FF broke a finger whilst playing volleyball (this injury was over 7 days and RIDDOR reportable, work is ongoing within the department to look at previous volleyball injuries/absences, and the impact it may have on the Service. This will be discussed at the next Health, Safety and Welfare Strategic Group in February).

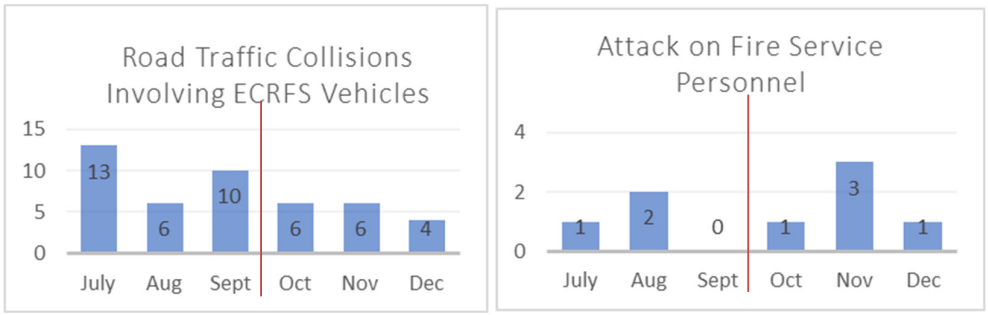
- **November 2021** – Of the 10 accidents reported this month, **5 were related to Operational incidents**: 1 injured ankle whilst hauling an extended hosereel uphill (this was an over 7 day injury and RIDDOR reportable), 1 twisted ankle on the edge of a pot hole (this was an over 7 day injury and RIDDOR reportable), 1 ill health whilst wearing BA, 1 back injury after slipping and

falling from a ladder and 1 FF suffered scalding to his hands and head at a domestic house fire. **1 injury relating to responding** where a FF fell from their bicycle whilst entering the yard (this was an over 7 day injury and was RIDDOR reportable). **2 relating to routine activities**: 1 fall whilst refuelling service vehicle (this was an over 7 day injury and RIDDOR reportable) and 1 back injury whilst gaining access to the battery compartment of the cab. **2 relating to Physical training**: 1 ankle injury whilst entering BA chamber and 1 injury to finger whilst trying to loacte pins in Paratech strut and footplate.

- **December 2021** – Of the 4 injuries reported this month, **3 were related to Operational incidents**: 2 injuries whilst attending an RTC persons trapped, 1 back injury and 1 arm injury, and 1 cut to arm also whilst attending an RTC and **1 relating to routine activities** where a FF's back went into spasm during weekly tests.

RIDDOR – there were 9 RIDDORs reported during Q2 compared with 7 reported during the last quarter (see above commentary). All RIDDORs reported were over 7 day injuries.

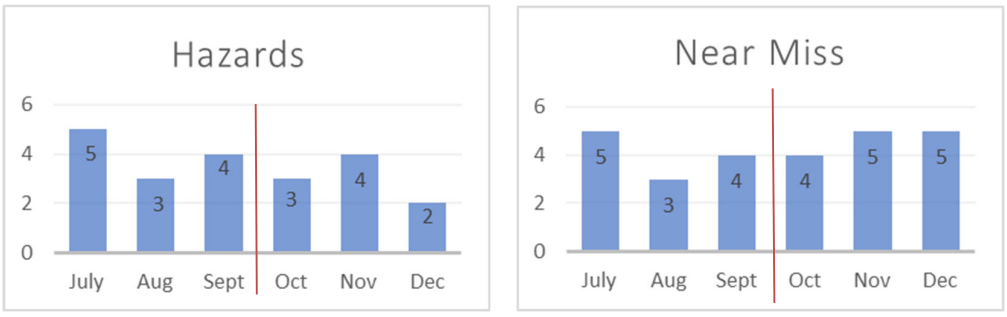
Road Traffic Collisions and Attacks on FSP



Road Traffic Collisions – There were 16 reported RTC's during Q3 compared with 29 reported during the previous quarter. Collision data is being analysed and discussed at the Operational Road Risk Group.

Attacks on FSP – There were 5 reported attacks on fire service personnel in Q3 compared with 3 of the last quarter. All reports were verbal attacks/threatening behaviour. No injuries were reported.

Hazards and Near Misses



Hazards - 9 hazards were reported during Q3 against 12 during the previous quarter. Reporting hazards is seen as part of a proactive health and safety culture and a Toolbox Talk was issued in June to remind personnel of the importance of reporting hazards following the low numbers of the previous quarter. Since release the department had seen Hazard reports steadily rise. The lower number reported this quarter could be attributed to less personnel within the workplace following the Omicron variant.

Near Misses - 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 previous quarter.

14 near misses were reported during Q3 against 12 in Q1. **3 reports relating to Operational incidents**: 1 air leaking from BA, 1 relating to difficulty with fitting hose coupling together and 1 report relating to the DIM vehicle avoiding a collision. **2 reported relating to responding**: both reports were related to 42P1 engine start failure. **7 near misses reported relating to routine activities**: 1 structural firefighting

gloves shrinkage, 1 fob failure to enter Station, 1 roller shutter door opening whilst vehicle in motion, 1 rolled ankle in yard, 1 relating to charging panels in the compressor room left unsafe, 1 lone worker attending a safeguarding visit where the resident had locked the door and 1 corrosion debris found whilst checking outlet extension for fire hydrant, Safety Flash 25 was issued following on from this report. **2 reports relating to Operational training**: 1 135 ladder jammed and 1 bonnet falling off a Service vehicle whilst travelling over a speed bump.

Key Risks (problems and opportunities predicted, not occurring)	**Mitigating actions – how prevent a problem or develop an opportunity**
OSHENS long term availability is not guaranteed and upgrades no longer available	Safety System Management replacement project initiated

Key issues (problems occurring now – needing action)	**Actions required ~~e.g.~~e.g., decisions needed**
Inability to integrate OSHENS system requires data to be manually extracted costing additional personnel hours and outstanding risk assessments are not automatically notified to owners which was raised as an exception during the last Health and Safety Audit	Project Initiation Document approval and commission successful health and safety management system