TAYSIDE FIRE BRIGADE INVESTIGATION

Report of Her Majesty's Fire Service
Inspectorate for Scotland

SCOTTISH EXECUTIVE

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TAYSIDE FIRE BRIGADE INVESTIGATION
TERMS OF REFERENCE

The Investigation was requested by the Minister for Justice on 31 May 2000. The terms of reference were:

- To review the handling by Tayside Fire Brigade of the incident at 13 Cardean Street on the night of 26 November 1997, taking into account previous inquiries and reports which are relevant to this;
- To consider the operational and other issues arising;
- To assess the extent to which any operational and other deficiencies have been remedied; and
- To make recommendations.

INTRODUCTION

1. Amanda Duncan died on 26 November 1997. Her death has resulted in a number of investigations being made at different times and by different responsible Law officers together with an internal investigation conducted by the Tayside Fire Brigade.

2. The incident in which Amanda died at 13 Cardean Street, Dundee was unexceptional in fire brigade operational terms. However, what occurred that night has had widespread implications not only for Tayside Fire Brigade but also for fire brigades further afield.

3. The incident itself lasted for little more than one hour. Amanda Duncan had recently moved into the flat. This was not her first occasion to be living away from home, although she was naturally excited at being in her new flat. It is speculated that she had been watching television, having a quiet night at home, when she became aware of the fire.

4. What happened next is unclear, but it is a fact that she was awake and alert at the time of the fire. The front door of Amanda's flat was also open at some time during the fire. Indeed there were heavy smoke deposits, most importantly in her living room. It was here that Amanda was ultimately found by firefighters. It is also apparent, from the evidence that has been collated, that at the time of the fire Amanda was not only fully alert but that she was able to shout for help.

5. She became aware of the fire, together with other residents, so that when the fire brigade arrived she with others all attempted to make their presence known. Her neighbours indicate that she not only called out for help and assistance but was answered to by at least one firefighter.

6. That she was not responded to effectively shortly thereafter remains at the heart of this Investigation. The circumstances of her untimely and unnecessary death remain extremely distressing, not only to her family but to a significant number of people in Dundee. Local people, their Parliamentary representatives and the news media have therefore ensured that her loss has not been forgotten.

7. Amanda died from smoke inhalation. As mentioned, key eye witnesses had made it clear that firefighters knew of her presence and whereabouts. The operational activities undertaken were flawed to the extent that Amanda was not found until after the fire was extinguished. What is less apparent is whether a successful operation would have found her in time to save her life, given that smoke had already penetrated her flat.

8. The documentation that has been reviewed in the course of this case is extensive. There has been a criminal case, a fatal accident inquiry, an internal discipline tribunal and now 2 HM Fire Service Inspectorate independent inspections. Because of these extensive reviews no further written evidence was sought but structured interviews were held with some of those closely involved.

9. In the Sheriff Court a Fatal Accident Inquiry was held in which some Tayside Fire Brigade procedures were criticised. A great deal of evidence was presented at this Inquiry.

10. The Sheriff specifically criticised personnel who attended to fight the outbreak of fire for defects in the Tayside Fire Brigade system of working. He also believed that a number of fire brigade witnesses did not answer questions truthfully.

11. Because of the seriousness of the Sheriff's comments and criticisms, an independent review was conducted by the Procurator Fiscal to identify whether members of the Brigade, in giving evidence, had committed an act of perjury. In the event the Procurator Fiscal determined this was not sufficiently clear to be able to proceed with any further action.

12. It should be remembered that the Procurator Fiscal had already been involved, successfully arguing that the fire itself was the result of an act of wilful fire raising. The individual responsible was identified following Police investigations and subsequently tried in the criminal courts. This individual was convicted and remains in custody.

13. However as a consequence of the Sheriff's comments, the Fire Authority, Tayside Fire Board, determined to conduct a further internal inquiry into the alleged misconduct of its staff. To assist them in this activity they appointed an investigating officer from another Brigade. This officer carried out inquiries that concluded that a number of members of the brigade had not acted fully in accordance with their orders on the night in question or had failed to carry out their duties in a fully satisfactory manner.

14. The result of these conclusions was that a number of members of the Brigade were formally charged with allegations of neglecting their duties under the Fire Services (Discipline) (Scotland) Regulations 1985 (Appendix A). A Disciplinary Tribunal was held which did find some members of the Brigade had neglected their duty and punishments were awarded accordingly. Information was therefore available from this Disciplinary Tribunal to this Investigation team.

15. During this Tribunal the Councillors, who were members of the Tayside Fire Board, hearing the case became aware that information existed concerning the action of Fire Control staff on duty at the time of the incident. This was information which was available but that had not been brought before any earlier hearing. This gave rise to a concern about the Brigade's openness on the whole incident.

16. Throughout the period since the incident the death of Amanda Duncan has remained within the public eye. Many people live in property very similar to that occupied by Amanda. It is therefore a matter of public concern that the questions of what happened and whether it could happen again should be answered.

17. It was as a result of this public disquiet that the Minister for Justice asked HM Fire Service Inspectorate to conduct a further Investigation. The Minister recognised that, as normal practice, HM Fire Service Inspectorate publish a public record on each of their inspections or investigations.

18. In asking HM Fire Service Inspectorate to conduct an Investigation the Minister provided the following terms of reference:

> To review the handling by Tayside Fire Brigade of the incident at 13, Cardean Street on the night of the 26 November 1997, taking into account previous inquiries and reports which are relevant to this;
>
> To consider the operational and other issues arising;
>
> To assess the extent to which any operation and the other deficiencies have been remedied; and
>
> To make recommendations.

19. In presenting this report the opportunity has been taken, using the information available from those investigations mentioned and following visits and discussions with some of those involved, to assess the current status of the Brigade and to attempt to meet the terms of reference provided by the Minister for Justice.

20. It is important however to recall that this incident took place nearly three years ago. Individual memories have inevitably become both faded and altered by the passage of time and, perhaps most importantly, by the various inquiries already held. Statements have changed, sometimes significantly, at various times.

21. Everyone who has been spoken to in the course of this investigation has fully co-operated in providing information. Many spoke freely and some have surprisingly expressed the opinion that this was the first occasion that they had been given to fully express their own views. Some too have been deeply hurt by allegations of misconduct or of acting outwith the public interest.

22. Most of those offered the opportunity to speak to the Investigation team did so readily, giving both of their time and information. We are very grateful for this support. Special mention must be made of Amanda's mother, Jane, and father, Bob Duncan, who helped despite the painful memory revived by the discussion. Their daughter was a bright, vivacious young woman who was on the threshold of a full life.

23. It is essential that we learn all the lessons that can be learnt, bitter though they may be, especially for the fire service. It is in that positive sense this Investigation looks forward with the benefit of hindsight to try and prevent a similar tragic death.

CONDUCT OF THE INVESTIGATION

24. The Investigation was led by HM Chief Inspector of Fire Services for Scotland Dennis Davis. The Inspectorate is based in Edinburgh and routinely visits brigades both to conduct formal reviews of efficiency and to assist in areas of fire service development.

25. The Chief Inspector was assisted by 2 further technical staff, HM Inspector Allan Whitton and Senior Assistant Inspector Charles Stewart, and the Inspectorate's Administrative Manager, Iain Fitheridge.

26. Prior to visiting Dundee in the week of 5 June 2000 the Chief Inspector invited, in writing, a number of individuals to offer their opinions on the purpose, as they saw it, of the Investigation. This included, at the Chief Inspector's express wish, Amanda's parents, Mr and Mrs Duncan.

27. Arrangements were made to utilise the facilities of HM Inspectorate of Schools offices at the Wellgate Centre, Dundee. This facility was most useful and thanks are recorded to the Schools Inspectorate for accommodating the Fire Inspectorate team with the inevitable disruption.

28. Whilst present in Dundee the Inspectorate staff visited or were attended by all those who intimated they wished to meet the Investigation team.

29. There were no formally recorded interviews during the period of the Investigation. When interviews were held, they were either open or loosely structured, or structured to gain answers to very direct questions.

30. Part of the reason for this open discursive approach was that abundant evidence generally existed from earlier inquiries. It was not within this Investigation's remit to deal with criminal or disciplinary issues, although all service personnel were advised that should breaches in law or discipline become evident then they would be reported to the relevant authority.

31. The evidence already in existence was gathered and is extensive (see Appendix B). It has now been reviewed. It is inconsistent in part. Views rather than fact emerged frequently. That said the open nature of the Investigation did provide an insight into the whole event.

32. This is an important point since hitherto each previous investigation has been distinctive - a criminal case, a fatal accident inquiry, an efficiency review, and a disciplinary tribunal. Each previous activity required very specific information and hence the individuals attending to give evidence for one investigation might not attend another. The consequence often of this approach is that there remains a feeling in many quarters, well expressed by the Fire Board's own internal Disciplinary Tribunal team, that all the facts did not get aired at any one previous hearing.

33. This Investigation has therefore attempted to look across the piece, at the event

as a whole. It has done that task without favour to the Tayside Fire Brigade. The Investigation Team, however, have remained alert to normal fire service practice and nationally agreed procedures by asking “What would other brigades have done in similar circumstances?”

34. Very clear underlying messages emerged at the beginning of this Investigation. Messages that affected behaviour. For example, simply put, the Brigade believed it was unfairly treated and constrained in any response by its own legal advice. Concerns surrounding future litigation possibilities for allegedly failing to do the job properly intruded into responding to real public demands for answers.

35. This restrictive attitude extended to involvement with the Procurator Fiscal who, in attempting to fulfil his statutory duties during the Fatal Accident Inquiry, found himself seeking technical support from the fire service, the very service likely to be criticised.

36. Recognising these limitations, perceived or real, has helped ensure the co-operation of the Brigade in this Investigation. The Firemaster and all those staff involved have been fully forthcoming in supplying information and answering questions - some of which to any professional person were possibly offensive.

37. The summation of the information and interviews held now forms the basis of this report. There are areas remaining of contradiction or unsubstantiated comment. Individuals have retired and statements given under oath have changed over time. The report, with those limitations, does however attempt to satisfy the Minister’s terms of reference.

38. This report does not therefore purport to be the definitive factual statement some might wish. It does, however, seek to provide an objective account of what probably happened and how a recurrence might be prevented.

SUMMARY VIEW

39. The following summary statements help clarify, in unambiguous terms, what the Investigation team believe to have happened They form the conclusion of that part of the Investigation relating to a review of the handling of this matter by Tayside Fire Brigade and others.

40. Amanda died because of a fire in her tenement. Her downstairs neighbour started that fire. She was alive when the Fire Brigade arrived. The Fire Brigade knew of her location. That location information was not given to searching firefighters in breathing apparatus. The search teams did not search properly. Understandable assumptions were made by those in charge that the search would be thorough. The consequence was that by the time Amanda was found she had lost her life to the fire. Some Brigade personnel made mistakes.

41. At the time of the fire it has been reported that internal disharmony existed on the duty watches at the East Kingsway Fire Station and Fire Control. Such tensions weaken communication and performance. The operational response required of firefighters and control staff to this incident was seen as the 'bread and butter' of fire service work. Strategy, operations and tactics were intuitive and action was primed by what was seen on arrival.

42. This was a Brigade confident in itself, experienced in tenement fires and close knit. Yet some things were not right before, during or after the fire. Staff relationships, supervision, personal performance and equipment and response to the failure, all show weaknesses. These issues are not unique to any single brigade. A chain of events began to form and the operational management process did not break the chain.

43. Leadership and resource prioritisation had created its own culture and attitude. Management believed they were in touch and "fully aware". Staff believed they were managed by paper and ignored. The truth is perhaps between these 2 observations. Staff believed that what they needed was more training and facilities to improve proficiency. Managers' priorities were to improve building and equipment assets and maintain an effective organisation. The minutes of meetings show, however, at that time and in the period since the fire, no real conflict in terms of priorities was recorded between staff and managers.

44. Fire service operations can be fast moving and highly threatening events. Decisions and actions are made rapidly, without quiet contemplation and sometimes with little solid information. Rightly the whole process is seen as one of dynamic assessment where decisions and actions change with the unfolding circumstances. This can be confusing to the public, perhaps even seen as chaotic. To the firefighters this is their workplace. The link between action and survival is real.

45. Many operations result in initial confusion as to who is accounted for and who may be missing. There is often a regular pattern of misinformation, no information and contradictions. The Officer-in-Charge, regardless of rank, experience and pressure, has

to make judgements and take decisions.

46. Training, equipment, procedures, practices, communication, command and control are therefore the safety net for the public and firefighters. Since the fire in severity or time cannot be predicted and the location or people involved preselected, this is a workplace where the skills, knowledge, good practice and equipment available to the firefighters largely determine how safe the public and firefighters will be.

47. After the event it could also have been anticipated that a public body, like a fire brigade, would supply a detailed report with professional support to help untrained non-fire service Crown legal officers explore the operational event. The Procurator Fiscal did seek further technical advice including reference to HM Fire Service Inspectorate prior to the Fatal Accident Inquiry. However in practice the Crown Office was left largely to find its own way without a good route map. In part this was because the Brigade had been advised, by its own Solicitors, to be careful to avoid matters which might prejudice the Brigade's position and in part it reflects how the Crown determined to present the case and the use of technical advice offered by HM Fire Service Inspectorate.

48. In a not dissimilar way the independently appointed disciplinary Investigating Officer did not access all the available information. This was again partly because he was not made fully aware of what existed and partly because of how he approached the investigation. He recognises that there is real concern that his judgement might have been different if, for example, he had seen the report on Control Room inadequacies. He remains confident, having now seen fresh information, that his conclusions would not have altered.

49. The Fire Board Discipline Sub-Committee have also been critical of their own Brigade. Not that they believed it to be a poor public service, but rather they believed they were presented with limited information and so gained the impression of a lack of openness and support from the very top of the organisation.

50. The Disciplinary Tribunal it has to be said, were very thorough and the hearing was possibly the longest held, at 17 days, in the fire service. The process resulted in considerable information coming forward which was different to that originally heard in the Fatal Accident Inquiry. So much so that different opinions were formed regarding whom it was who had spoken to Amanda - a central fact to the public disquiet over the whole affair.

51. The Disciplinary Tribunal itself, in considering this information and other information, such as the Control Room report which had not been considered before, had to reach decisions as to whether the individuals charged with offences were culpable or not and then punish those found culpable. The substantive information contained in the Control Room report had been available earlier but was not utilised at any other hearing. This is an onerous task under any circumstances, but especially so when a person has lost their life. Indeed the absence of a Control Room report challenged the quality of the very investigation they were hearing evidence about, suggesting other real gaps of evidence might exist.

52. Disciplinary procedures can involve an adversarial, rather than inquisitorial, style

of presentation. On this occasion that style of presentation was heightened by both the court like appearance of the hearing room and the 'beyond reasonable doubt' test of proof of culpability. Those present suggest this hearing was very much treated as a 'criminal case'. Partly because of this higher level test of proof, one key witness, the Sub-Officer who was the immediate subordinate of the Officer-in-Charge, did not attend, having had those charges laid against him withdrawn by the Presenting Officer who-failed to offer any evidence. This is a significant point since this individual not only knows a great deal about the incident but also was effectively accused, at the Fatal Accident Inquiry, of lying. He has never had a further formal opportunity to explain his own actions. Likewise although an independent technical adviser was present his advice was not sought until quite late in the proceedings. Retaining technical relevance after so many days of detailed information is not easy under such circumstances. Two witnesses also behaved with such disdain towards the Tribunal that a subsequent disciplinary investigation into their behaviour had to be undertaken.

53. It is to the credit of the Disciplinary Tribunal members that they fulfilled their duties and reached conclusions given all these circumstances, circumstances which appear to be some way from the spirit and intention of an internal disciplinary procedure for a public service which although uniformed is not a military service. It is also questionable as to whether using the procedures in this manner fully served the public interest.

54. The internal disciplinary process of taking statements from individuals within the Brigade also had one serious fault. One person, who was required himself to give a statement, was present at most other occasions when statements were given by his colleagues. No one segregated the individuals before they each gave their own statement. Such a procedure clearly runs the risk of someone gaining personal advantage and presents an opportunity for collusion for the purpose of concealing the truth. Collusion, for example, may very well have occurred on the fireground, very shortly after Amanda was found, as individual officers began to assess what had or had not happened.

55. Overall HM Fire Service Inspectorate consider this is not a bad brigade, with bad leadership and bad internal relationships. But desirable qualities, which to an extent the Brigade possessed, may through poor communication appear to be faults. Confidence can be seen as arrogance, experience as complacency and being close knit as secretive. These perceptions can be wrong yet they can shape opinions. Improvements can be made to both address the faults and reassure the public, especially in Dundee, that the failings can be rectified. Openness is a key element in that process.

56. Public education can also help. People have expectations of rescue operations which are sometimes at variance with the fire service's view of priorities. Smoke had entered Amanda's home. The most important contribution an individual can make to their personal survival in a fire is to prevent fire and smoke entering. The fire entered her home because it was within a common close and stairway trapping everyone. Tenements and other buildings in multiple occupancy with a single stair are vulnerable to fire in this way. Finding affordable and practical solutions is a further important step, in helping avoid further tragedies.

57. All of those within Tayside Fire Brigade with whom there was contact expressed

the deepest sense of sympathy with the family, profound distress that the service had let Amanda and her family down and an absolute determination to put things right and regain the full support of the public. This was not found to be an organisation that was casting off or rejecting what had happened. It was one which, yes, had been hurt by criticism and had argued forcefully its case, but knew deeply and intuitively that the Brigade's success in its core mission - to save life from fire - rested in achieving the public's willing co-operation and support and that it now required to regain this trust.

CHAPTER 4

THE FIRST SEVEN MINUTES

58. This Chapter attempts to provide insight into how those directly involved believe they acted in the first few minutes. There were fundamental conflicts in the evidence presented. This summary therefore recounts what was claimed by those present. The Officer-in-Charge was a Station Officer, and the Crew Commander of the second appliance a Sub-Officer. The first 7 minutes have been selected for the fireground operation. That is, from 23.38 until 23.45 hours, since this was a period critical both to the survival of Amanda and for decisions on the fireground. The Fire Control records provide insight into the call handling and the support system provided to the fireground. Later comments regarding the Fire Control reflect the period from 23.29 until 23.45 hours, ie 16 minutes, during which calls were received and mobilisation actions carried out.

59. To help set these first crucial moments in context the following sequence of times has been adopted from the official log recorded on the evening of 26 November 1997.

Time	Action
23.29	This is the estimated time that the fire started.
23.34	First call saying that there was a fire at 13 Cardean Street, Dundee. The following fire engines were despatched:- Call Sign A11.1, Call Sign A11.2, Call Sign A1.3. In addition the covering Assistant Divisional Officer (ADO) and the Police were informed.
23.35	2nd further call. The caller had stated that "the windows had blown and smoke was coming out". 3rd further call received. The caller said that " There is a fire underneath me". 4th further call reporting the fire
23.36	Four further calls received including one from one occupant, saying "We are on the second floor and we can't get out because there is smoke belching through the corridor".
23.36	The Control Room radioed the Officer-in-Charge to say that "For your information, the occupants of the flat above are unable to exit due to the smoke". 9th further call received to fire.
23.37	10th further call from Amanda Duncan stating her address and saying "It's my house".
23.38	Appliances A11.1 and A11.2 arrive at Cardean Street.
23.39	Appliance A1.3 arrived and the Officer-in-Charge sends back the message "Make pumps 3". [This is an assistance message used in the fire service to request a third engine.] Fire Control seek confirmation "Is this person reported or just make pumps 3". A11.1 radios back "Make pumps 3".
23.39	11th further call received in which the caller refers to someone "screaming for help".
23.40	12th further call received from an occupant at 13 Cardean Street saying " I am trapped at the top of a close". The caller goes on to say that " I cannot get out, the smoke is that thick. I cannot breathe or open my door".
23.41	Divisional Officer (DO) on cover informed.
23.43	Ambulance Control informed this is a "persons reported".
23.44	The third fire engine arrives.
23.45	Officer-in-Charge sends a radio message saying "Ground floor well alight, 2 jets [of water from hoselines], 4 CABA (Compressed Air Breathing Apparatus) in use,persons reported".
23.49	Officer-in-Charge sends a radio message "3 people removed from the First Floor by ladder". One man is led to safety by breathing apparatus crew.
23.51	ADO arrives at Cardean Street and takes command.
23.54	Further radio message reporting that "One further male removed from 2nd floor flat by ladder. Six breathing apparatus sets are in use."
23.55	Divisional Officer arrives at Cardean Street.
00.00	Radio message from DO saying that ADO will remain in charge of the incident and that DO will undertake health and safety monitoring.
00.04	Radio message from ADO that "all persons are accounted for".
00.14	Radio message from ADO indicating "Stop, (ie no further resources required) and that a Fire Investigation was now proceeding.
00.31	DO leaves scene.
00.40	ADO leaves scene.
00.41	Original OIC resumes command.
00.45	Amanda Duncan located in her flat.

60. On arrival the Officer in Charge [OIC] assessed the situation. There was a serious fire in one flat, on the left at ground floor level, and a number of persons were at windows calling for assistance. Within one minute the OIC had ordered a hoseline through the front window into the ground floor left flat, which was on fire (Appendix C). Firefighters could not pass through the close of No. 13 because flames were coming out of the door of the ground floor left flat and the close was full of smoke. The OIC ordered a second hose line through the close of No. 11 and into the rear of No. 13, to assist with the firefighting.

61. The OIC, realising he had limited resources, requested from Fire Control the assistance of a third fire engine. The OIC, by torch light through the ground floor right bedroom window, could see the room was clear of smoke and that the flat entrance door, which could be seen through the open hallway door, was closed and the hall clear of smoke. His assessment was that this flat was probably empty and smoke-free. He could see and had spoken through an open window to the occupiers of the first floor right flat, telling them to stay put but to close their window to stop smoke entering the flat. The smoke was travelling from left to right across the front of the building and upwards.

62. The OIC could see a light on at first floor left and caught a glimpse of a man further back in the room. On the second floor the occupant of the left flat was also at the window and again he was told to wait but stay in contact.

63. Within 2 minutes the Sub-Officer, who had helped lay the firefighting hoseline to the front of No. 13, took charge of laying the hose line through the close of No. 11. He asked a member of the public to hold the close door open and with a firefighter laid the line of hose to the rear of No. 11. Confronted by a high wall between No. 11 and No. 13 he assessed the rear upper floors, but not the ground floor, of No. 13 as not particularly showing any major fire difficulties or any persons requiring assistance. He requested from another firefighter a short extension ladder to scale the wall from No. 11 to No. 13.

64. Again at the front of No. 13 the OIC could not see any light on in the right hand second floor flat and assessed this occupant might be inside with the door shut, given the time of night. Likewise at third floor right there was no light or sign of the occupant. Finally on the left at third floor level there was a light on but no occupant to be seen.

65. At around 3 minutes after arrival the attack on the fire was taken over by a 2-man team dressed in breathing apparatus at the door of the flat. The Sub-Officer returned to the front of No. 13 to reassign one firefighter, who had initially been engaged in firefighting, to the rear of No. 11 as part of a second firefighting team in breathing apparatus. The OIC conferred with the Sub-Officer. The assessment was that: the ground floor was covered by firefighting operations and one empty flat opposite; at first floor level right one group was safe but there was no confirmation of the other occupier in the opposite left flat; at second floor level one occupant was identified on the left but no one on the right; and likewise at the top level neither left nor right flat occupant had been identified.

66. The Sub-Officer, who had been to the rear of No. 11, confirmed all appeared quiet there and that the second BA entry team was now being set up and deployed to the rear of the building, the wall between the properties having delayed access. The Sub-Officer indicated to the OIC, whilst at the front of No. 13, that smoke was coming from the small windows of the flats at the second floor right and top right.

67. After this discussion, at around 4 minutes after arrival, the fire was being fought from the door of No. 13. The OIC reconfirmed with the Sub-Officer the tactics of making an entry from the rear close, with a BA crew, to see if they could access the stairway. Because he now knew a wall had prevented the Sub-Officer going to the rear of No. 13 via No. 11 he also instructed the first firefighting BA crew to check out the back of the property as soon as they could pass the fire into the back court.

68. The Sub-Officer returned to the rear of No. 11 to check progress, having now assembled the necessary rear BA entry crew and organised access over the rear wall.

69. During these general operations a physical disturbance occurred at the front of No. 13 which resulted in the occupant of the ground floor left flat being arrested. This not only interfered with firefighting operations but, according to the OIC, created the impression that someone might actually be trapped in the ground floor left flat, which was the one on fire. Entry into that flat therefore became an important priority.

70. At 5 minutes after arrival the OIC ordered, in discussion with the Sub-Officer who had returned to the front of No. 13, that a third BA crew be organised and briefed to proceed upstairs to commence searching.

71. Simultaneously to giving these orders the OIC had noted that the first BA crew with the firefighting hose line had reduced the fire intensity sufficiently to allow them to move into the affected flat. The OIC could also see under the bottom of the smoke to the foot of the No. 13 stairway. The first BA crew had also briefly checked out the back court, slipping the bolt on the rear close door, and returned to tell the OIC that all was clear before going back to firefighting inside the flat.

72. The OIC, still unclear about the occupancy of the second right and top floor flats, crouched low and moved under the smoke to the rear of No. 13 to check for himself the likelihood of any occupants. In the rear yard he met the second BA crew who had now climbed over the wall from No. 11.

73. The OIC changed their orders telling them now to enter the building, not for firefighting since the close was now accessible, but to go to the top floor and start the process of search. He returned under the smoke to the front of No. 13 conscious that whilst he had been away he had not detailed anyone to watch the front or keep contact with the occupiers of the first floor right and first and second left flats.

74. The Sub-Officer in this period had responded to the order to find a third BA crew by starting to assemble from the few remaining available firefighters on the fireground a new BA crew. Just then, at 6 minutes, the third fire engine requested by the OIC arrived and the Sub-Officer transferred the order for a third BA crew to the Crew Commander from this appliance. This third BA team was briefed by the Sub-Officer to start at the top of the building and search downwards.

75. It was during these vital early stages that evidence given by members of the public states that a firefighter spoke to Amanda Duncan. However both the OIC and Sub-Officer are adamant that information regarding Amanda's predicament never reached them from any firefighter or member of the public. Had it done so they are equally both adamant it would have altered their priorities. One of the firefighters, who did subsequently enter the building in BA, had been in the back court and gave evidence of gen-

erally acknowledging various occupants at upper floors who called for assistance. He did not, however, find Amanda. That task fell to the Sub-Officer much later after the fire was extinguished and some other occupiers had returned to their own or another flat.

76. Throughout these early operations the OIC and Sub-Officer continually assessed what was happening at both front and rear of No. 13 and frequently spoke at the front of the building to occupants, to help reassure them that the situation was being brought under control. Naturally some residents were concerned and vocal, others were calm and quiet watching the operation. The OIC in particular describes how he remained fairly constantly at the front of No. 13, both to ensure he had a good command and observation position and to remain in contact with those occupants he could see.

77. The situation report, transmitted to Fire Control 7 minutes after arrival, confirmed that the fire was well alight and firefighting and breathing apparatus were in use and reported that persons were still within the premises.

78. Integral with the actions at Cardean Street were the initial and subsequent actions undertaken in Fire Control. These actions formed a major part in the deliberations of the Disciplinary Tribunal where it was identified that a management report, prepared shortly after the fire but not heard before the Fatal Accident Inquiry, had been self-critical of a number of the responses made during the call handling period.

79. In Fire Control the watch on duty from 1800 hours had an early evening that passed off quietly. The Supervising Officer, a Senior Fire Control Operator, who had returned from sick leave that night, had a conversation with a member of another watch briefly assigned to her watch to cover staffing deficiencies. Their discussion revolved around there being a strained working atmosphere in Fire Control that night which the Supervisor explained involved personnel issues.

80. At 2334 hours the calls began to come in for Cardean Street. The first gave a good address. A pre-determined response was selected of 2 fire engines and one turntable ladder. Other officers and the Police were informed. The calls continued to come in and for a short time modest stacking, that is calls that could not be instantly answered, occurred.

81. In this generally busy activity period between 2334 and 2338 hours the Supervisor believed she overheard another Control Operator refer to 'persons reported'[1], the distinctive fire service phrase to indicate rescues might be required. A 'persons reported' call status would also trigger other pre-determined responses, such as one more fire engine and wider notifications.

82. The Supervisor spoke to the Operator concerned - there was no response. The Operator was busy transmitting a radio message and possibly didn't hear. Then the incident OIC requested a third fire engine at 2339 hours. The Operator acknowledged and a colleague advised a senior officer by telephone that there was a 'persons reported' incident in progress. Later the Supervisor stated that, alarmed that she was missing some important information, she had checked this with all other operators "Have we got a persons reported?" The Supervisor states the answer was in the negative. Because of this assurance the Supervisor asked that the fireground be contacted by radio to confirm why they required the third fire engine. The answer back confirmed they had enough pumps on the fireground. The Senior Officer was recontacted by telephone to

1 'Persons Reported' is a standard phrase which indicates the persons may be trapped or requiring assistance. It frequently results in an increased attendance of firefighters and appliances to a call. It also alerts the responding crews to the likelihood of rescues being required immediately upon arrival.

advise him this was not a ‘persons reported’ incident. Control subsequently received a situation report at 2345 hours that confirmed ‘persons reported’.

83. Thereafter the normal incident management process took over with requests and support being managed by Fire Control. It was with real surprise and annoyance that the Supervisor heard the first message confirming the presence of a person requiring an ambulance. Much later it emerged that the loss of Amanda had occurred and that Fire Control had actually spoken to her as one of the multiple callers who reported the fire.

84. In Fire Control the initial mobilisation and response procedures worked adequately. The initial fire brigade attendance matched the first caller’s description of the incident. As the Fire Control became busier, the Supervisor also began answering calls. The concern was always that mixed in with the repeat calls to Cardean Street might be another different but equally important call.

85. It is not unusual during a busy call stacking period for the Supervisor to answer calls, rather than being alert and available to monitor the actions of all the remaining staff. However the uncommunicative atmosphere appears ultimately to have given rise to misinterpretation of vital information. Although individual members of the watch knew what was happening, for example one Control Operator spoke directly to Amanda on the telephone, collectively they did not and hence the Supervisor had what she termed a sense of unease. She had concluded, after the initial flurry of activity, that all had gone reasonably well except for the Senior Officer being advised incorrectly. The circumstances, we now know, were altogether different.

CHAPTER 5

ANALYSIS OF INCIDENT

86. The attendance at Cardean Street was the Brigade's standard response to a building fire. At the time of arrival 'persons reported' had not been confirmed and therefore a standard city response of 2 fire engines, together with a turntable ladder, had been made. On arrival the crews found a serious fire extending from the windows of the ground floor left flat into the street. They were able to see quite clearly the front of the building, albeit with some smoke drifting across.

87. The Officer-in-Charge took the strategic decision to extinguish the fire as the best method of ensuring the safety of those occupants that he could readily identify at the various windows. It was, in fire service terms, very much a normal tenement incident. This normality is also probably one of the reasons for the public concern that surrounds the way the incident was managed on that evening, ie how could the fire service get it so wrong on a typical fire.

88. The speed of events was again nothing unusual. Frequently in tenement fires it can be anticipated that the priority will be the need to extinguish the fire to avoid ladder rescues. The strategy therefore of the Officer-in-Charge reflected what was in effect a routine incident.

89. There was, however, one distraction. That was caused by the occupant of the ground floor flat which was on fire. He had on arrival of the fire brigade caused such a degree of concern and excitement amongst the crowd that the police present ultimately held him under arrest. The Officer-in-Charge found his attention diverted by this individual and by the subsequent need to ensure that sufficient evidence was gathered surrounding this individual's actions relating to the fire.

90. The fire itself was therefore fought in a conventional way, albeit that the hose line into the front window had the impact of driving some of the fire, and more particularly the products of combustion, into the stairwell since the door had been left open by the occupant when he exited the flat.

91. Crews made good progress in this firefighting endeavour, although there was during firefighting a need to change over one individual in order to form a Breathing Apparatus team to enter at the rear of the premises. BA work in fact became a crucial part of the operation, although it cannot be ascertained with any certainty how good the BA control system was in operation. A mix of tactics and operations did lead to the successful extinguishing of the fire although the initial use of firefighters did delay bringing into use the second Breathing Apparatus team.

92. It was during these operational changes that some of the public present raised their concerns about Amanda Duncan with a firefighter. In all the subsequent enquiries it has proved impossible to identify who, ie which firefighter, was actually spoken to. This has resulted in a clear suggestion by the Tayside Fire Board's Discipline Tribunal that the fire brigade should seek to place individual identification upon all firefighting uniforms.

93. The mixture of activities and the relevant and hurried discussions between the

Officer-in-Charge and the Sub-Officer at the front of the building illustrated that the rapid pace of response was maintained for quite some time.

94. Both officers indicate that they had a very real concern that, within the building, there remained people who were unaccounted for. This partly resulted from the fact that, whilst fire-fighting was being undertaken, it was proving particularly hard to identify whether all the occupants within the building were alert and aware of what was going on. Both the Officer-in-Charge and the Sub-Officer assert that they did not receive the information that a woman, at the rear of the building on the second floor, required urgent assistance. Where this information got lost in the system will prove impossible to identify without the testimony of the fire-fighter who is reported to have had the conversation with Amanda. There is sufficient corroboration in the evidence provided, however, to make it clear that a firefighter did have that conversation and yet there is no substantiated evidence to suggest he did convey that information to either of the 2 officers responsible. It begs incredulity in fire service ethos and in common sense to suppose that had either officer known a rescue was required they would not have diverted resources to that prime task. This is particularly so given the coincidence of the approximate timing of the conversation with Amanda and the effectiveness of the fire-fighting operation to extinguish the fire, since at that time there may have been the possibility of effecting a rescue using the main stair.

95. In discussion with some of those present the point has also been raised that because one of the later ladder rescues from the first floor right included a woman, then those on the ground, and that might include the firefighter who spoke to Amanda, began to believe that the woman who had been spoken to had in fact safely exited the building. This point has been made by independent witnesses outside the fire service. It was only much later that it became obvious that the woman who had left by ladder from the first floor was not Amanda Duncan.

96. Knowledge of the incident, post event, indicates that BA search procedures were crucial in this operation if there was to be any hope of survival for Amanda. Reviewing the information given regarding the search procedures, and in particular the first statements given to the police by BA crews, reveals that it is incontrovertible that BA crews were given clear objective requirements to search the building from top to bottom and account for everybody.

97. Four Breathing Apparatus wearers did enter the very small flat in which Amanda was lying. All 4 must have failed to enter the living room. This is concluded since had any of the 4 Breathing Apparatus wearers entered the flat's living room they would have found Amanda. The floor space of the living room in this flat was very small, less than $10m^2$. Stepping through the doorway exposes the whole room to view. The smoke at that stage had begun to clear. People outside could see into illuminated upper rooms from the ground. What must be concluded is that not one breathing apparatus wearer entered the living room although the door was partially open and all say they entered through the entrance door into the short hallway.

98. It is therefore a conclusion of this report that the BA search procedures were not conducted in accordance with training and guidance and that those who had been given the search instruction failed to effectively carry out this instruction.

99. The debriefing process which followed the incident was itself short and concentrated upon the successful rescues that had been conducted at that time. Members of the Brigade knew by then that the BA search had failed to locate a missing person.

100. Overall it can be concluded that this was an operation which failed primarily because the skills of those deployed did not reach the high standards to which they had been trained and that individuals on the fireground did not effectively communicate with each other. The missing element of an effective management process of command and control, which should have identified these shortcomings and put the operation back on track, is therefore highlighted. In later sections of this report comments are offered on why this system failed and improvements that can be made. The impact of effective command and control cannot be ignored. In this case had there been an effective system then the absence of location and accounting for all individuals would have been detected early and appropriate actions taken. It must be remembered that at many incidents every day the fire service confronts situations without all the details. Questioning what is involved, who might be missing, etc is a feature of fire service work designed to overcome these very obvious difficulties. At Cardean Street that did not happen in appropriate time for efficient operations to be conducted.

101. Turning to the actions of Fire Control on the night, the independent disciplinary Investigating Officer, appointed to review evidence which might lead to culpable disciplinary offences, was unaware of the existence of the self-critical management report prepared shortly after the fire. He has since been shown a copy and has confirmed that despite the absence of this information at the time of the investigations he remains satisfied that no substantive disciplinary offence occurred during the period.

102. The situation, reported upon in the earlier chapter, indicates that there were difficulties in Fire Control, not least in the eyes of the senior operator present. The management report itself concludes more could have been done to both extract information from callers, provide information to the attending firefighters and offer life safety advice to occupants trapped by smoke and fire. There can be little doubt therefore that having early access to the management report would have aided the Procurator Fiscal and, in consequence, the Sheriff and subsequently the disciplinary Investigating Officer and Disciplinary Tribunal.

103. It is apparent, listening to the recorded messages of callers, that some, in distress, required reassurance and information. Others offered information about their location which would help firefighters. Little was done with this information and, importantly, the 'persons reported' status of this call was misjudged despite clear information to the contrary from occupants within the building and other callers.

104. Occasionally the important part played by Fire Controls in how well any incident progresses is not recognised. Sadly in this case the early difficulties of not despatching the right level of resource and helping locate trapped occupants were not recovered by the firefighting and rescue operation. This flawed initial response must rest firmly with the Fire Control as the Brigade's own management report concluded.

105. Shortly after the fire written statements were made by those present who witnessed the events. These statements, made primarily to the Police or Brigade, represent the significance of events as they were perceived at the time. Subsequently some have changed as new memories are invoked through wider discussion and the inquisitorial processes involved. Two matters of concern remain, however, in trying to identify what actually happened.

106. Firstly there is the issue of discussion between those present. It is usual at all fire service operations to consider successes and failures immediately after the incident. This in effect is what happened with Fire Control where a management review was initiated. However, given the substantive discrepancy in this case between various accounts of what

happened, the question of collusion, in an unhelpful and obstructive way, has arisen.

107. This is most apparent in regards as to who it was that spoke from the rear close to Amanda. The evidence that exists indicates that a number of persons in firefighting uniform entered the rear close of No. 11 Cardean Street. One firefighter spoke to Amanda. Those non-service persons present could not identify this firefighter, although they do differentiate between those present. One firefighter accepts he spoke generally to occupants. Clearly the testimony of at least one firefighter must be untruthful if the eye witnesses are believed. This has posed the question as to why someone in the fire service should act in this way. The view formed is that, at the time, the importance of the action of speaking to Amanda was not seen in the light of the full circumstances by the individual involved. Only later when the full facts began to emerge did the enormity of the situation become apparent.

108. In a similar way the direct contradiction by the Sub-Officer of one firefighter's evidence, that he told him about Amanda, indicates one person must be right and the other wrong. Why such a contradiction should arise raises public concern about the truthfulness and competency of those involved. It has to be accepted that without further testimony this contradiction cannot be resolved.

109. This gives rise to the second issue. That is whilst giving statements the individual members of the Brigade were supported by their trade union official. Whilst this is a perfectly normal and acceptable procedure and usually does not create any difficulties, on this occasion the official was also a witness to the events who, after attending many interviews, then gave his own statement. The undesirability of such a practice in both protecting the official and those others being interviewed is apparent.

110. These issues highlight the importance of testimony and the clear need to ensure that any practices or procedures used do seek to avoid the possibilities of collusion to conceal the truth and the possibility of discrediting statements whilst protecting the rights of the individual.

CHAPTER 6

CULTURE

111. Throughout the Investigation considerable comment has been made regarding the "culture"[2] of the Tayside Fire Brigade. These comments have ranged from accusations of arrogance and defensiveness expressed after the incident, particularly aimed at the Firemaster and senior management, with the evidence of a lack of apology relating to the death of Amanda Duncan, to accusations of a 'them' and 'us' working arrangement between staff and managers within the organisation.

112. In this Brigade the usual decision process was formal and disciplined, rather than inclusive and participative, suggesting that decisions once made were fairly rigid rather than flexible and challenging.

113. In a uniformed and disciplined service it can be seen how this style of management is acceptable, particularly so on the fireground. In the course of the Investigation, however a number of contrary views were expressed which indicated that this particular style of leadership may have intruded unhelpfully within the general management of the organisation. The Firemaster is however very experienced and has achieved significant progress for the Brigade and Fire Board. Measuring this success and identifying whether a change of approach is now appropriate is a matter for senior members and officers of the Brigade and Fire Board to consider.

114. Transposing this culture from Brigade level, for example, onto the watch involved was very much dependent on the role and relationship between the Watch Commander and his immediate subordinate. In discussion between these 2 individuals it becomes clear that, whilst there was a proper professional standard of behaviour between them, their management styles and characters are quite different.

115. The Sub-Officer was a relatively new appointee to the watch which had been well established by the Watch Commander, the Station Officer. These 2 individuals as mentioned had different approaches as to how and when activities should be undertaken and the scale and scope of these activities. The Sub-Officer apparently adopted a more enthusiastic approach towards certain activities like training, whereas the Watch Commander assumed that people knew what they would have to do and that he could depend upon that.

116. The difficulty that this presented was that effectively the watch had 2 different approaches towards overall management. In discussions some indications emerge that watch members began to choose which style of approach they preferred. It becomes evident that having 2 such different styles of leadership on the one watch affected watch behaviour, given this natural tension between the 2 managers.

2 Culture may be defined as "The shared values and beliefs of people within an organisation which through rules, expectations, decisions and policies are expressed as attitudes and behaviour".

117. These issues are, of course, not unique. In any organisation there will frequently be a degree of healthy tension between a supervisor and his subordinate which is reflected within the workforce. Again, in discussion, it was asserted that at operational incidents this tension did not in any way interfere since the process of operational management demanded a very precise and rigorous form of management, which is itself autocratic. Individual responsibilities are, however, evident throughout all fire service operations and it is clear that when this incident devolved to the individual's level, such as within the Breathing Apparatus search crews, some of these individual responsibilities were not fulfilled comprehensively. It is also evident at this incident that the management of the operation was not rigorous enough to detect these shortcomings.

118. So, at the time of the incident, it has to be said that there was some tension on the watch and that this culture had pervaded into the way this particular group of firefighters functioned. In a not dissimilar way, at Fire Control, there were similar tensions. Again the supervisor of the on duty watch had found herself somewhat isolated from other members of what is a very small team of people. Part of this isolation rested upon her own views of how the watch should function and the individual standards and responsibilities she expected of each member of the watch in carrying out their jobs. The supervisor had found that to some extent her style and presentation had been questioned. As a supervisor she believed she was disciplined, requiring actions to be carried through precisely. Other members of the watch she believed saw this as an overrigid approach to what was a very close group of people working together within a relatively small space for an extended shift period.

119. The tension here had spilled over to the extent that it affected the health of the supervisor and had begun to create a 'them' and 'us' approach between her and some members of the watch. At the time of the incident the supervisor had recently returned from a period of ill-health. It was her first shift on duty and she was naturally apprehensive about how she would be received following a period of absence. She was also unfamiliar with what may have occurred within the interim period. Once on duty she was totally reliant upon the support of her subordinates for any incident that had to be managed. This is particularly so in Control Room work where the individual operators receive calls and may, under spate conditions, ie when many calls are being made simultaneously, have to operate at a very high level of personal responsibility, executing and despatching resources and handling messages of operational importance.

120. So it was on the night in question. The Fire Control Supervisor had received a number of calls and also supervised others by listening in. She had become directly involved in the process of dispatch and receiving calls, since all other operators were busy. This is not unusual in smaller control rooms with limited staffing since a balance of risk has to be taken between not answering all calls quickly, so missing a 'new' and hence important call, against actively supervising. Experienced supervisors mix these 2 activities on factors such as the experience of their watch and the management of the original call. Because she was therefore unable to detach herself to only supervise it became important that all other operators shared their information with the supervisor. The supervisor has since indicated that on the night she was unsure of having all of the information that the other operators were receiving.

121. This is evidenced clearly in the statements relating to whether or not this was a "persons reported" incident in progress. The supervisor was therefore operating from a position of partial knowledge. Her actions revolved around a response to a fire which

had occurred at 13 Cardean Street. She was not familiar with the fact that rescues were about to be undertaken or that some of her colleagues had received messages, and in particular a message from Amanda, which did indicate that there were persons involved. Such information was of importance, both in the mobilising of the predetermined attendance and in subsequent notification to other officers.

122. It has to be concluded that to have this level of confusion within such a tight group of people can only have resulted from a failure to communicate properly between the individuals on duty.

123. It has also been suggested that the culture within Tayside Fire Brigade prevented a full disclosure of information to a range of external sources. The evidence for this may be gained from the statements made at the Disciplinary Tribunal, to the Sheriff's Court and, of course, to the Procurator Fiscal.

124. In discussion with those principally involved, led by the Firemaster, what becomes abundantly clear is that the Brigade felt obliged to operate in its own defence. This seemed necessary because there was some concern that the Brigade had not performed effectively at the fire, and that those insuring the Tayside Fire Board and Brigade had indicated that great care should be taken in any disclosure of information. The Firemaster, therefore, believed he was walking a tightrope. The more open he wished to be, the more he might find he was working against the interests of the Brigade and his employer, the Fire Board, and ultimately the public who paid for the fire service. He did, however, instruct his officers to participate and act in every way they felt they could and this ultimately led to an officer being assigned to the Procurator Fiscal to provide support and suggesting that HM Fire Service Inspectorate be approached.

125. For the Brigade this uncomfortable position extended to not expressing an appropriate apology to Amanda Duncan's family.

126. This is again not a unique situation for any organisation, least of all a public body, and it should be possible for any organisation to acknowledge a tragic loss without implicitly accepting liability. The Brigade continues to believe that it did what it could, after the incident, to meet the expectations of those who placed demands upon it.

127. The culture of the organisation was one of reaching a decision and then sticking to it. In this case that culture served to limit, rather than assist the Brigade. A more open style may have not only assisted the personnel involved, but also the presentation of its case in the subsequent enquiries which have led to so much criticism. Current thinking is that the public interest requires that a public organisation should first consider openness, honesty and integrity towards those that it serves, recognising the problem of safeguarding the liabilities of third parties still remains.

TRAINING

128. This Investigation has revealed that the actions taken on the evening of the fire did not correspond with procedures which are well documented and which form the foundation of training in all UK brigades. Three areas are of particular interest: Command and Control with its allied issues of communication and information; Breathing Apparatus Operations and the overall Training Culture. The operations conducted at this incident required precise and clear instructions be given to a range of individuals, both to conduct firefighting and breathing apparatus operations. There was also a requirement for an overall view to be maintained of what was happening across the scene of the incident.

129. In discussion and reviewing the evidence, it becomes apparent that whilst the Officer-in-Charge had formulated a strategy which basically allowed the occupants to remain within their premises whilst the fire was extinguished, this was not directly and unambiguously conveyed to his support staff. In particular his immediate subordinate, the Sub-Officer had to assume this was the strategy from the actions he was being asked to undertake. This is not necessarily so unusual at firefighting operations where frequently the close working of personnel allows an almost intuitive response by crews. However as this incident progressed, this particular strategy was found to be questionable, not least because some of the residents were becoming agitated at having to remain within their property for an extended period.

130. Whether or not it was the right strategy is difficult to draw a conclusion upon at a distance and after so much time. The severity of the fire would have been one of the factors that the Officer-in-Charge would have had to have taken into account. Observations made by a number of individuals clearly showed that it was a severe flat fire with flames extending out into the street. The use of one hose line was, however, sufficient to extinguish this fire in a fairly short timescale, indicating that the Officer-in-Charge's decision was therefore not inappropriate. What is less clear is how the Officer-in-Charge intended to identify and formulate a plan which took account of all the occupants which he could certainly see and was in conversation with some of the occupants, he was not able to account for all of the occupants and there is no evidence that he gave this particular task to any one individual until quite late in the incident.

131. The consequence was that as ladder rescues were conducted, it was still difficult to identify which flat had been emptied safely, and only at that stage was the task of identifying all occupants given to the Sub-Officer. The key learning point reinforced here is the need to have a clear range of options, which those others responsible for the incident management understand, so that central command and control of the incident remains effective.

132. It has also been identified that within the Brigade there was frequently a lack of use of portable radio communications. The importance of this point is that portable radio is of course there to facilitate fireground communications. At this incident it was necessary for the Sub-Officer on a number of occasions to proceed to the rear of the properties in Cardean Street to ascertain progress of the second BA crew. Unfortunately he

did not utilise radio to keep in touch with the Officer-in-Charge so he was of necessity involved in frequent movement from the rear to the front of the property.

133. The impact of poor communication upon the whole operation can be seen in that ultimately we now know that information was given by Amanda Duncan to a firefighter at the rear of the property yet this vital information, that she was in her flat, did not reach the Officer-in-Charge at the front of the building. It is this failure to convey information which is at the heart of the poor operational performance at the Cardean Street fire.

134. Turning to the Breathing Apparatus operations communications between the Breathing Apparatus teams, the Entry Control Officer and the Officer-in-Charge are again suspected to have been less than effective during the discharge of the search and rescue procedures.

135. This excludes the failure by individual team members to carry out effective searches. That remains an individual responsibility for which every individual involved in the search has to account. The fire service methods of search as taught at the Scottish Fire Service Training School, if carried out effectively, would have found Amanda Duncan. That she was not found confirms that there was a failure to search properly.

136. Returning to the control procedures, evidence also tends to suggest that the Entry Control Officer [ECO] was not fully familiar with what was happening with the BA teams. As a direct consequence, the Officer-in-Charge would also be unaware of progress. Limited entries were made upon the BA Entry Control Board and the ECO was himself unclear as to exactly where the teams were operating. The subsequent lack of control is evidenced further by the failure to have a required emergency crew on standby for what was a 6 BA set operation in a building of 4 floors with 2 entry points. Firefighters conducting the search were not equipped with radio to give advice to the ECO or to receive further instructions from that officer. This inability to communicate quickly had impact upon how much the Officer-in-Charge knew, at any particular stage in the BA operations, about what was happening inside the building.

137. Turning to the overall training culture, some staff allege that the Brigade's attitude towards training was generally blasé, that the facilities available for realistic training of Breathing Apparatus crews are insufficient and there is some evidence that simple matters, such as record keeping, are inadequate. Evidence obtained during the Inspectorate's own visit to the Brigade and that appertaining at the time of the incident, as recorded in management and trade union minuted meetings, tends to indicate that lack of resources is not a serious weakness. What appears to be more central is the overall approach adopted to training.

138. While the local facilities available for realistic training may fall short by modern standards, at the time there was certainly no reason why the simple process of BA search and command and control of incidents should have been below standard. During the Inspectorate's own visit a successful BA search and rescue operation under training conditions was carried out. During that training exercise the deficiencies, such as those already mentioned in the use of radio and the conveying of information around the fire ground, were seen. What was also seen was the competency of the junior officers and firefighters as they carried out their search procedures.

139. The view that therefore emerges is that the Brigade was perfectly capable of conducting successful operations and providing the necessary training but had for a period of time adopted a stance in which repetitious training had apparently been perceived as adequate to maintain successful operations.

140. Evidence collected since has indicated that this approach to training has been superseded by a greater willingness to embrace change so as to ensure Tayside's firefighters are amongst the most well trained. Such a change in attitude has been one positive outcome from this tragedy.

CHAPTER 8

FIRE SAFETY

141. Tenement buildings, with their multiple occupants and single stairways, have always presented a higher risk to their occupants and firefighters when compared to single household domestic premises. The design of a multi-occupied building with a single staircase places great reliance for the survival of the individual occupants upon the integrity of the building construction and early awareness that a fire has occurred, linked to the behaviour of those involved. In the case of the fire at 13 Cardean Street the premises themselves were of traditional 'Jute Tenement' construction. They did not incorporate the most modern of features, such as sprinklers or an installed fire alarm system, and the integrity of the central staircase owed a great deal to its original construction features of brick and stone. The doors leading from each flat to the staircase were of an unknown standard or capability in resisting penetration by fire and smoke. They were not, however, required to be constructed to meet any specific fire safety standard, having been built early in the century as part of an overall development scheme for Central Dundee.

142. Modern day buildings are required to conform to the Building Regulations[3] and, as such, any newly designed house of multi-occupancy corresponding to 13 Cardean Street (not more than 8 dwellings and no storey higher than 11m) having single stair access, would require each flat to have a minimum of 30 minutes' internal fire-resisting construction with all internal doors providing a minimum of 20 minutes' resistance. The door from the flat would be a minimum of 30 minutes' fire resistance, be self closing and provided with smoke seals.

143. The stair enclosure would be constructed to a one hour fire resisting compartment wall standard and have the facility of being ventilated to open air at each level by the fire service or a permanent ventilator fitted at the top of the stair. Additionally the escape-route from this type of flat would be illuminated by emergency lighting provided on a protected circuit. Constructing buildings to this standard is designed to offer a high degree of protection to the individual occupants. None of this is to say that existing buildings do not offer similar standards of protection. It is a fact that the large number of tenement buildings constructed to traditional designs throughout Scotland have shown very good fire resistance to quite severe fires originating in individual premises.

144. The focus of attention, however, does turn towards the protection of the single staircase. In the case of 13 Cardean Street fire escaped from the ground floor flat and entered the close and hence the common stairway. This penetration, it is believed, was due primarily to the occupant of the ground floor flat leaving the flat entrance door open, having wilfully set fire to the premises. Once the fire and products of combustion had entered the common stairway escape from the upper floor became impossible. One tenant who did subsequently travel the distance down the stairway was assisted to do so by firefighters wearing Breathing Apparatus after the fire had been substantially extinguished. The products of combustion were heavy as shown in the photographic details presented at the Fatal Accident Inquiry concerning Amanda Duncan's flat. Survivability under such conditions can be extremely short and, although Amanda had managed to hold a conversation with a number of her neighbours and a firefighter, she

3 Technical Standards for Compliance with the Building Standards (Scotland) Regulations 1990

would eventually have succumbed to such toxic smoke. Those trapped could then only look to the advice of firefighters when the fire brigade arrived and would need to follow their instructions.

145. A fire safety approach to achieve protection, both to prevent fire spread and to maintain the integrity of the common stairway, is therefore an important part of any preventative measures taken to reduce the possibility of repetition of such a fatal occurrence. All fire services throughout Scotland have already undertaken public education and information campaigns on the need for occupants of domestic premises like tenements to be alert should a fire occur. The fire service also encourages within existing homes the provision of a smoke alarm, usually battery operated, within common spaces such as hallways and stairwells, as a component in this alerting process. In any new modern dwelling provision must be made of a means of warning the occupants of an outbreak of fire. The Building Regulations require a suitable fire detection and alarm system except where any storey is less than 2000m^2 in floor area. In those cases one or more mains operated inter-linked smoke alarms are to be provided and suitably located on each storey.

146. This, however, is only partly the answer. More active systems of control, such as sprinklers, are a possibility for tenement buildings. The effectiveness of domestic sprinklers is well evidenced in parts of the United States where common staired buildings often have the installation of sprinkler systems. The sprinklers themselves are both useful at alerting occupiers to the presence of a fire and also to commencing a firefighting operation by the discharge of water.

147. Sprinklers may be useful in common stairwells where it is difficult to regulate the nature of storage. Although this was not identified as an issue at Cardean Street unregulated storage of rubbish or furniture being thrown out by individual occupants are fairly common occurrences. Legal controls exist to help combat this hazard[4]. However the incidence of fire with such materials is obviously high, particularly if smoking, vandalism or similar anti-social behaviour is evident. The use of sprinklers in such buildings may be seen as one very effective way of helping to manage the risk of fire and the limitation of fire spread. Limited work has been undertaken within Scotland on the effectiveness of such operations, but it is possible that within common stairways, such as the type evident at Cardean Street, a surface installed sprinkler system could have protected the main central stairway.

148. Fundamental to all fire safety is the behaviour of individuals. Most members of the public learn how to respond to fire either through their formal education or through subsequent training as part of their employment. The fire service in Scotland continues to support fire safety learning and frequently offers general information to the public in a variety of ways.

149. A key component of survival in any fire is the protection of the individual from the toxic gas produced by fires, even quite small fires such as those which occur within domestic premises. In modern buildings generally all rooms in dwellings should be constructed with materials that have a very low surface spread of flame, other than small rooms less than 4m^2 (except kitchens). However materials used in the construction of the furniture and fabrics used to make houses more comfortable do in themselves carry a number of harmful substances where very small exposure under fire conditions can

4 Civic Government (Scotland) Act 1982 contains powers to remove unauthorised storage from common areas.

give rise to fatal consequences.

150. In domestic premises, separating the individual from the fire may require little more than the firm closing and smoke sealing of a doorway to prevent fire penetration. Where the fire is threatening the individual directly then clearly rescue or evacuation becomes essential. Thinking through this process and developing an individual plan is a helpful way of seeking to improve personal safety. It has to be remembered that at Cardean Street a number of residents threatened by the fire survived because they were able to stay within their premises with the door closed. Promoting education which reinforces this point therefore remains central to any future fire safety strategy.

151. It is also important that Fire Control staff be trained to provide this level of advice at the time. It is recognised that a difficulty that can emerge in these circumstances is that Control Operators may find themselves required to both action the receipt of fire calls whilst also trying to reassure someone who is trapped by fire. This serves only to reinforce the requirement to prioritise calls so that those who require this level of assistance are identified in the early stages of actioning any call.

152. Overall the Cardean Street fire illustrates that there are further steps that might be taken to reduce still further the risk to residents of tenements. It is important for all residents to recognise the importance of ensuring the single stairway escape route is not compromised, either through structural modifications, to doorways for example, or by storage or rubbish accumulation on the stairway. Having a personal escape plan and understanding that fire penetration, especially of hot smoke, can be reduced by simple actions, such as closing and sealing doors, is also a key component to survival. Early warning and rapid attendance by the fire brigade are also important. Moreover given the predominance of tenements in Scotland and that multiple occupied single stairway buildings present a higher risk to more residents than low rise single households, then further work to examine the possible introduction of active warning and firefighting systems, like domestic sprinklers, would appear worthwhile.

PROGRESS TO DATE

153. Training has formed a central thread of this Investigation. The Inspectorate first advised Tayside Fire Brigade to review and revise their training programme in November 1996. Since then recommendations to that effect have been contained in subsequent Inspection Reports up to and including the Specific Inspection Report covering the period 27th & 28th July 1999. Many comments by the Sheriff and Disciplinary Tribunal have further emphasised the need to improve competency and performance. Training improvements remain very important.

154. Identified training improvements made since the Specific Inspection of the Brigade in July 1999 are:-

(a) Following the issue of the Fire Service Manual – Incident Command in 1999, the Brigade Management Team agreed to adopt the procedures outlined in the document. Documentation was prepared and an extensive training programme, incorporating both lectures and exercises, was commenced in January 2000 for wholetime, retained and volunteer personnel, with a scheduled implementation date of July 2000. During this training particular emphasis was also given to specific training issues identified in the Action Plan attached to the HM Inspectorate of Fire Services – Report on the Specific Inspection of Tayside Fire Brigade of 25th – 27th July 1999, comments made by the Sheriff in his Determination following the Fatal Accident and Sudden Deaths Inquiry and comments made by the Disciplinary Tribunal of Tayside Fire Board. Areas covered included:

(i) Command and Control;
(ii) Functional Management on the Fire Ground;
(iii) Use of Radio on the Fire Ground;
(iv) Operational Breathing Apparatus Procedures;
(v) Accounting for Missing Persons.

(b) Specific refresher courses on Breathing Apparatus have also been provided to all personnel during the period June 1999 to July 2000 that covered all of the areas where specific comments were made.

(c) The comment was made during the Fatal Accident Inquiry regarding the apparent lack of understanding by personnel of the physical properties of the products of combustion and the effects that smoke, sooty deposits and carbon monoxide would have on the average human. This particular issue was addressed during training related to the introduction of new resuscitators (completed in August 1999) and will also be included in future first-aid training courses.

(d) Comment was made by the Inspectorate regarding the need for further training in unfamiliar circumstances. The Brigade Management Team consider

this is a now well-established practice within the Brigade with at least 2 Divisional level exercises being conducted at non-fire service premises each year along with regular confined-pitch ladder training being included in the Continuation Training Programme.

(e) Investigations following the incident identified a number of shortcomings in the functions carried out by Fire Control. Revised procedures have been introduced through Control Room Standing Orders (CRSO) and the Continuation Training Programme has been amended to introduce refresher training in the areas of:

(i) Emergency Call Handling Techniques;
(ii) Discretion by Control to Mobilise Additional Appliances to an Incident;
(iii) Fire Survival Guidance;
(iv) Topography and Special Risks.

155. Since November 1999 whilst the improvements listed have been made the underlying training programme has remained substantially unchanged. However the Brigade, along with all other brigades in Scotland, is now in the process of implementing a programme for the development of a training for competence system. The 2 main areas where progress has been made regarding this matter are:

(a) In training of selected personnel to the Training and Development Lead Body Assessor Qualification D32. A total of 6 personnel are now qualified to D32 level and a further 14 personnel are undergoing training.

(b) Following a pilot scheme at 4 fire stations a formal Debriefing System is scheduled to be implemented from December 2000. This will include Wholetime, Retained and Volunteer personnel. Wholetime personnel will be required to carry out a debrief session once per tour of duty with Retained and Volunteer personnel carrying out this function once per month.

156. This further development will mean that the Brigade will need to continue these improvements by incorporating a methodology that will enable the competence of individuals and the measurement of workplace performance to be determined satisfactorily. To achieve this the Brigade recognises it needs to produce a written training development policy and strategy. The following steps are important to this overall process.

(a) Confirmation of the Brigade's medium and long term organisational goals and objectives.

(b) Identification and definition of the Brigade's strategic training and development needs.

(c) Setting a Brigade strategic training aim, objectives and priorities.

(d) Establishing the structure, management, resources and facilities for the training function.

(e) Identification of assessment methodologies.

(f) Establishing the process for auditing, evaluating and reviewing the training function.

(g) Detailing the process for reviewing the training policy.

This approach will also require a detailed training need analysis of uniformed staff to be conducted as a prerequisite to the introduction of any training for competence system.

157. Such further improvements require an adequate resource, for those delivering training in a standard format so that the quality and consistency of training is maintained. It is therefore essential that an adequate provision of 'Lecture Packages' covering the relevant subjects identified from the Brigade's training needs analysis is readily available to all firefighters for training purposes.

158. Likewise current reliance in the training in supervisory duties for Fire Control Operators relies on attendance at courses at the Fire Service College or specific exercises carried out within the Brigade. Specific training in supervisory duties remains to be incorporated into the Senior Fire Control Room Operator (SFCO) and Leading Fire Control Room Operator (LFCO), Continuation Training Programme.

159. Investment to improve information management at incidents is now underway, both with the inclusion, within incident management procedures, of note boards to record essential information on occupants and through the introduction of a paper based risk information system onto fire engines. The existing paper based risk information system is to be replaced, in turn, with an information technology based vehicle mounted data system.

160. To help improve public information at incidents loud hailers have been installed on fire engines and the Brigade, through the Scottish Region of the Chief and Assistant Chief Fire Officers' Association, will raise discussion on the matter of marking individual fire tunics to improve personal identification.

161. In a similar manner actions which compromise the fire safety arrangements in existing buildings, such as the storing of materials or securing of windows in stairwells, are now pursued vigorously when failings are found.

162. Audit arrangements have been put in place to monitor the recording of information on training records to ensure accuracy is included within the recently improved training record system.

163. Staffing levels in the Brigade's Fire Control have been increased since the incident by one person on every watch.

164 Overall all the comments made by the Sheriff and HM Fire Services Inspectorate have received consideration. Action has taken place locally where appropriate. Some matters require wider consideration since the procedures and practices of the Brigade conform generally to fire service practices elsewhere in the United Kingdom and assessment requires a broader consensus amongst the profession.

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS

165. The following conclusions and recommendations seek to achieve improvement in performance to help prevent any repetition of the errors made by Tayside Fire Brigade at Cardean Street, Dundee. Those errors in operational practice have resulted not only in accusations of poor performance but also have created considerable public disquiet and in so doing have damaged the reputation of the Brigade.

166 It is believed that the loss of Amanda Duncan in such tragic circumstances firstly deserves an appropriate apology.

Recommendation 1.
The Tayside Fire Board consider offering an apology on behalf of Tayside Fire Brigade for elements of poor performance at the incident.

167. The nature of the errors made by members of the Brigade were ultimately shown to be sufficient to give rise to investigations into whether there had been breaches of discipline. That the Brigade decided not to pursue this line of inquiry earlier than it did gave rise to further serious public disquiet. The value of the Fire Service Discipline Regulations in protecting the individual rights to a fair hearing and the method of conducting internal discipline are perhaps not readily understood by the public, who are much more aware of procedures under general employment law. The question may then be asked as to why the fire service continues to use an internal discipline code, based loosely upon a military procedure.

168. There have for some time been concerns regarding the efficiency of the application of these Regulations and recently the Chief and Assistant Chief Fire Officers' Association (CACFOA) has suggested a review be undertaken into all aspects of the application of the regulations, including a need for procedures to reflect more the accepted practices of the general working environment.

169. In welcoming this initiative the public interest, shown so clearly in this case, also requires to be recognised as does the need to consider the whole hearing process with its current status of legal formality. Involvement of staff interests, in this case the Fire Brigades Union (FBU), to ensure that in any modernising process the individual's rights remain protected must be included.

Recommendation 2.
The Scottish Executive and the Home Office, together with HM Fire Service Inspectorate, CACFOA and the FBU and other appropriate interests, consider further the discipline procedures currently adopted by fire brigades with emphasis towards improved public accountability, of what is a distinct internal procedure, and to modernising the way in which the regulations operate.

170. Of far reaching consequence throughout this Investigation have been the comments made in the original Fatal Accident Inquiry. The comments made gave rise to the initial allegations, both of dishonesty and poor performance. It is apparent, reviewing

those comments, that whilst they were made from a perspective of public expectations, some required, a professional assessment of the fire service standards, given the universal nature of many fire service procedures, practices and equipment.

171 It is suggested that these concerns of broader context and universal application could be satisfied if an assessor having special knowledge of the fire service was present in the Sheriff Court during such cases. The Procurator Fiscal did draw attention to the provisions of Section 4(6) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 and the guidance contained in Section 12(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Rules 1977 in this regard and the application of these provisions is considered worthy of detailed examination between HM Fire Service Inspectorate and the Crown Office.

Recommendation 3.
HM Fire Services Inspectorate contact the Crown Office to develop a review mechanism for findings made under such circumstances prior to their application in the fire service.

172. One major difficulty involved the presentation of information. The Brigade had a straight dilemma. They were required to assist the Procurator Fiscal and at the same time, in order to protect the interests of the Brigade, the Fire Board and the community costs, they were advised to be careful in what they said. Independent investigation into the Brigade's actions did not occur until the internal discipline case and the appointment of an external Investigating Officer. The impact of this lack of independent external review was that members of the Brigade found it necessary to assist the Procurator Fiscal whilst also seeking to explain their own Brigade's actions. This conflict of interest should not be allowed to continue should similar events occur in the future. A new procedure could be developed which will require under similar circumstances the Fire Authority to appoint an independent assessor who could both assist the Procurator Fiscal and provide advice to the Authority, to identify malpractice by a brigade. Determining the threshold when such an investigation procedure should be brought into practice will require considerable further discussion and debate.

Recommendation 4.
HM Fire Service Inspectorate contact the Crown Office to ascertain if such a procedure might be appropriate. If so then HM Fire Service Inspectorate would lead a review group with Firemasters, Fire Authorities, Staff Representatives and the Scottish Executive to develop and introduce a suitable procedure.

173. The Investigation also revealed that statements when being formally gathered by the fire brigade had been gained in what is considered to be a fundamentally flawed way. This may have offered advantage to one individual and did not prevent the possibilities of collusion with others. Part of the responsibility for these arrangements rests with trade unions which rightly seek to support their individual members. It is important and in the public interest that the procedure adopted be capable of independent scrutiny to demonstrate that any method adopted for the collating of evidence is capable of preventing collusion or individual advantage.

Recommendation 5.
HM Fire Services Inspectorate jointly with the Fire Brigades' Union and Chief and Assistant Chief Fire Officers' Association develop a procedure which ensures evidence when gained can be publicly demonstrated to have been obtained under truthful and open circumstances.

174. Some of the Investigation time has concentrated upon the culture of the Tayside Fire Brigade. It is the view of HM Fire Service Inspectorate that the culture at the time of Cardean Street may have inhibited acceptance of errors and learning through open discussion. Since that time changes have occurred and it is suggested these be further improved.

Recommendation 6.
The Tayside Fire Board instruct the senior management at Tayside Fire Brigade to continue to introduce a more open and transparent leadership and cultural style which encourages individual responsibility and openness and that the Fire Board monitor the efficiency of those changes.

175. Further important steps in the process of improvement since the fire have been the initiatives and energy devoted to training. These improvements are welcome showing a renewed interest in training within the Brigade and its practices.

Recommendation 7.
The Tayside Fire Board, being responsible for the efficiency of training arrangements, should direct senior management at Tayside Fire Brigade to report periodically upon progress in the introduction of a training for competence system based upon a detailed training needs analysis of uniformed staff along with the production of a training development policy and strategy as outlined in Chapter 9.

176. Progress since the fire has involved a number of changes in the practices, procedures and equipment of the Brigade. These changes reflect the effort made by the Fire Board and Brigade to acknowledge in particular the Sheriff's comments made at the Fatal Accident Inquiry. It would be useful for the public to be made aware in practical terms of these changes.

Recommendation 8.
The Firemaster prepare for the Fire Board a summary of the changes made in response to the call for improvements following the fire.

171. The death of Amanda Duncan resulted from an act of wilful fire raising. Such occurrences cannot be prevented and will therefore continue to arise. However it is vitally important that when fires do occur the best practice and prevention techniques are available to help limit the consequences of any fire. Improving fire safety is therefore a key component to the future life safety in multi-occupied buildings.

Recommendation 9.
The Scottish Executive and Home Office take account of the experience of the Cardean Street incident in developing future fire safety proposals.

178. Finally but importantly it has to be recognised that many tenements exist throughout Scotland and the lessons from this incident and the subsequent actions have relevance beyond Dundee. The experience of Cardean Street needs to be seen in this context. The changing nature of fire service management, from hierarchical to open proactive styles, the developing methods of training to improve not just technical skills but to recognise how individuals learn and the realisation that operational management is not just a question of experience but requires an identified process, all point to a better service. The Firemaster and his colleagues in other brigades acknowledge this is a service which cannot stand still but must continuously learn and improve. The production of a public report and its wide dissemination is therefore an important step in encouraging discussion and learning.

Recommendation 10.

HM Fire Service Inspectorate for Scotland distribute this report to all fire authorities and fire brigades within the United Kingdom and assist where practical in any ongoing learning experiences.

The Fire Services (Discipline) (Scotland) Regulations 1985.

The present Regulations were made under section 17 of the Fire Services Act 1947 to provide for the maintenance of discipline and appeals against dismissal or disciplinary action in Scottish fire brigades. They consist of four Parts dealing with:

Part I	General Matters
Part II	Investigation of Offences
Part III	Hearings and Internal Appeals, and
Part IV	Appeal to the Secretary of State.

Part I simply deals with the commencement, application and interpretation of the regulations and lays down whom they apply to viz. all members of a brigade who are liable to engage in firefighting or who are engaged in fire-control.

Part II determines that any member commits an offence if they breach the following code of discipline.

Disobedience to orders.
Insubordination.
Abuse of authority.
Absence from duty.
Neglect of duty.
Falsehood.
Misconduct in relation to official documents.
Improper disclosure of information.
Corrupt or improper practice.
Loss of, or damage to, fire authority property.
Unfitness for duty.
Criminal conduct.
Untidiness.
Conduct prejudicial to discipline.
Conduct prejudicial to the reputation of the brigade.

When a report or allegation is received by the Firemaster that an offence may have been committed the Regulations provide for the nomination of an officer to investigate the alleged offences against discipline. There is further provision for;

(a) a preliminary investigation of the alleged offence,
(b) for summary dismissal in cases of gross misconduct (including, in both (a) and (b), the right to a hearing) and,
(c) a right of appeal against such dismissal.

EVIDENCE GATHERED FOR THE TAYSIDE FIRE BRIGADE INVESTIGATION

Incident

Tayside Incident Management Timetable
Copy of Control Tapes submitted by Brigade
Control Mobilising Confidential Report
Internal memo of visit to 13 Cardean Street.
Fire Incident File 13 Cardean Street, including: -

- Role call of crews attending
- Main incident times
- Fatal Accident Inquiry 25/1/99
- Fire Investigation Report
- Incident photographs/Layout drawings
- Notes on non fire brigade persons statements:
  Malcolm Chisholm, SOCO Tayside Police, Constable Kenneth Martin
  Majit Mooker, Stanley O'Shaughnessy, Norman Brown, Alan Donechy,
  Eric Thomson, John Gibson, John MacDonald (visitor),
  Dr Sadler, Pathologist, Bill Herald, Kathleen McLean,
  Michael McGregor, David Hunter
- Brigade Witness Statements and Comments:
  ADO Carrie, StnO Allan, SubO Anderson, Lf Roger, Ff Graeme Nicoll,
  Ff Ian Robertson, Ff Mark McArthur, Ff Ewan Baird,
  Ff Richard Horsburgh, Ff Derek Marshall, Ff Bruce Scott
  Ff William Welsh, Ff Graham Webster
- Commentary by HMI Whitton

Tayside Fire Brigade Action Points Regarding Training, Equipment and Procedures
Notes for Case: DO Robertson, DO Hay, ADO Carrie (see also Criminal)
Statement taken by DO Charles – December 1997
Precognition Statement taken by Lyall Fitzpatrick Solicitors to Criminal Trial
Tayside Fire Brigade Operational Safety Monitor Sheet
Incident – Cardean Street – Notes and comments by DO Hill
Pictures of rear of 13 Cardean Street and the wall separating 13 and 11 Cardean Street

Criminal

Police Photographic evidence for Criminal Case Productions 1 & 2
Notes for Case:DO Robertson, DO Hay, ADO Carrie (see also Incident)
Notes from Criminal Trial by DO Steele

The investigating officer has the responsibility of deciding, at the end of an investigation, whether the member in question should be charged with an offence.

In ***Part III*** there are special provisions for cases involving members holding the rank of Assistant or Deputy Firemaster or above. Such cases, and such other cases as the Fire Authority directs, are to be heard in the first instance by a disciplinary tribunal consisting of a committee of the fire authority.

Provision is also made for minor cases, where the highest award likely is a reprimand, to be heard under a less formal procedure presided over by an officer nominated by the Firemaster. Disciplinary awards to be made under such a procedure are limited to reprimand or caution.

At the conclusion of the hearing the disciplinary body shall either find the charge proved or dismiss the case. Should it find the charge proved it awards one of the following punishments and will inform the member in writing.

The punishments are namely:-

(a) dismissal;
(b) requirement to resign;
(c) reduction in rank;
(d) stoppage of pay or retaining fee;
(e) a reprimand; or
(f) a caution.

Where a Firemaster or a disciplinary tribunal, in deciding to impose a punishment (other than a caution), are of the opinion that any future conduct of an accused may warrant dismissal, they are under a duty to issue a final warning. Both the final warning and the award are to be subject to appeal. Neither a reprimand nor a caution carry a right of appeal.

Punishments are not to take effect until they are confirmed on appeal or the time limit for appeal has expired.

There is also a right of appeal to a committee of the fire authority (known as “the Appeal Committee”) from a decision, at first instance, of the disciplinary tribunal. The appeal must be made within 7 days of being notified that a punishment has been imposed.

Part IV enables Scottish Ministers to appoint not more than two persons to act as assessors at an inquiry for the purpose of determining an appeal which must be written within 14 days of receiving written notice of the decision of the Disciplinary Tribunal or the Appeal Committee.

Fatal Accident Inquiry

Sheriffdom of Tayside Central and Fife at Dundee under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 determination in respect of the death of Amanda Duncan (d.o.b. 7.2.76)
Summary of Sheriffs Recommendations
FAI Amanda Duncan Copy Production
Letter Procurator Fiscal to Firemaster re Death of Amanda Duncan
Remit of Procurator Fiscal – Extract from Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Tribunal

Paper for Tayside Fire Board Special Meeting on 24 April 2000 on Fatal Fire at 13 Cardean Street Dundee on 27 November 1997
Disciplinary Tribunal Guidance for the Presenting Officer
FBU Submission following the findings of Disciplinary Tribunal
Note of meeting with Sub Committee of Tayside Fire Board
Points raised by Tayside Fire Board
Decision of Disciplinary Hearing Tribunal
Letter from Clerk of Tayside Fire Board to The Scottish Executive re Disciplinary Tribunal
Statements and evidence supplied by Investigating Officer for Disciplinary Tribunal.
List of Documents supplied to HM Inspectorate by Tayside Fire Brigade
Correspondence between DO Charles and DO Hill regarding bringing charges under the Discipline Regulations.

Specific

HMI Specific Inspection of Tayside Fire Brigade 27-28 July 1999

Training

Fire Service Circular 10/1993: Training of Fire Control Staff
Tayside Fire Brigade Paper for Management Team 23 June 1999 – Departmental Response (Technical Services Department)
Tayside Fire Brigade 1(i)(d) Inspection sheet
Tayside Fire Brigade – Non Uniformed Personnel: Training Plan –2000/01
Brigade Routine Order Part 1 No /00
Training Note Section 1 Part 1
Training Note Section 1 Part 64
Safe System of Work –2- Incident Command System
Minutes of SCO/LCO Meeting held in the Command and Control Centre 12th July 1999
Training Note Section 12, Part 4, Training Syllabus for Control Room Personnel
Control Room Standing Order Part1 No. 1.14 Persons Reported or Trapped by Fire
Control Room Standing Order Part 2 No. 3.2 Telephone Call Procedure
Control Room Standing Order Part 2 No. 3.8 Fire Survival Guidance
Brigade Orders – Section Eight: Training
Training Note Section 12, Part 1, Training Syllabus for Operational Watch Training
Tayside Fire Brigade Watch Training Programme – TRG 14A
Training Note Section 9, Part 2, Brigade Radio Scheme and Procedures
Training Note Section 9, Part 8, Philips PRP 73 VHF Hand Portable Radio
Training Note Section 9, Part 8, Motorola HT 600E (UHF) Radio

Investigation

Written Parliamentary Question on Terms of Reference for HMI Inspection
Availability of Senior Officers and Crews attending Cardean Street
Sickness Record of Personnel involved in Cardean incident
Letter from Sheriff Clerk re visit.
HMCIFS Letters to FBU, Investigating Officer, Sheriff Davidson, Procurator Fiscal, Kate McLean MSP, Technical Adviser, Chief Constable, Firemaster, Mr & Mrs Duncan.
Copy of letter distributed to occupiers of 13 Cardean Street
Letter received from Tayside Police regarding access to Police evidence

Miscellaneous

HMI Report on Tayside Fire Brigade 1992
HMI Report on Tayside Fire Brigade 1993
HMI Report on Tayside Fire Brigade 1994/5
HMI Report on Tayside Fire Brigade 1995/6
HMI Report on Tayside Fire Brigade 1996/7
HMI Report on Tayside Fire Brigade 1997/8
Management Team Meetings
FBU/PO Minutes
Fire Board Reports/Minutes
Press Cuttings supplied by Tayside Fire Brigade
Press cuttings collected by HM Inspectorate

PLAN AND OTHER DETAILS CONCERNING 13 CARDEAN SREET, DUNDEE

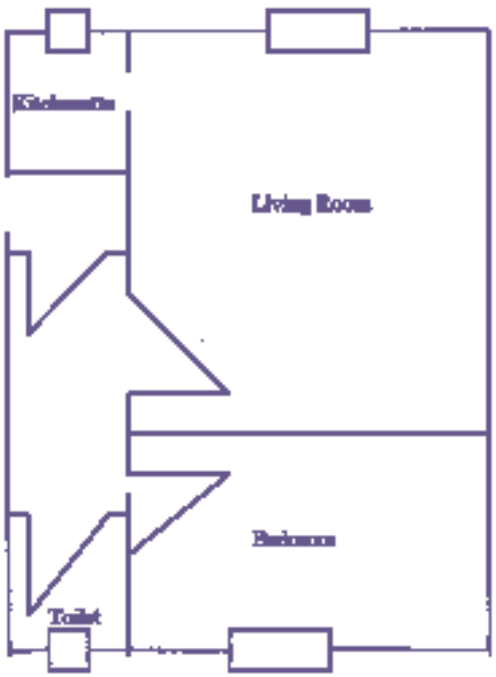
Street Map of Central Dundee

Front of 13 Cardean Street

Occupants of Number 13

Not Available 6/6 BROWN 49	Interviewed 6/6 O'SHAUGNESSY 65
(Not speaking) DONECHY 29	(Not speaking) New Tenant DUNCAN 21
(Not speaking) THOMSON 40	Not Available MOOKER 25
New Tenant (Grant) CRABBIE	Out at Pub GIBSON 52

Amanda's Flat



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