



Keeping our Safety and Environmental Practitioners informed

Action required on the Coroner Conclusion following Service Inquest into the Camp Bastion Fatalities 14 February 2011

When it takes effect:	May 2016
Valid for:	Until rescinded
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Description developed

1. In July 2014, Defence Fire Risk Management Organisation (DFRMO) published "Regulation 28 Report following the inquest into [REDACTED] on 14 February 2011 - Camp Bastion" to ensure that Duty Holders are aware of the concerns raised by her Majesty's Coroner following a fire that resulted in the deaths of two Service personnel and the required actions to prevent further fatalities.

2. DE&S Heads of Establishment and appointing staff responsible for managing fire safety on their sites will need to ensure that all Site Fire Orders and SOPS include the specific references which were initially detailed in 2014DIN06-010, namely:

- a. The requirement for building managers to get advice from a competent fire risk assessor:
 - Before any changes take place within the premises; either temporary or permanent (e.g. office to sleeping, office to store etc.);
 - If there is proposed structural alterations to the layout or fabric of the building; including any self-help work;
 - If there is suspicion that the current fire risk assessment is no longer valid;
 - Where a fire has occurred.
- b. The Appointed Person/Unit Fire Safety Manager is to seek documentary assurance from the Building Manager or relevant appointed representative(s) that no other form of temporary, casual or other occasional sleeping (i.e. Duty Bunk) takes place in premises that are primarily designed and used for non-sleeping purposes (e.g. offices, stores);
- c. Clear direction and advice on the risks associated with overloading electrical supplies, including advice of who to contact if there are any concerns.

3. Addressees are also reminded that the DFRMO Fire Safety Diary and Log Book on the [DFRMO Fire Safety Website](#) covers all the above issues and can be downloaded, but must be used in partnership with Unit/Station Fire Orders and SOPs and not instead of or in isolation.
4. Regulation 28 Report following the inquest into the deaths of [REDACTED] on 14 February 2011 - Camp Bastion is attached.

Actions to be taken

5. For information and action as necessary.

*Issued under the Authority of
Andy Bostock
DES TECH-QSEP SEP DepHd*

ATTACHMENT – REGULATION 28 REPORT FOLLOWING THE INQUEST INTO THE DEATHS OF [REDACTED] ON 14 FEB 2011- CAMP BASTION

HQ DFRMO/FS/Pol

17 June 14

TLB/TFA CESOs

Copy to:

DFRMO - CFO DFRMO
RFSMs
Area Managers

DSEA - Director
CPA TL

REGULATION 28 REPORT FOLLOWING THE INQUEST INTO THE DEATHS OF [REDACTED] ON 14 FEB 2011- CAMP BASTION.

Purpose

1. To make Duty Holders aware of the concerns raised by the Coroner following a fire that resulted in the deaths of [REDACTED] and identify the actions already taken and those that the TLBs need to take to prevent further deaths.

Background

2. At around 0540 on the morning of 14th Feb 2011 a fire broke out inside the Transport Troop Tent office located in Camp Bastion 2. At the time the fire started the tent was occupied by 3 personnel who were asleep in separate cot beds. Once started the fire spread rapidly to the whole tent and cut off the available exit from the tent this trapping 2 of the 3 occupants inside. On arrival of the on site Fire & Rescue service what remained of the tent was quickly extinguished and the fire crews discovered 2 x bodies that were confirmed dead at the scene. It was later confirmed that they had died from the inhalation of products of combustion and severe burns.

3. Following the investigations the most likely cause of the fire was determined to be caused by the overloading of a four way strip extension block that was feeding a 3000 watt Burko boiler a 380 watt chiller cabinet and a 160 watt television. It was determined by an electrical SME that the overloading of this extension block over a period of time eventually caused arcing and sparks that ignited adjacent combustible materials that spread to the tent lining.

4. On the 12 May 2014 the Coroner resumed the inquest into the deaths of [REDACTED] and during the course of the inquest heard evidence from a number of witnesses the inquest concluded on the 22 May 2014. In his sealed narrative conclusion the coroner also detailed the following as factors that contributed to the deaths:

- a. The systematic Failure via the chain of command to communicate the occurrence of sleeping on duty at nights to key personnel such as the Unit Fire Safety Officer and the safety measures associated with its practise to all Transport Troop personnel;
- b. The failure to police the occurrence of sleeping on duty at nights through the use of random checks;
- c. The failure to effectively check the working functionality of the 9v smoke detector located inside the tent where the fire started resulting in it not being in working order at the time of the fire.
- d. The systematic failure to provide effective training especially to Fire NCO's to identify the potential risk of overloading sockets/extension blocks.
- e. The failure to rectify the 2010 Fire Risk assessment when it became known that sleeping was taking place within the tent mid December 2010.
- f. The failure to request a fresh Fire risk assessment following the structural alteration that took place mid January; and
- g. The absence of the Transport Troop Tent from the Theatre Asset Register.

Coroners Concerns¹

5. During the coroners summing up it was recognised that a significant number of changes have been put in place following the incident but he was not satisfied that more could not be done and raised matters of concerns under a Regulation 28² report to the Minister of State for the Armed Forces as he felt that that there is still a risk of future deaths. These matters of concerns are detailed below:

- a. The need to carry out a risk assessment prior to any structural alteration taking place and the wording of the fire diary to clearly reflect the emphasis of the risk assessment being conducted before any changes take place.
- b. The Fire Diary to provide guidance to the fire NCO on who to contact for expert advice on overloading (qualified electrician)
- c. The Fire Risk Assessment must clearly highlight in bold capital letters the need to declare sleeping in office accommodation to act as a reminder for fire NCO's to check.
- d. To consider using the case to illustrate the danger of sleeping in the office and reinforcing the training to junior officers and NCO regarding random checks to act as a deterrent and stop personnel sleeping on duty at night.

The Min AF has to respond to the report by 29 July 2014 detailing of what action has been taken or proposed and setting out the timetable for action and if necessary explain why no action is proposed.

Action Taken

6. Action taken and planned by DFRMO so far in response to the Regulation 28 concerns are detailed below:

¹ See Regulation 28 Report to Prevent Future Deaths for full details.

² The report was made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulation 28 and 29 of the Coroners (Investigations) Regulations 2013.

- a. The wording of the fire diary has been amended to make it very clear that the advice of a competent fire risk assessor must be sought before any changes take place within the premises or if there is a suspicion that the fire risk assessment is no longer valid.
- b. The Fire Diary has been amended to provide additional guidance and advice on the risks of electrical overloading including advice of who to contact if there are concerns.
- c. The fire risk assessment template used by DFRMO is currently under review. The review has taken into account the Coroners concerns and has been updated to further emphasise the need to record if any sleeping is taking place on the premises regardless of purpose group. The reviewed version is due for release in Aug 2014.
- d. The matter at 5.d. above currently sits with the Army HQ who are still considering the action.

Further Considerations

- 7. While the above actions taken by DFRMO in relation to the fire risk assessment template are applicable across Defence the matters relating to the fire diary only apply to TLBs and units that have chosen to utilise the fire diary available on the DFRMO Fire Safety website or those who send staff to attend the unit fire safety training provided at the Defence Fire Training and Development Centre, mainly the Army.
- 8. Other TLBs who have their own fire safety arrangements and their own bespoke systems of training and appointing staff responsible for managing fire safety on their various establishments will need to ensure that the concerns raised by the Coroner are addressed. To achieve this TLBs are requested to bring the concerns to the attention of all their establishments and ensure that all Unit/Station Fire Orders and SOPs include specific references to the following:
 - a. The requirement for building managers to get advice from a competent fire risk assessor before any changes take place within the premises or, if there is a suspicion that the current fire risk assessment is no longer valid.
 - b. Clear direction is provided about the unauthorised sleeping in premises
 - c. Clear direction and advice on the fire risks associated with electrical overloading including advice of who to contact if there are any concerns.
- 9. DFRMO regional staff will be available to advise COs and HoE on any specific issues.

Signed on DII

R MM Fenton
Strategic Director Fire Safety
DFRMO HQ