Investigation report into the fire safety arrangements at Woodlands Psychiatric Unit, Ipswich Hospital site, Ipswich, Suffolk, in relation to the serious fire incident on 26th October 2011

Suffolk Fire and Rescue Service
November 2012
## Investigation Report

### Name of Responsible Person(s)

1. **At the time of the Incident:**
   - Suffolk Mental Health Partnership NHS Trust
2. **From 1st Jan 2012 to present:**
   - Norfolk and Suffolk NHS Foundation Trust

### Address of Responsible Person

Hellesdon Hospital, Drayton High Road, Norwich, Norfolk. NR6 5BE

### Role of Responsible Person

Employer

### Chief Executive Officer

Mr Aidan Thomas

### Address/Location of Incident

Woodlands Psychiatric Unit, Ipswich Hospital NHS Trust site, Heath Road, Ipswich. Suffolk. IP4 5BD

### Date(s) of Investigation

26th October 2011 – 1st November 2012

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**Disclaimer:**

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### Part A – Investigation details

<table>
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<tr>
<th><strong>A1 - Case Number</strong></th>
<th>WPU/01/11</th>
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<tr>
<th><strong>A2 – Matter under investigation</strong></th>
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<tbody>
<tr>
<td>Investigation of potential breaches of the Regulatory Reform (Fire Safety) Order 2005 following a fire at the Woodlands Psychiatric Unit on 26th October 2011 in which a patient who was resident in the unit was seriously injured.</td>
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<table>
<thead>
<tr>
<th><strong>A3 – Date of incident</strong></th>
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<tbody>
<tr>
<td>Wednesday 26th October 2011</td>
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<table>
<thead>
<tr>
<th><strong>A4 – Name of Responsible Person(s)</strong></th>
</tr>
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</table>
| Suffolk Mental Health Partnership NHS Trust (until 1st January 2012)  
Norfolk and Suffolk NHS Foundation Trust (since 1st January 2012 to present)  
(Norfolk and Suffolk NHS Foundation Trust is the name of the integrated organisation following the acquisition of Suffolk Mental Health Partnership NHS Trust by Norfolk and Waveney Mental Health NHS Foundation Trust on 1st January 2012.) |

<table>
<thead>
<tr>
<th><strong>A5 – Role of Responsible Person(s)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
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<table>
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<tr>
<th><strong>A6 – Address of Responsible Person</strong></th>
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</thead>
</table>
| Hellesdon Hospital  
Drayton High Road  
Norwich  
Norfolk  
NR6 5BE |

Suffolk Mental Health Partnership NHS Trust (SMHPT) and Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHT) are no longer legal entities.

<table>
<thead>
<tr>
<th><strong>A7 – Location details</strong></th>
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</table>
| Woodlands Psychiatric Unit  
Ipswich Hospital NHS Trust site  
Heath Road  
Ipswich  
Suffolk  
IP4 5BD |

<table>
<thead>
<tr>
<th><strong>A8 – Date investigation commenced</strong></th>
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<tr>
<td>26/10/2011</td>
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</table>
A9 – Articles and areas of the RRO that were part of the investigation

<table>
<thead>
<tr>
<th>FSO Article</th>
<th>Regulatory Reform Fire (Safety Order) 2005 apparent Offence</th>
</tr>
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<tbody>
<tr>
<td>Article 8</td>
<td>Measures to reduce the risk of fire had not been implemented; in that a patient’s initial risk assessment was not completed in its prescribed timescale following his admission to the Woodlands Unit and, without adequate risk assessment, a patient was left in unsupervised possession of an ignition source contrary to documented Trust procedure (SMHPT Positive Clinical Risk Management Policy, SMHPT Admission, Transfer and Discharge Policy, Poppy ward welcome pack).</td>
</tr>
<tr>
<td>Article 9</td>
<td>Mitigating preventive and protective fire safety measures in relation to existing circumstances, and foreseeable fire risks, had not been adequately documented in The Premises’ Fire Safety Risk Assessment.</td>
</tr>
<tr>
<td>Article 11</td>
<td>Significant findings in the Fire Safety Risk Assessment (FRA) had not been translated into action. SMHPT admit to having no policy for the review and monitoring of fire safety preventive and protective measures.</td>
</tr>
<tr>
<td>Article 14</td>
<td>Final fire exits from the Premises were locked - with a key not being available.</td>
</tr>
<tr>
<td>Article 15</td>
<td>Suitable evacuation drills, to be followed in the event of serious and imminent danger, had not been undertaken. SMHPT admit that it did not carry out fire drills on wards.</td>
</tr>
<tr>
<td>Article 18</td>
<td>One or more competent persons had been appointed by the Responsible Person to assist him in undertaking preventive and protective measures, without effectively assuring their competence.</td>
</tr>
<tr>
<td>Article 19</td>
<td>Relevant fire risk information and emergency fire action plan details were not made available to employees in The Premises.</td>
</tr>
<tr>
<td>Article 21</td>
<td>Staff fire safety training on their induction into The Premises, which had newly opened, had not been carried out.</td>
</tr>
<tr>
<td>Article 23</td>
<td>Employees, while at work in The Premises, had failed to take reasonable care of themselves and others; and/or, had failed to cooperate with their employer to enable it to carry out its duty to comply with the provisions of the Order.</td>
</tr>
</tbody>
</table>

The following offence(s) was investigated but would not have been laid against the Responsible Person, ie; The Trust, but appropriately against any relevant individual employee(s).
Supporting evidence

SFRS Fire Safety Officers’ inspection reports and contemporaneous notes.
SFRS Fire Investigation report.
Suffolk Constabulary Officers’ reports
Correspondence between Suffolk Fire and Rescue Service and The Trust.
Trust policies, records and relevant documentation.
The patient’s medical records.
Witness statements.
PACE interview responses.
CCTV imagery and Digital Photographs.
Relevant guidance.

Criminal Procedure and Investigations Act 1996

<table>
<thead>
<tr>
<th>Investigator</th>
<th>Paul Viner</th>
<th>Officer in charge of investigation</th>
<th>Sally Hammond</th>
</tr>
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<tr>
<td>Disclosure Officer</td>
<td>Mark Labdon</td>
<td>Prosecutor</td>
<td>N/A</td>
</tr>
</tbody>
</table>

A11 – Brief Executive summary

Suffolk Fire and Rescue Service (SFRS) were first alerted to potential fire safety management issues at the Woodlands unit (which had opened for patients on 4th July 2011) on 20th July 2011. At that time and into August, SFRS operational crews attended the unit on several occasions in response to activations of the premises’ automatic fire alarm (AFA) system.

On each occasion the activation was found to be a trivial or unwanted signal. But the SFRS personnel noted that the conduct of the unit’s staff in response to the AFA actuations, and their apparent lack of understanding of the unit’s fire emergency action plan, demonstrated a general level of knowledge about fire safety in the unit and its emergency procedures that was lower than should be expected of staff in a premises of this type.

These concerns were reported internally and SFRS contacted the Trust on 10th August 2011 to arrange a fire safety audit of the premises under the Regulatory Reform (Fire Safety) Order 2005 (‘The Order’). The audit took place on 13th September 2011 and resulted in a Notification of Deficiencies being issued to Suffolk Mental Health Partnership NHS Trust (SMHPT). Among other things, this correspondence identified that the Woodlands’ staff had not been provided with suitable training on new systems of work and emergency procedures, and safety drills had not been carried out; which indicates a failure in the fire safety management systems within the newly opened unit.

21st January 2012 was stated in the Notification of Deficiencies as the follow-up date when SFRS would check that action had taken place to remedy the identified failures.
At 15:20 on Wednesday 26th October 2011, the Woodlands’ AFA system activated showing a fire had been detected in ‘Poppy Bed 19’. The SFRS fire investigation which followed concluded that a patient had set the bedding in their room alight with a cigarette lighter and then stayed in the room as the fire developed.

CCTV footage of events within Woodlands at the time of the fire, requisitioned by SFRS from SMHPT as part of the fire safety investigation following the fire, has been an invaluable source of information on what occurred.

The CCTV shows that staff members on the Poppy and Avocet wards did not respond immediately to the fire alarm and check the indicated location as would be expected by the unit’s fire emergency plan, but carried on with their normal activities whilst a patient with mental health issues in their care was breathing in the toxic products of combustion in a room which was on fire.

The CCTV footage shows that 5 minutes and 20 seconds passed, and the Woodlands’ fire alarm log records that the fire alarm was silenced and reset several times, before any member of the Woodlands’ staff went to check the source of the fire alarm in the patient’s bedroom; despite all the fire alarm panels available to staff showing exactly where a fire had been detected.

As a consequence of that delay, the patient was unresponsive and the conditions in the room were so bad that their assisted evacuation was not possible. The patient was therefore left in the smoke-filled bedroom until they were rescued by SFRS firefighters at around 15:48.

Following their rescue the patient underwent resuscitation and treatment at the scene, and was taken to a hospital in Norfolk, where they were treated for serious smoke inhalation; which included sessions in a hyperbaric chamber. The patient then spent two weeks in critical care before going back to Woodlands for ongoing treatment for their mental health issues.

Suffolk Fire and Rescue Service policy dictates that, following a fire in a premises which falls under the Regulatory Reform (Fire Safety) Order 2005, a formal fire safety investigation is commenced. One immediate issue of concern was that the attending fire officers reported that several final fire exit doors from the building were found to be mechanically locked during the fire.

A ‘post-fire’ audit was also arranged, and was carried out on 2nd November 2011. This identified, among other failings; a failure to adequately train staff at the Woodlands unit in fire safety, and that no safety drills had been carried out there since it had been open and occupied. An Enforcement Notice was issued requiring remedial work. This was not appealed, thereby impliedly accepting the failures which were identified in the Notice.

31st January 2012 was set in the Enforcement Notice as the follow-up date when SFRS would check that action had taken place to remedy the identified failures.
While the SFRS investigation into the circumstances surrounding the fire incident was progressing, a legal issue was identified with regard to the transfer of the criminal liabilities of Suffolk Mental Health Partnership NHS Trust to the new entity of Norfolk and Suffolk NHS Foundation Trust (NSFT) on the former’s dissolution. It was eventually established that SMHPT’s criminal liability had not been specifically transferred to the successor entity NSFT.

As a result, despite members of the successor NSFT executive board being in senior director positions at SMHPT for some eight months prior to the fire, no criminal prosecution could be brought against the NSFT, even if all the appropriate tests showed that there had been failings by its predecessor which warranted prosecution.

However, while the matter of the transfer of legal liabilities was being fully explored, and because the Order enables enforcement to be against individuals in certain circumstances, in the light of the severity of the injury to the patient, the recent negative inspection history at the premises, and the ongoing findings of the fire safety investigation, the investigation into breaches of The Order continued.

This report has been compiled to enable Norfolk and Suffolk NHS Foundation Trust to draw lessons from the apparent failings surrounding the fire incident and take appropriate action to prevent any future reoccurrence.
Part B – Report of the Facts and Circumstances

B1 – Description of the facts and circumstances leading up to and at the time of the incident.

1. 20/07/11, 28/07/11, 03/08/11, 05/08/11 – Internal reports were submitted by SFRS operational officers noting their fire safety concerns when they had attended the Woodlands unit after the fire alarm had activated. Those concerns were mainly regarding the level of staff training and the staff’s response to the fire alarm. On one occasion, the attending fire officer reported that a ‘post-it note’ was attached to a ward’s (Willow Ward) fire alarm panel which read; “silence and reset the alarm panel.”

Early August – A SFRS fire safety officer contacted the SMHPT Fire Safety Manager (FSM) to arrange an audit visit.

10/08/11 – A SFRS fire safety officer visited the Woodlands Unit. The FSM was present, but could not produce the premises’ Fire Risk Assessment (FRA) when requested.

11/08/11 – An 8-page Woodlands’ FRA (dated 11/08/11) was received by the SFRS inspecting officer from the FSM as an email attachment.

The FRA identified the Woodlands unit’s Modern Matron as the ‘Responsible Person’, and it concluded that; “The patients are considered to present a high risk of fire and therefore a high standard of supervision and assessment is in place”, and that the fire safety measures were; “unsatisfactory but not serious.”

12/09/11 – A 12 page Woodlands’ FRA (dated 11/08/11) was received by the SFRS inspecting officer from the Trust FSM as an email attachment.

13/09/11 – The SFRS fire safety officer carried out a pre-arranged audit of Woodlands Unit. Present were the SMHPT FSM and the fire safety advisor, and the Acute Service’s manager. The SFRS officer identified that: FRA action points had not been implemented; Woodlands Unit staff had not been given adequate fire safety training; and fire safety drills had not been carried out.

14/09/11 – A Notification of Deficiencies (NOD) was issued to SMHPT.

2. At 02:15 on 25th October 2011, a patient voluntarily presented into the care of the Woodlands unit, and was admitted into Avocet Ward. Within a few hours they were transferred to the 1st floor Poppy Ward.

The SMHPT ‘Positive Clinical Risk Management Policy’ in force at the time of the fire, states; “For in-patient or residential units, where 24 hour staffing is available, it is expected that an Initial Risk Assessment and management plan should be completed within the first 24 hours of admission.”

The patient’s medical records disclose that at the time of their admission, their Health and Social assessment (which was not completed in its entirety; having numerous questions filed as ‘not asked’ or ‘not known’), comments that they demonstrated aggressive behaviour, and that the patient was
This assessment rates the patient's risk to others as moderate, and says that full assessment was not able to be completed at the time due to their presentation issues.

At the time of the fire, approximately 37 hours after their admission to the unit, the patient had not had a full Patient Risk assessment carried out.

The patient’s medical records disclose that their Patient Risk profile was undertaken after their readmission to the Woodlands unit following treatment and recovery elsewhere from the effects of the fire.

At the time of their original admission, the patient’s Health and Social assessment observes that they appeared very agitated, and were pacing up and down and chain-smoking.

In accordance with the Trust’s documented ‘admissions’ process, the admitting staff should have established whether the patient had cigarette lighters or any other items on them that would pose a risk to them or others, and then risk assessed whether to remove and withhold any such items for safe-keeping.

3. On 26th October 2011, at around 15:05, a member of Woodlands’ staff made an observation visit to the patient, who was alone in their room (bedroom 19) on Poppy Ward.

4. At 15:20:31, the Woodlands unit’s automatic fire alarm log records that it had detected a fire.

The location information; ‘Woodlands Psychiatric unit – H82-1 Poppy Ward Z14 Bed 19 08S276’ was relayed in the emergency call received by SFRS Combined Control at 15.22.13 originating from the Ipswich Hospital switchboard - where the main fire alarm panel is situated. This location information contains precise details of the activating fire detector head and would have been displayed on all the fire alarm panels (inclusive of ‘repeater’ panels) in the Woodlands Unit.

Based on the CCTV footage supplied by SMHPT, hard copy of the fire alarm system log, Woodlands staff members’ accounts and those of SFRS personnel who attended the fire, a timeline of events has been compiled (Appendix A). The following is a narration of those events matched against the Woodlands’ fire alarm log timestamp:

Poppy Ward (First floor) – immediately following fire alarm activating:

- At 15:20:34, two members of the unit’s staff enter the Poppy Ward outer office (where there is a ‘repeater’ fire alarm control panel) from the communal area. One then leaves and carries on with work elsewhere on the ward. Another member of staff comes out of the
‘inner’ office then goes back into it. All three staff members appear to show a momentary interest in the fire alarm control panel.

- The Woodlands’ fire alarm system is ‘addressable’, which means that the precise location of the detector activating would have been shown on the fire alarm panel.
- Had the unit’s fire emergency plan been followed at that time, when the fire alarm sounded designated members of the unit’s staff should have gone to their nearest fire alarm panel and, having read the location information from the display, one or more staff members should have proceeded immediately to the indicated location to ascertain the cause of the fire alarm.
- At 15:21:24, the remaining staff member who had entered the Poppy Ward outer office, leaves it, clears some cups from the nearby communal tea area tables, then carries on with work elsewhere. Nobody in Poppy Ward shows any further reaction or movement regarding the fire alarm sounding.
- Therefore, the CCTV shows that at least these three members of Poppy Ward staff were in the same room and were ‘attracted to’ the fire alarm panel seconds after the system had activated. Instead of then implementing the unit’s documented emergency procedure to investigate that fire alarm, they are seen to walk away from the fire panel; and to do nothing to promote a response to it from their colleagues or other people.
- At 15:23:20, with the building’s fire alarm continuing to activate, the CCTV shows two other staff members entering the Poppy Ward outer office. One moves into the inner office and remains there, the other leaves shortly afterwards and chats with nearby people in the communal area. Still no positive action is taken by Poppy Ward staff to investigate the fire alarm’s indicated location.

Avocet Ward (Ground Floor) – immediately following fire alarm activating:

- At 15:20:34, the CCTV shows that a member of the Avocet Ward support staff, an Avocet Ward Charge Nurse, and a colleague, who were chatting in the Avocet Ward outer office, were attracted to the nearby fire alarm control panel. A moment later the Charge Nurse and colleague walk away from the panel and resume work.
- 15:20:56, This support staff member, who has had no apparent training on the fire alarm system and does not have any personal authority or role designated to the individual in the event of a fire, opens the fire alarm control panel cover, which is glass fronted so the information displayed may be read while it is closed, and the individual raises a hand and apparently interacts with the control panel.
- 15:21:02, the fire alarm is recorded as being silenced.
- 15:21:05, the team manager leaves the office.
- 15:21:21, the fire alarm is recorded as being reset.

In the ensuing six minutes the Woodlands’ fire alarm (which could be globally accessed and controlled from any control panel on the entire Ipswich hospital-wide system) is recorded as being silenced five
times and reset three times in total. These eight events coincide with the cover of the fire alarm control panel in Avocet Ward being open, and occur while a Woodlands unit staff member is apparently interacting with the fire alarm control panel.

- 15:23:50, the Avocet Ward Charge Nurse appears to gesture to a group of people who have gathered around her in the Avocet communal area to ‘calm down’. This indicates that the fire alarm may be becoming a cause of concern for some of the patients.
- 15:24:22, the member of Avocet support staff who had been attending the fire alarm control panel since it first activated leaves the Avocet Ward office and is shown on the CCTV to go upstairs to Poppy Ward.

Poppy Ward – 4 minutes and 32 seconds after first activation of alarm:

- 15:25:02, the CCTV shows that, on their way to the Poppy Ward office upstairs, the member of support staff from Avocet Ward walks past the closed door of bedroom 19 where the fire is. This would indicate that despite having spent four minutes interacting with the Avocet Ward fire alarm control panel, this staff member does not comprehend the location of the fire.
- 15:25:40, that staff member enters the Poppy Ward inner office; wherein that individual finds several Poppy Ward staff members who had still not investigated the cause of the fire alarm in the patient’s bedroom on their ward.
- 15:25:52, that Avocet staff member, now with three members of the Poppy Ward staff leave the office and first check bedroom 20 on Poppy Ward, then the staff members open the door to bedroom 19 where they discover the fire and that the patient is in this room.

Failure to implement the unit’s documented fire emergency plan had led to 5½ minutes passing since the automatic fire alarm first detected the fire in the patient’s bedroom.

- The CCTV shows that this is apparently the first time any member of Woodlands’ staff checked the fire room; so by the time the fire was discovered the patient’s room where the fire occurred was so heavily smoke-loged that their assisted evacuation by the staff was no longer tenable. During this action the CCTV shows thick black smoke billowing out of the room and entering the corridor; which placed anyone in the corridor at serious risk.
- The unresponsive patient was left in the room where the fire occurred and was rescued by firefighters in breathing apparatus at around 15:48.
- 15:26:00 The staff members who had discovered the fire dispersed from that immediate area and began the evacuation of unaffected parts of the unit without first checking into the neighbouring rooms for anyone who may not yet have evacuated; which constitutes their second failure to properly implement the unit’s fire emergency plan.
- Instead, at 15:26:20 and 15:26:50, the CCTV shows two individuals emerging into this smoke filled corridor under their own volition. It appears to be only a matter of fortuitous timing that they appeared
while staff were present to usher them away.

- 15:26:32 the CCTV shows a member of staff returning and entering the fire room to attempt to tackle the fire with an extinguisher. That individual then quickly withdraws.

- 15:27:12, (seven minutes after the fire had been first detected), the CCTV shows some staff members returning to search the neighbouring rooms in this area; the corridor is rapidly filling with thick black smoke issuing from the fire room; which placed anyone in the corridor at serious risk. The camera view is finally obscured.

- 15:31:02, the Suffolk Fire and Rescue Service appliance arrives. The officer-in-charge and some of his personnel are escorted through the Woodlands building closer to the scene of the fire by the Poppy Ward manager.

- However, when attempting to return to his fire appliance and crew outside the building, they were delayed by the fact that they found some nearby fire exits from the wards mechanically locked, and the ward manager could not open them from inside.

- They exited the building by a circuitous route elsewhere. The fire crew made a forced entry where required by breaking in through another locked fire exit door onto Avocet Ward at 15:40:36, and rescued the patient back out to fresh air around 15:48. The patient underwent resuscitation treatment and was taken away to hospital in Norfolk.
B2 – Description of information found during the investigative process and the events following the incident.

1. Based on evidence captured at the scene by Suffolk Constabulary’s ‘scene of crime’ officers, and on his own findings at the time; including two cigarette lighters found on the floor of the patient’s room, the SFRS Fire Investigation officer concluded in his report that the fire was caused by the patient igniting the bedding in their room using a cigarette lighter.

This SFRS officer records in his statement submitted to this investigation that, in a later phone conversation, after having reviewed a copy of the Woodlands’ fire alarm printout the SMHPT Fire Safety Advisor told him, in relation to events surrounding the fire, that the Woodlands unit staff had made; “…a huge mistake.”

2. In the course of one line of our inquiry, a member of the Woodlands Unit front-line management provided a written response to questions that SFRS put to them under the Police and Criminal Evidence (PACE) Act 1984.

Q. How surprised are you that fire exits were found locked?

A. “Very surprised. I am also very surprised that the weekly fire alarm testing and physical inspections undertaken by the Estates Department did not pick up on this issue. One of their fire inspections had been undertaken less than 2 hours before the Incident itself occurred.”

Q. Who would make the decision to lock the doors?

A. I do not know. Clinical staff would not make this decision so if this was a determined action it would be decided by the Estates Department.

They also commented:

“As far as I am aware Clinical Staff did not lock these fire doors. There would be no exceptional circumstances which would permit mechanical locking of fire doors. A programmed delay in fire door opening had been provided for to allow for incidents where patients may set off a fire alarm in order to abscond but even in that instance it would not be acceptable for fire doors to be mechanically locked.”

3. In the course of one line of our inquiry, a member of the Woodlands Unit staff provided a written response to questions that SFRS put to them under the Police and Criminal Evidence (PACE) Act 1984.

Their response to the question, “Did you receive any specific fire safety training when you began working at the unit?” was:

“Before Woodlands opened, I attended a fire lecture (in June 2011) which was given by a fire safety officer. I do not recall his name. The training took
place in the conference room of Avocet Ward. The training did not cover evacuation procedures and did not cover the details of the ward layout. The trainer had no more knowledge of the layout than we did, and we had none. It was my first visit to the Woodlands unit. It was not adequate to deal with an incident such as happened in October. We were not shown the ward as part of this training and we were not shown the alarm panels either.”

Q. Did you understand how to interpret the read out on the fire alarm panel?

A. “I had no training on how to interpret the alarm panel reading.” adding, “none of us knew how to use the panel”.

4. Suffolk Constabulary took no further action in relation to this fire incident. However, Suffolk Fire and Rescue Service immediately commenced a formal investigation into the fire safety measures at the Woodlands unit and potential breaches of the legislation by Suffolk Mental Health Partnership NHS Trust. A second, ‘post-fire’ audit took place on 2nd November 2011. This inspection identified, among other failings, that:

- Woodlands’ staff had not apparently received adequate fire safety training on their induction into the newly opened unit;
- Safety drills had not apparently been carried out;
- The FRA had apparently not been reviewed in light of the recent NOD’s findings and several action points in the FRA had not been implemented.

On 10th November 2011, independent of this investigation, an Enforcement Notice was served on SMHPT, with 31st January 2012 set as the follow-up inspection date when SFRS would check that action had taken place to remedy the identified failures.

The Enforcement Notice was not appealed by SMHPT, and led to a written response from the Trust which acknowledged failings that had been, or would be addressed:

- “FRAs and progress on prioritised actions to eliminate significant findings will now form part of regular ward and departmental meetings.”
- “FRAs are reviewed but they will now be formally documented and form part of the regular ward and departmental meetings.”
- “…all smoking materials will be removed from clients for the duration of admission.”
- “The Trust emergency planning document, Fire Policy and Woodlands fire procedure; “…are now being reviewed to reflect the lessons learned from the incident.”
- “…full evacuation drills will be undertaken for inpatient wards.”
- “The Trust is reviewing its current position that the responsibility of initial fire training to new members of staff rests with their line managers.”
- “We intend to fully comply with the content of the notice.”
5. On 31st January 2012, SFRS fire safety officers revisited Woodlands to check on the remedial works required by the Enforcement Notice. Based on the sum of the works that had been completed, and/or planned, the Service issued a ‘broadly complied with’ letter to the Trust.

However, that letter contained reference to breaches mentioned in the Enforcement Notice in which there had been progress, but which remained ‘outstanding’. These included; some action points in the FRA had yet to be actioned; safety drills had been scheduled but had not yet been carried out; around 30% of Woodlands staff had yet to receive adequate fire safety training.

SFRS described in the ‘Broadly complied with’ letter that its officers would return to Woodlands in July 2012 to check on those outstanding items.

6. Incidental to this investigation into the Woodlands unit’s fire incident and fire safety management issues, as the result of a procedural follow-up on a pre-existing Enforcement Notice which had been served on SMHPT in April 2010 in relation to its ‘Wedgwood House’ mental healthcare unit on the West Suffolk Hospital site in Bury St Edmunds, SFRS fire safety officers reinspected that premises.

In July 2012 SFRS served an Enforcement Notice on the Norfolk and Suffolk NHS Foundation Trust (NSFT) when its inspecting officers identified issues of concern at the Wedgwood House unit, including:

- failure to suitably manage ignition sources, ie; patients’ smoking materials.
- FRA not suitable and sufficient.
- deficient fire safety management arrangements.
- structural means of escape issues, and key-operated fire exit issues.
- no record of a fire emergency plan or practise drills.
- failure to provide comprehensible and relevant information to employees on appropriate procedures and drills to be followed in the event of serious and imminent danger.

Because of this, SFRS will instigate a programme of audit of other NSFT properties to determine the level of fire safety compliance of the Trust across its estate in Suffolk.
B3 - Description of the facts and circumstances regarding the Responsible Person

1. In 2011, members of the Norfolk and Waveney Mental Health NHS Foundation Trust (NWMHFT) executive team, namely its Chief Executive Officer and its Medical Director, were appointed to concurrent positions at the Suffolk Mental Health Partnership NHS Trust prior to the pending integration of the two Trusts. The SMHPT’s Director of Environmental Performance position remained with the SMHPT incumbent.

2. On 1st January 2012, SMHPT was formally dissolved and acquired into the entity with NWMHFT renamed Norfolk and Suffolk NHS Foundation Trust.

3. The Suffolk Mental Health Partnership NHS Trust’s ‘Fire Policy’ in force at the time of the fire incident recognises that SMHPT has a statutory duty to comply with fire safety legislation, and states that the Chief Executive retains the overall accountability for the Trust’s compliance with fire safety legislation. It also states that the Trust’s Director of Finance (DOF) is ‘the board level Director nominated with responsibilities for fire safety.’

The fire policy says that; ‘The Nominated Director will be responsible for overseeing and monitoring the response by managers, including the Fire Safety Manager, to reports received from Fire Safety Advisors or from the Fire Service.’

The Trust fire policy also describes that the DOF delegates the fire safety duties to the Director of Environmental Performance (also the Head of Estates) in a role identified as the Fire Safety Manager (FSM); “…who will have overall responsibility for co-ordination and implementation of the Trust Fire Policy.”

4. The SMHPT Fire policy describes that:

The Fire Safety Manager and/or the nominated Director will ensure that all fire alarms, emergency lighting systems and items of fire fighting equipment are regularly serviced, tested and recorded in accordance with statutory and Firecode requirements.

The Fire Safety Manager will maintain an electronic register of Fire Risk Assessments for all Trust occupied properties and ensure that the original signed document is sent to all premises for retention on site, so as to be readily available for inspection by the Authorities.

The Fire Safety Manager will liaise with the Trust’s Fire Safety Advisor concerning all aspects of fire safety, fire risk assessment, staff training, identified action points…’

SMHPT's Director of Environmental Performance went on long-term absence from work in early 2012. SFRS decided then to not contact this individual during their absence. At the time of compiling this report that individual had not returned to work.
5. The FSM is described in the fire policy as having to provide ‘regular’ reports to the DOF, and the Trust’s ‘Environmental Health and Safety, Risk Management Group’, which the fire policy says; “...will monitor quarterly compliance with this policy. Standard agenda items might include fire incidents; unwanted fire signals, enforcement action and staff training.”

6. Within the Estates Department, the FSM is supported by a dedicated fire safety team.

7. The SMHPT Fire Policy also designates that:

1) “Each Head of Department and Senior Manager is responsible for all fire safety matters within their departments and must ensure fire safety standards are maintained and all faults, defects or omissions are reported and/or actioned.”

2) “To ensure that all staff under their supervision participate annually in fire safety training and fire drills, line managers are to ensure that a record of fire safety training is kept for all staff under their supervision.”

3) “Heads of Department, Senior Managers and Managers in consultation with the responsible person* shall organise fire drills/exercises for their premises and ensure they are conducted at least twice per year to form an important part of staff training.”

*The SMHPT Fire Policy defines ‘The Responsible Person’ as:

The person (or person(s) who has (have) overall responsibility for the day to day management of the premises. Responsible for reporting fire safety issues to their line manager and for co-ordinating the actions of staff in a fire emergency.’

This discloses a fundamental misconception regarding responsibility under the Order, which in Article 3 defines the Responsible Person as:

(a) in relation to a workplace, the employer, if the workplace is to any extent under his control;
(b) in relation to any premises not falling within paragraph (a) -
   (i) the person who has control of the premises (as occupier or otherwise) in connection with the carrying on by him of a trade, business or other undertaking (for profit or not), or;
   (ii) the owner, where the person in control of the premises does not have control in connection with the carrying on by that person of a trade, business or other undertaking.

8. In the course of one line of our inquiry, the person at the Woodlands Unit who was designated as ‘The Responsible Person’ on the August 2011 Woodlands Fire Risk Assessment, provided a written response to questions that SFRS put to him under the Police and Criminal Evidence (PACE) Act 1984, in which they say:
- At no stage prior to the fire incident on 26 October 2011 (the Incident) was I aware or informed of the responsibilities referred to in the question in respect of the SMHPT Fire policy.
- I was not aware or informed by my employer that I had any fire safety responsibilities.
- I was not aware and was never informed that I was the Responsible Person. Had I been aware or informed of being nominated for this role, I would have requested appropriate training prior to accepting it.
- I was not informed at any stage that the Fire Risk Assessment was for me to address and instead understood that it was for the Estates Department to action as they were responsible for dealing with these issues.
- Even had I been aware of being the Responsible Person, I do not consider that I had the requisite authority to exercise the control necessary to make that an effective position. That is confirmed by the fact that all decisions in respect of fire safety for the Woodlands Unit were made by the head of the Estates Department.
## B4 – Preventive and Protective measures taken by the Responsible Person BEFORE the incident

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| **1.** | The Woodlands Unit opened on 4th July 2011. It is a modern, purpose-designed mental healthcare unit, constructed in accordance with Building regulations.  

The following are the principal Trust documents which pertain to fire safety:  

- Fire Risk Assessment – 11/08/11  
- Fire emergency plan (undated) |
| **2.** | As part of the Ipswich Hospital site, the Woodlands unit’s fire detection coverage is part of the addressable, hospital-wide automatic fire alarm system; which was supplemented by numerous break-glass manual call points around the building.  

In addition to the locations all around the premises, each ward office had a fire alarm control panel installed. |
| **3.** | As is usual in premises of this type, to maintain the security of the environment, the fire alarm system was interfaced with numerous electro-magnetically locked final fire exit doors designed to be ‘secured’ closed during normal times, but released after a 90 second delay following the fire alarm activating. |
| **4.** | The unit is provided appropriately with emergency escape lighting and portable fire extinguishers. |
| **5.** | The Woodlands’ unit fire emergency plan documents that a system of progressive horizontal evacuation (PHE) is in place. PHE involves a coordinated, reactive checking of the immediate area and moving only those people at risk from the fire into an adjoining fire-separated area. |
| **6.** | The Trust’s ‘Smoke-free environment’ policy in force at the time of the incident permitted patients to smoke in designated outdoor locations, but states that patients are not allowed smoking materials, or to smoke, in their rooms. |
B5 – Fire Safety Management BEFORE the incident

1. The Fire policy in force at the time of the fire incident recognises that SMHPT has a statutory duty to comply with fire safety legislation.

   The Trust had a Board level director delegated with fire safety responsibility, who was to oversee and monitor the response by managers, including the Fire Safety Manager, to reports received from Fire Safety Advisors or from the Fire Service, and was to be regularly reported to by the Fire Safety Manager; who managed a small fire safety team.

2. SMHPT has admitted to SFRS in its responses to Fire Safety Order Article 27 requisitions for information that, at the time of the incident; “The Trust had no formal policy for monitoring and reviewing their fire safety preventive and protective measures.”

3. In that Article 27 response, SMHPT also states that; “The Trust had no formal policy” with regard to the checking for, and removal of, ignition sources from patients.

4. In another Article 27 written response, SMHPT admitted that at the time of the fire; “…the Trust did not carry out fire drills on its wards.”

5. The building’s fire safety devices, eg; detection and alarm, emergency lighting, etc, were tested and maintained to regimes managed by the Fire Safety Manager and the Estates department.
Part C – Suffolk Fire and Rescue Service's Conclusions

C1 – Conclusions from the Investigation

1. This Suffolk Fire and Rescue Service (SFRS) investigation followed a fire in which a patient with mental health issues, who had voluntarily presented into the care of Suffolk Mental Health Partnership NHS Trust at its Woodlands Psychiatric Unit on the Ipswich Hospital site, was seriously injured. As a result of their protracted exposure to a fire in their hospital bedroom, they underwent hyperbaric treatment in a specialist hospital and were in the critical care unit at a hospital in Suffolk for two weeks.

Our investigation has gathered sufficient evidence to have supported the prosecution of the premises’ Responsible Person (RP) for a range of offences under the Regulatory Reform (Fire Safety) Order 2005. However the RP - the Trust at the time of the incident - cannot be pursued as it does not now exist and criminal liability for that former Trust’s activities was not transferred to the new Trust.

Had this legal issue not arisen and criminal liability been transferred, Suffolk Fire and Rescue Service would have given consideration to prosecuting ‘Norfolk and Suffolk NHS Foundation Trust’ (formerly Suffolk Mental Health Partnership NHS Trust) as the Responsible Person for the apparent fire safety breaches we have identified.

2. The serious potential consequences of a fire in mental healthcare premises demand that high standards of fire safety are observed at all times, promoted by a strong, leading management culture.

The Trust’s own Fire policy states:

“Fire is a potential hazard in all premises. The consequence of a fire in a hospital and other health care premises can be especially serious because of the difficulties and dangers associated with the emergency evacuation of patients.

The aim of this policy therefore must be to ensure that, if possible, outbreaks of fire do not occur but that if and when fires do occur, they are rapidly detected, effectively contained and quickly extinguished”.

A wealth of evidence has been collected and processed in this investigation and Suffolk Fire and Rescue Service has formed a clear understanding of what happened at the time of the fire and why it happened.

We have concluded that the evidence apparently shows that significant breaches of the fire legislation occurred at the Woodlands Unit prior to and on the day of the fire, which resulted in a vulnerable patient in the care of the Trust being left alone in their bedroom with a developing fire for over five minutes before staff started to look for them; and they had to remain there for another twenty minutes until they were rescued by Suffolk Fire and
3. Based on the substantial amount of evidence compiled during this investigation, SFRS believes that the inaction and inappropriate actions of the staff in the Woodlands unit during the fire event were the effects of an apparent failure by the Trust to ensure that its relevant policies and procedures always met the requirements of the fire safety legislation to ensure the safety of relevant persons.

The apparent fire safety failings identified at the Trust’s Woodlands Psychiatric unit include:

In the time leading up to the fire:

- The Trust began operating (ie; accepted patients) in the Woodlands building on 4th July 2011; which was some weeks before the unit’s documented fire safety risk assessment (FRA - dated 11/08/11) was undertaken.
- The 11th August FRA, which was provided to the SFRS fire safety officer the day after his first visit to the Woodlands unit, appears to incorporate his observations made at that visit, and has been found to include unsubstantiated generic findings brought 'into the present' which had, it appears, been cut-and-pasted from a fire safety strategy document written by the building’s refurbishment architects back in 2009.
- The Trust failed to appropriately review its Fire Risk Assessment, and it failed to revise its contents appropriately, for example; following SFRS audit and correspondence.
- The Trust had not effectively transferred the recognised guidance on the vulnerability of people with mental illnesses into any action; simply relying upon the patients’ clinical assessments; which, it would appear, are not always completed.
- The Trust had, seemingly, not adequately considered the impact on its initial patient risk profiling process of patients foreseeably presenting with ‘issues’ during their admission. Consequently, it appears that no generalised risk management contingencies were available while the patient’s full risk assessment remained pending.
- The Trust began operating in the Woodlands building without providing adequate, premises' specific fire safety training to all its employees when they started working there.
- The Trust failed to prepare staff working in the newly opened unit for an emergency, i.e; it did not carry out drills for them to practise its emergency procedures.
- Trust employees in the unit were appointed with specific fire safety roles, responsibilities and duties of which they had no knowledge, over which they had no control, and for which they had received no additional training. For example; the designation of the Woodland’s Modern Matron as the ‘Responsible Person’, in the premises’ FRA. This, as abovementioned, was also legally incorrect, in the light of
Similarly, despite certain staff roles having specific actions nominated to them in the unit’s fire emergency action plan, no members of staff at Woodlands had been sufficiently well informed so as to know they had those duties. Nor were they trained to carry them out.

And on 26th October 2011 itself:

- Of the eight staff working on Poppy ward at the time of the fire, Trust records show that none had received the Woodlands specific ‘Post-opening’ fire safety training.
- An apparently foreseeable means to start a fire on the premises had not been identified or monitored, i.e; without adequate risk assessment, personal lighters were left in the unsupervised possession of a vulnerable patient with mental health issues.
- The Trust had failed to ensure that final fire exits from the wards were maintained readily available, i.e; unlocked, during a fire emergency.
- Contrary to the Woodlands’ fire emergency action plan, no person with the appropriate authority or designation to do so intervened to effectively manage the fire alarm activations prior to the discovery of the fire. Such that a member of Avocet ward’s support staff, who admits to having no training in or understanding of the fire alarm panel, was allowed to repeatedly interact with the unlocked fire alarm control panel without supervision.
- Contrary to the Woodlands’ fire emergency action plan, the fire alarm was repeatedly silenced and reset without any member of Woodlands unit staff physically checking to confirm the location and cause of the alarm. SFRS’s Fire Investigation officer recorded in his report that a member of staff told him that when the fire alarm activated at 15:20, that individual heard a message broadcast over the staff radios, (which was acknowledged on air at the time by the Poppy ward manager), that said: ‘It’s a false alarm on Poppy.’
- Consequently, for over five minutes whilst the building’s fire alarm was sounding, being silenced and reset, then sounding again, the patient in whose bedroom there was a developing fire was unattended as Poppy ward staff members disregarded the fire alarm and carried on normal duties.
- The Woodlands’ fire alarm log does not record who silenced and/or reset the fire alarm system multiple times, nor from which control panel. Indeed, the Woodlands’ fire alarm was part of the Ipswich hospital-wide system and could have been controlled from any panel on that global system.
- However, the eight recorded events of the system being silenced or reset are each shown on CCTV to correspond in time while Woodlands’ staff are interacting with the fire alarm control panel in the Avocet Ward office. SFRS therefore believes that an inference can be drawn from the evidence that the Woodlands unit’s fire alarm system was not coincidentally affected from elsewhere every single time that the system was silenced or reset.
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

- SFRS regards much of what the Avocet Ward support staff member did during the incident as inappropriate from a fire safety viewpoint. However, it is mindful that this was the sole member of Woodland’s staff to respond to the fire alarm in any concerted way.
- For some five minutes while the building’s fire alarm was repeatedly sounding, despite being equipped with hand-held radios, Poppy Ward staff had failed to effectively coordinate and investigate the cause of the fire alarm, until that member of the support staff from another ward came upstairs and physically fetched members of Poppy ward’s staff from their office to investigate the fire that was being indicated as occurring in their ward.
- The Woodlands unit’s fire emergency plan documents that a system of progressive horizontal evacuation (PHE) is in place. PHE involves checking the immediate area and moving only those people at risk from the fire into an adjoining fire-separated area. PHE is common in this sort of care environment where it is not desirable or necessary to fully evacuate a building.
- Once the fire had been discovered, contrary to the Woodlands’ fire emergency action plan, the unit’s staff failed to effectively comprehend the situation and coordinate their actions, and they did not then correctly implement the PHE procedure. Consequently, some patients who had not yet responded to the fire alarm fortuitously and of their own volition evacuated from the fire risk area at that moment; while time and staff resources were diverted from the relevant area by evacuating people from parts of the building not affected by, or at risk from, the fire.

4. During this investigation, The Trust reported to SFRS that, following its own “detailed investigations” into the fire incident, it had concluded; “…problems associated with the incident…we believe revolve around individual human error.”

The Trust also told SFRS that; “Staff evacuated the ward, fought the fire and operated professionally as per agreed systems and training.”

Suffolk Fire and Rescue Service recognises that some of the identified failings on the day might be attributable to the individual human error of staff members in the heat of the moment. However, this recognition is in the light of the evidence that Woodlands’ staff had received:

- No suitable Woodlands specific fire safety training once they began working at the newly opened unit, and;
- No fire drills had been arranged for them to practise its emergency procedures.

…so the conduct of staff while they were evacuating the premises during the fire is understandable in the context of the level of training and supervision they had received.

But SFRS is of the view that in consigning the problems surrounding the fire
to ‘individual human error’, the Trust’s concluding position is misconceived; and it suggests an investigation and interpretation of the events surrounding the fire which are inadequate. This bears on the acceptance of due responsibility for the fire and its consequences.

5. SFRS has identified the apparent breakdown or inadequacy of numerous management practices and systems that should otherwise have been expected to ensure the effective superintendence and delivery of fire safety at the Woodlands psychiatric unit. For example:

- The Trust admits that it had no policy for the review and monitoring of its preventive and protective measures.
- The Trust admits that it did not carry out fire drills on wards.
- The Trust admits that it had no policy with regard to the checking for, and removal of, ignition sources from patients.
- The Trust’s numerous and distinct risk assessment systems, e.g; clinical, health and social, fire, H&S, etc, and their attendant timescales, delegations, and reporting mechanisms, did not appear from the evidence to be coordinated into a meaningful patient and premises risk management methodology which adequately reflected the complex risk dynamics in such a setting.
- The arrangements for monitoring and quality assurance at strategic level of the Fire Safety team’s implementation of Trust policy did not appear to be effective.
- There appeared to be little ownership or awareness of fire safety issues by staff at the unit. Despite the numerous nominations of fire safety duties and responsibilities to department heads, managers, shift coordinators, etc, within the Trust fire policy, in reality there appeared to be a widely held acceptance by unit staff that ‘The Estates Department’ dealt exclusively with fire safety issues on Trust property.
- Erroneous use of otherwise relevant and existing definitions, eg; ‘Responsible Person’, demonstrates the Trust’s misinterpretation of the legislation and its obligations under it.
- No effective training and support mechanisms were apparent which would equip front-line staff, whose roles were nominated with specific fire safety duties, with the awareness that they had the duties, nor the knowledge and skills to ensure that they were personally competent to carry out those duties.
- The processes to ensure that Trust staff receive suitable fire safety instruction and training when due, including induction training when employed at new premises, and practise drills in all areas, did not appear to be effective.
- The day-to-day checks, and the inspection and testing arrangements for the Woodlands unit fire safety systems and equipment did not appear to be effective. For example; between 13.30.00 and 14.48.26 on the day of the fire the Woodlands fire alarm system and its interfaced devices, ie; the electro-magnetic automatic fire exit door release devices, were tested by the Estates department and were recorded as operating without fault. Yet final fire exit doors were
found mechanically locked during the fire. In addition, there appears to have been no effective communication to staff in the unit at the time when testing of the fire alarm had ceased.

- The processes within the Trust for the investigation of serious incidents did not appear to be effective.

6. Ultimately, Suffolk Fire and Rescue Service has identified that in the run up to the fire incident, for all practical purposes there appeared to be significant disengagement between the respective parties at the Trust, such that:

   a) Strategic managers failed to make themselves effectively aware of what was happening with regard to how Trust fire safety policy and procedures were being implemented by the Fire Safety team and Trust staff to ensure compliance with the legislation; and;

   b) The Fire Safety Manager and team failed to effectively engage with staff at the Woodlands unit, and failed to examine or report how effectively the fire safety team itself was delivering those policies and delegated fire safety arrangements into action; and;

   c) On a day-to-day basis the employees working at the Woodlands unit were functionally detached from, and demonstrated little knowledge or understanding of, the requisite fire safety arrangements and emergency procedures in their workplace.

SFRS wishes to emphasise that it is a matter of serious concern that such apparent fundamental fire safety failings were identified within a public healthcare organisation that has a board level director designated with the fire safety responsibility and a Fire Safety Manager and dedicated team tasked specifically with putting what’s needed into practice across its estate.

7. Suffolk Fire and Rescue Service urges the Norfolk and Suffolk NHS Foundation Trust to earnestly draw lessons from this incident to ensure ongoing compliance with the fire legislation, and most importantly to ensure that the near tragic fire of 26th October 2011 could not be repeated.

Therefore, in light of this investigation and its findings, SFRS now expects the Trust to undertake a robust review of all relevant policies and implementation practices to make sure that its systems are ‘fit-for-purpose’ and that such systems ensure Trust-wide compliance with the fire safety legislation.

Disclaimer:

"What is stated in this report is based on material available to SCC at the time of preparing and could be subject to revision if further material becomes available. SCC offers no warranty to any other agency or private individual in respect of its content. Should any other person seek to rely upon the contents, including in the course of any action or proceedings, then they do so entirely at their own risk."
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Appendix A - Timeline of events at Woodlands on 26th October 2011

Key to staff members:

A – Avocet ward support staff member
B – Avocet ward Charge Nurse

This timeline has been compiled using the Woodlands AFA log as a datum (top timeline), correlated with data supplied by SMHPT to the effect that 61m 45s should be added to the Poppy ward CCTV timestamp (middle timeline), and 59m 40s should be added to the Avocet ward CCTV timestamp (bottom timeline).
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

SUPERFIRE sensed Poppy Bed 19

AFA call received into SFRS Combined Control

A opens AFA panel
Interacts with the panel

No observed activity to investigate fire alarm

Fire Alarm +1m
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

Fire Alarm +2m
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

**Fire Alarm +3m**

- **14:23:00** - B leaves office
- **14:24:00** - A opens AFA panel
- **14:24:00** - Interacts with the panel
- **14:24:10** - A refers to AFA panel
- **14:24:30** - A leaves office

**AFA log**

- **14:23:45** - Alarm Silenced (4th)
- **14:23:50** - SUPERFIRE sensed Poppy Bed 19
- **14:24:00** - Alarm RESET (3rd)
- **14:24:10** - A opens AFA panel
- **14:24:20** - Interacts with the panel
- **14:24:30** - A leaves office

**1st floor Poppy CCTV**

- **14:21:45** - No activity toward fire room

**Avocet CCTV**

- **14:24:00** - No activity toward fire room
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

Fire Alarm +4m
FIRE sensed corridor o/s room 14-21 Poppy

B enters office

B refers to AFA panel

FIRE discovered (5m 20s after 1st alarm)

Manual Call Point corridor o/s rooms 14-21
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

Alarm Silenced (6th)

SUPERFIRE sensed Corridor o/s rooms 14-21

FIRE sensed Bedroom 18 Poppy

FIRE sensed Bedroom 20 Poppy

AFA log

1st floor Poppy CCTV

Avocet CCTV

B opens AFA panel Interacts with the panel

B leaves office

Corridor smoke-logging Staff search the rooms.

Fire Alarm +6m
Suffolk Fire and Rescue Service Investigation of the Serious Fire Incident on 26/10/11

CCTV ends

Fire crew break in

Fire Alarm +20m

Fire Alarm +7m

SFRS arrive

AFA log

1st floor Poppy CCTV

Avocet CCTV
Appendix B – Plan Layout of Poppy ward

Poppy Ward
(same as Ground floor – Avocet ward)