REPORT REFERENCE NO.	**DSFRA/18/6**
MEETING	**DEVON & SOMERSET FIRE & RESCUE AUTHORITY**
DATE OF MEETING	**30 APRIL 2018**
SUBJECT OF REPORT	**THE "MOLLY" PRINCIPLE**
LEAD OFFICER	**Chief Fire Officer**
RECOMMENDATIONS	***That the report be noted.***
EXECUTIVE SUMMARY	This paper advises of the introduction of an improvement in Control Room operating procedures following the fatality at Sussex Road in October 2016.
RESOURCE IMPLICATIONS	Potential mobilisation of resources not actually required.
EQUALITY RISKS AND BENEFITS ANALYSIS (ERBA)	The contents of this report are considered compatible with existing equalities and human rights legislation.
APPENDICES	Nil.
LIST OF BACKGROUND PAPERS	Nil.

1. BACKGROUND

1.1. The Authority has previously been advised of the fatality that occurred at Sussex Road, Plymouth, in October 2016. The background to this tragic incident was that, following receipt of the initial call concerning a suspected incident, the Officer in Charge (OIC) of Control at that time made a decision not to mobilise an appliance despite at least one other person within the Control Room believing that this was the wrong decision and stating so.

1.2. The subsequent Coroner's Inquest delivered a narrative verdict (a verdict which sets out the circumstances of the death in a detailed way based on the evidence that the Coroner has heard) and concluded that the cause of death was smoke inhalation. While the Coroner commended firefighters who subsequently attended the incident for their courage and professionalism, it was nonetheless accepted that there were a number of learning points for the Service to ensure that a similar incident should not happen again. Service officers attending the Inquest outlined a number of identified Service improvements including the "Molly Principle", named in memory of the deceased, which is outlined in this report.

2. THE "MOLLY PRINCIPLE"

2.1 Within the Airline Industry and Health Service, for example, there are documented cases where junior staff have been aware of a potentially high risk scenario but have been unable to override or even influence a pilot or senior doctor or consultant. There are various explanations for this which centre around cultural factors and organisational hierarchy. In recognition of the risks that this situation presents steps have been taken to empower and educate staff at all levels to ensure that all staff are engaged in safety critical communication. At the very least a junior staff member should be able to challenge more senior staff and be listened to.

2.2 In line with this learning, and in light of the Sussex Road incident the Service has introduced a change in Control Room operating procedures whereby any staff member present in the Control Room when a call is received can require the attendance of an appliance where they reasonably believe that life could be at risk. This will result in the mobilisation of at least one appliance. It should be noted that there is potential for unnecessary mobilisation of appliances and consequently the position will be kept under review and further refined as necessary.

2.3 The Authority is asked to note the introduction of the "Molly Principle".

GLENN ASKEW
Chief Fire Officer