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Manchester Arena Attack: Reflections and lessons learned in relation to JESIP / Interoperability

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Manchester Arena Inquiry (MAI)

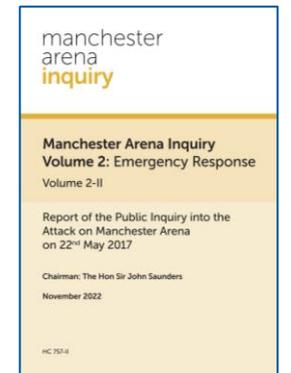
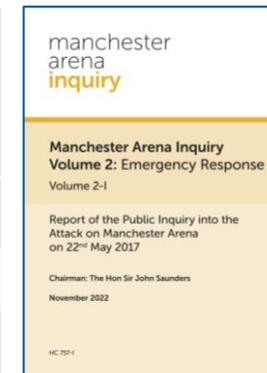
22 people died

Estimated 940 victims

237 people physically injured

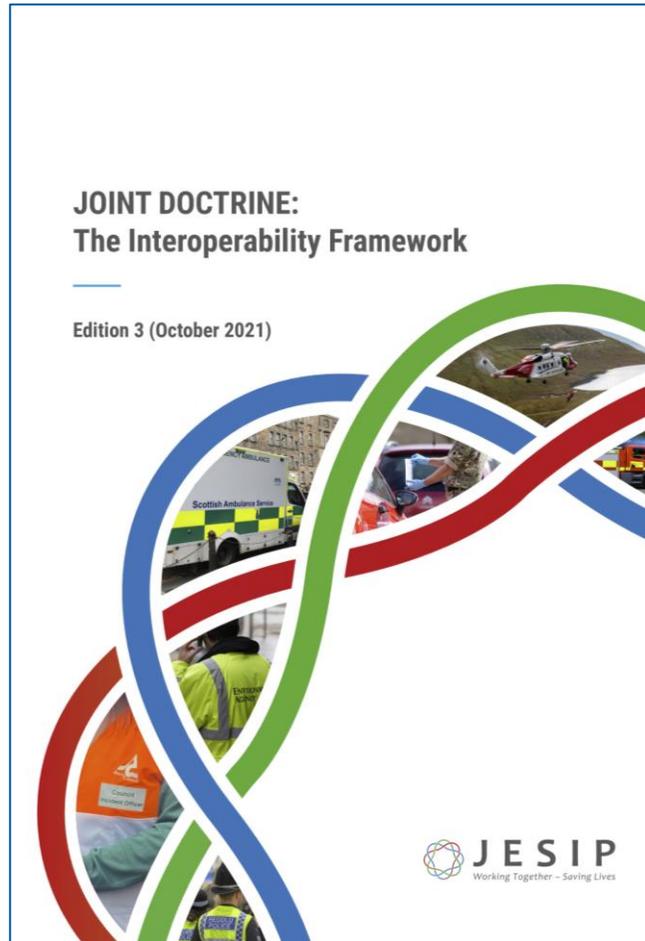
111 people required hospitalisation

91 categorised as being serious or very seriously injured



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All Hazards Approach: Resolving emergencies



JESIP Provides a framework of common models and principles, when applied consistently will help improve interoperability.

Integrated Emergency Management (IEM) is a structured, 'all hazards' approach to the management of any disruptive challenge, whatever its cause, nature or consequence.

People Centred Approach

To achieve our overarching aim of 'working together, saving lives, reducing harm', we need to continue to put people at the centre of the incident when considering resolution strategies.



Everything operates within a system

Joint Emergency Services Interoperability Principles (JESIP)

Co-locate, communicate, co-ordinate,
Jointly understand risk, shared situational awareness.

Civil Contingencies Act 2004

Assess risk, emergency plans, BCPs, share info warn/inform,
shared information with responders to enhance co-ordination and
efficiency, provide advice and assistance.

Integrated Emergency Management Principle (IEM) CCA (2004)

Assessment, prevent, preparation, response, recovery.



1st reflection: Systems thinking and acting

In complex & dynamic environments;

Linear thinking may be less useful;

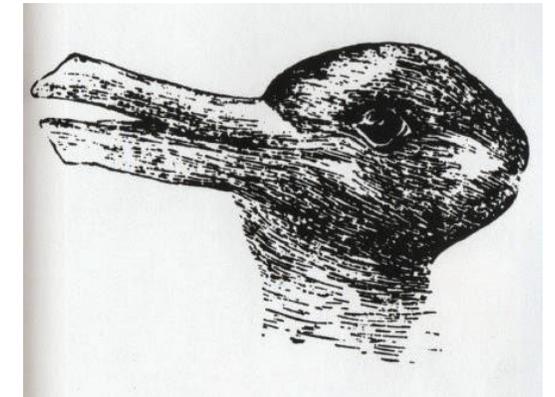
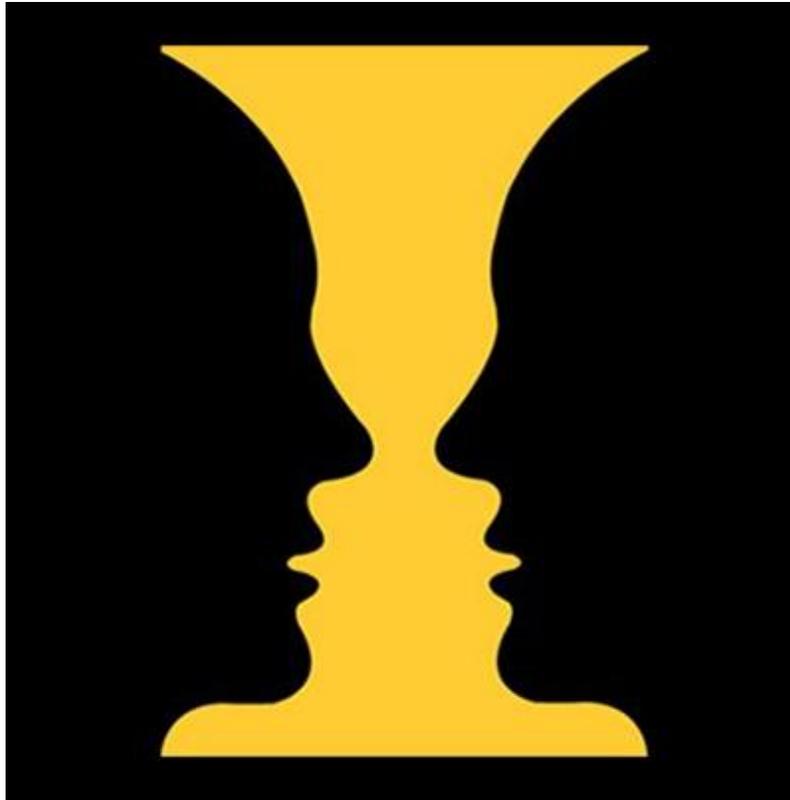
See the wider picture rather than just the individual parts;

Understand the often subtle interconnectedness of things;

Appreciate the impact of cause, effect and implications of actions and /or inactions.



Perception: Importance of communication & understanding



Just because we are presented with the same information
doesn't mean we see the same things all the time.
Focussing on just one or a limited number of things risks
missing the wider context



This is the big picture.

The problem is, if you are too close you sometimes don't see it clearly.

Sometime we all need to step back, look around and ask questions to see what's really happening and how it all links together.

Seeing the Big Picture (are we all seeing the same thing?)



The bit you saw.

When you are too close, you risk missing the wider context.

Key Reflection:

Everything occurs within a context and we might not all be seeing or thinking about the wider issues.

Maximising people safety requires a systems approach.



Principles of Joint Working: **2nd reflection**, sharing Learning

CO-LOCATE

Co-locate with other responders as soon as practicably possible at a single, safe and easily identified location.

COMMUNICATE

These are not a list to be followed from top to bottom necessarily, they should be used in any order that makes sense given the context.

SHARED SITUATIONAL AWARENESS

Establish shared situational awareness by using M/ETHANE and the Joint Decision Model.



JOL ONLINE

Joint Organisational Learning
Learning together for safer, stronger communities

We must learn together and from each other.

Capturing lessons learned from incidents, events, debriefs and Inquiries;

Accepted as the standard for multi agency learning opportunities;

BUT, unless the lessons are applied they are meaningless.



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Vol 2; R45: Joint Doctrine & Joint Operating Principles

‘...review and, as necessary, update the Joint Doctrine: Interoperability Framework...and Responding to a Marauding Terrorist Firearms Attack and Terrorist Siege:...’

- a) achieving a situation in which commanders **understand that the critical decisions of the commander most directly concerned** in the issue under consideration are followed, unless there is a good reason for not doing so;
- b) achieving a situation in which **risk appetite is common** across the three emergency services – this will require collaborative work;
- c) achieving a situation in which **forward deployment of specialist resources is the presumption**, to be displaced only in the presence of a properly evidenced basis for not deploying resources forward; and
- d) achieving a situation in which the **possibility of a secondary device does not delay forward deployment of resources**, unless there is a proper basis for believing that such a device exists.



3rd reflection and lessons being progressed

- Embeddedness of JESIP (what does embedded look and feel like?)
- Command training and the ability to implement an effective command structure quickly in response to a Major Incident and knowledge of Ops Plato;
- Joint training, exercising and assurance that JESIP is embedded;
- Annual JESIP awareness training & 3 yearly commander training;
- Casualty treatment, responder training and pre hospital care (ten second triage);
- Communication, understanding, awareness and refocus on a people centred response, limit any single agency focussed thinking.



Working together to make progress

You cannot demonstrate JESIP (interoperability) fully as a single agency, it requires all blue light services (and others) to work together on this.

JESIP Ministerial Oversight Board

Interoperability Board

National Police Chiefs Council

JESIP / MAI recommendations
Chief Superintendent Sally Phillips

MAI Portfolio Lead
ACC Vicki Evans

National Fire Chiefs Council

JESIP / Interoperability Lead
DCFO Peter Heath

MAI Oversight Group
CFO Chris Lowther

Association Ambulance Chief Execs

JESIP / MAI recommendations
ACO Keith Prior

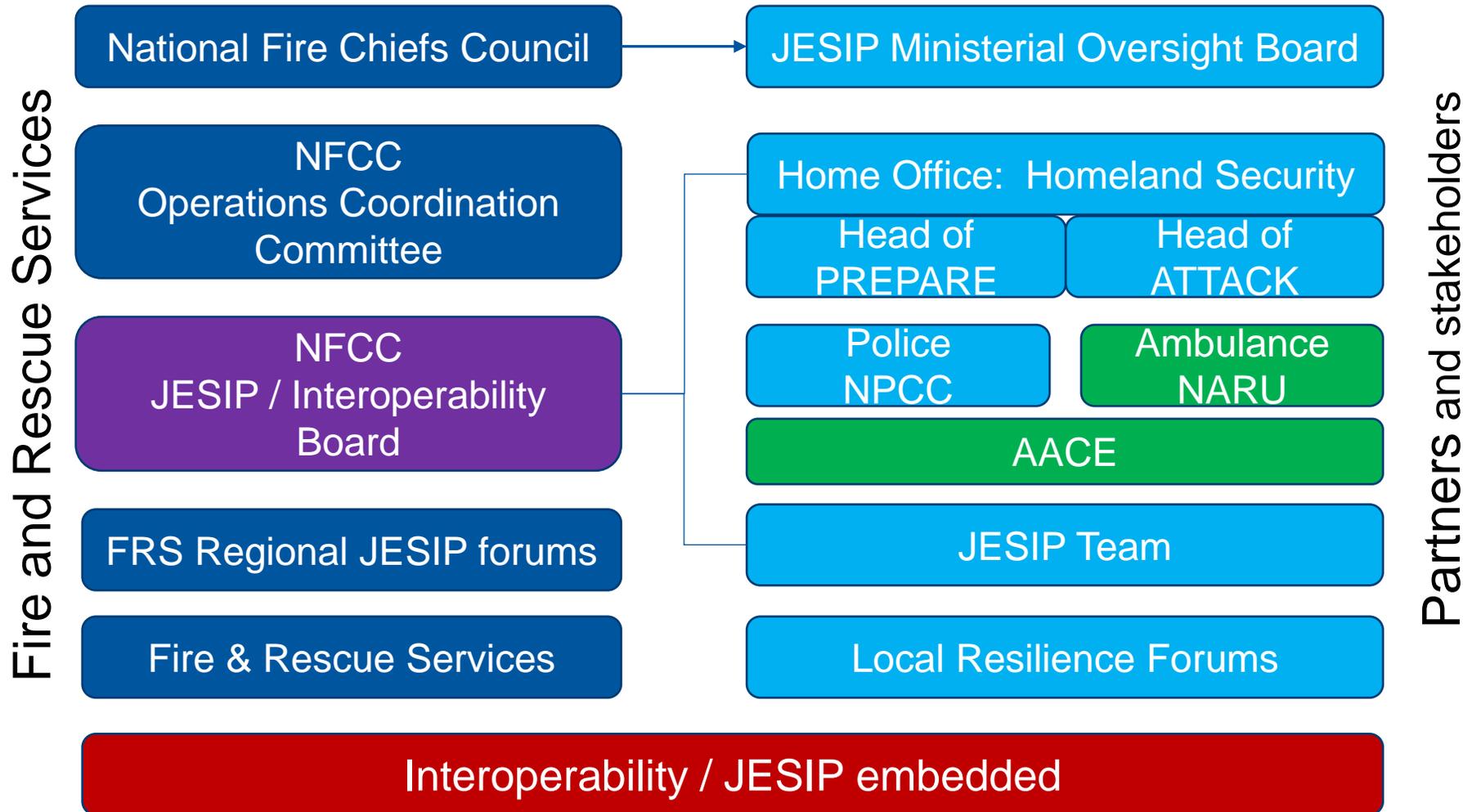
MAI Portfolio Lead
CEO Daren Mochrie

JESIP Team

Senior Responsible Officer Chief Constable Charlie Hall
Deputy Senior Responsible Officer Carl Daniels, West Mids Ambulance Service



Governance: An FRS model



Summary: Reflections on MAI through a JESIP lens

- There is effective multi agency / interoperability activity taking place but there remains gaps that can lead to serious consequences;
- No single agency on their own can make JESIP / interoperability as effective as it must be at the point of a major or serious incident;
- We have good aides, guides, processes and frameworks to support interoperability but these alone are not enough, its always about people and understanding;
- Understanding and sharing a clear definition of what embeddedness of JESIP / Interoperability means to us all should provide a basis for assurance across organisations;



Some final thoughts and reflections

Addressing the issues identified during the Manchester Arena Inquiry and improvement requires all agencies working together with a people centred approach.

JESIP / Interoperability may be the key enabler for this.

A system is never the sum of its parts its the product of their interaction.

Nothing ever exists entirely alone; everything is in relation to everything else.

Thank You

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