



## AUDIT COMMITTEE REPORT

<b>Report Title</b>	<b>Lessons Learned - Cliftonville House Power Failure</b>
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**AGENDA STATUS: PUBLIC**

<b>Meeting Date:</b>	22 <sup>nd</sup> March 2010
<b>Directorate:</b>	Finance and Support
<b>Accountable Cabinet Member(s):</b>	Cllr David Perkins and Cllr Brian Markham
<b>Ward(s)</b>	Not Applicable

### 1. Purpose

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- 1.1 To provide an overview of the circumstances surrounding the Cliftonville House Power Failure on 1<sup>st</sup> December 2009 and an outline of the lessons-learned from the event.

### 2. Recommendations

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- 2.1 To note the circumstances and lessons-learned from the Cliftonville House Power Failure.

### 3. Issues and Choices

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#### 3.1 Report Background

- 3.1.1 At the Audit Committee meeting on 11 January 2010, the Committee requested a report detailing the circumstances surrounding the Cliftonville House Power Failure that occurred on 1<sup>st</sup> December 2009, the report to include lessons-learned from the event.

#### 3.2 Issues

- 3.2.1 Detailed below is a brief summary of the circumstances that led to the power failure at Cliftonville House and subsequent evacuation.
- 3.2.2 Tuesday 1<sup>st</sup> December, 2009 Events at Cliftonville House:
- 3.2.3 At 7.15 am, the Caretaker on duty heard a “bang” and saw a small puff of smoke coming from the Sub station, which activated the fire alarm. The Caretaker attended the fire alarm panel and ascertained the source which was the sub station. The building was immediately fully evacuated. All entrances to and from the building were paroled to ensure the health and

safety of all staff. There was no supply of electric within the building (apart from emergency lighting). This left the building unsafe and unusable for working in.

- 3.2.4 The Fire Service arrived on site and attended the sub station with the assistance of the Caretaker. The Fire Service diagnosed an electrical fault and as a result electrical experts were called in. The alarm was silenced however it was still unsafe for staff to work in the building due to the lack of power as there was limited lighting, no heat and the emergency doors were inoperable.
- 3.2.5 The fire alarm activation immediately instigated the Facilities Management on-call procedure:
- Electricians were contacted
  - The Head of Service with responsibility for the emergency pager was contacted
  - Senior management were alerted and their advice sought
  - Time line following on-call procedure:
    - NBC Electricians on site 7.25am
    - Facilities team on site 7.30am
    - Central Networks on site 7.40am
- 3.2.6 Following discussions with the Fire Service, Facilities Management allowed staff to re-enter the building as there was no threat of fire although there was still no power (apart from emergency lighting).
- 3.2.7 Staff were instructed to collect any work they might require to work from home or an alternative location and to report to the Guildhall to await further instruction. The timescales offered by E-On indicated that the Cliftonville Offices would not be suitable for occupation for the remainder of the day due to the lack of power. Staff were offered transport to the Guildhall and upon arrival were given hot refreshments and met by members of Management Board.
- 3.2.8 Throughout the day, regular meetings were held between Management Board and Service Heads of the affected services to ascertain current information and issue directives accordingly.
- 3.2.9 Signage was clearly displayed on the outside entrances of Cliftonville House informing the public of the closure and the alternative methods of accessing services for that day
- At 3pm, a back-up generator arrived on site which had been provided by Central Networks, and at 5.00pm the Electric supply was connected.
  - Facilities staff remained on site at Cliftonville House until 8.00pm
  - ICT Staff remained on site at Cliftonville House until 8pm
  - Electricians remained on site at Cliftonville House until 8pm
  - Central Networks staff remained on site at Cliftonville House all day

- A decision was made to have a Security Guard on-site overnight, due to the fact that the intruder alarm was not operating, and to guard the generator.
- 3.2.10 The following day, Wednesday 2<sup>nd</sup> December 2009, Facilities Management were on site at 6.30am. They checked that all the electrics were working and that the building had been returned to the correct temperature for staff to work in. The electricians arrived on site at 7am.
- 3.2.11 An outline of why the incident happened:
- 3.2.12 Please see Appendix A and B, reports from Central Networks and the Fire Service.
- 3.2.13 Initially it was thought that the D/O box on the switchgear had faulted and was the cause. Subsequent investigation on site found that the initial problem was a cable joint on Cliftonville Road which had faulted, this then caused a flashover in the D/O box on the switchgear at the council offices and subsequent failure. A weakness had developed within the D/O box that was not evident under normal conditions but became a problem when abnormal fault current was passed through the cables and switchgear at the time of the fault.
- 3.2.14 The unit at the council offices was an oil filled ring main unit and has been replaced with a refurbished unit of similar function but a different design. The unit still uses oil as an insulation medium inside the switchgear but the D/O boxes are now a dry box, this means there is now no bitumen compound inside these boxes.
- 3.2.15 Attached to this report, Appendix C, is a summary of the lessons-learned from the incident. This unexpected disruption provided an excellent opportunity to test the resilience of our continuity arrangements both at a corporate and service level.
- 3.2.16 On the 10<sup>th</sup> and 15<sup>th</sup> December the Chief Executive held de-brief sessions to enable all lessons learned from the event to be captured and discussed. These meetings involved members of Management Board and officers from ICT, Communications, Facilities Management, Emergency Planning, Customer Services and Risk Management. The attached summary focuses on the lessons that were identified as part of these de-briefs. It should be noted that for those services heavily affected, de-briefs were also held at service level.
- 3.2.17 Requests for lessons-learned were made to all staff via the Chief Executive's Brief and via email to all Council Members on 11<sup>th</sup> December 2009.
- 3.2.18 Action owners and completion dates have been identified for each of the lessons identified, this will ensure the lessons are incorporated into the appropriate continuity plans.
- 3.2.19 Undertaking an assessment of the lessons learned for this event will strengthen the council's resilience and help to prevent similar situations occurring in the future.

### **3.3 Choices (Options)**

- 3.3.1 To suggest any additional areas to cover in future updates.

## **4. Implications (including financial implications)**

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### **4.1 Policy**

4.1.1 None.

### **4.2 Resources and Risk**

4.2.1 This report provides an overview of what caused the Cliftonville House Power failure and the lessons that can be learned from the incident, enabling the Council to improve its resilience to similar events in the future.

### **4.3 Legal**

4.3.1 There are no specific legal implications arising from this report.

### **4.4 Equality**

4.4.1 There are no specific equalities implications arising from this report.

### **4.5 Consultees (Internal and External)**

4.5.1 The Director of Finance and Support, the Head of Finance & Assets and the Head of ICT and Customer Services have been asked to comment on this report.

### **4.6 How the Proposals deliver Priority Outcomes**

4.6.1 Reduction in interruptions to service delivery.

4.6.2 Continuity of critical Council activities.

4.6.3 Enabling the Council to act proactively, avoiding reactive management wherever possible.

4.6.4 Protecting and enhancing the reputation of Northampton Borough Council.

### **4.7 Other Implications**

4.7.1 Not applicable

4.7.2

## **5. Background Papers**

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5.1 Appendix A – Fire Service Report

5.2 Appendix B – Central Networks Report

5.3 Appendix C – Lessons Learned Summary

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**and**  
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