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DE FRANCE

COVID-19 CRISIS

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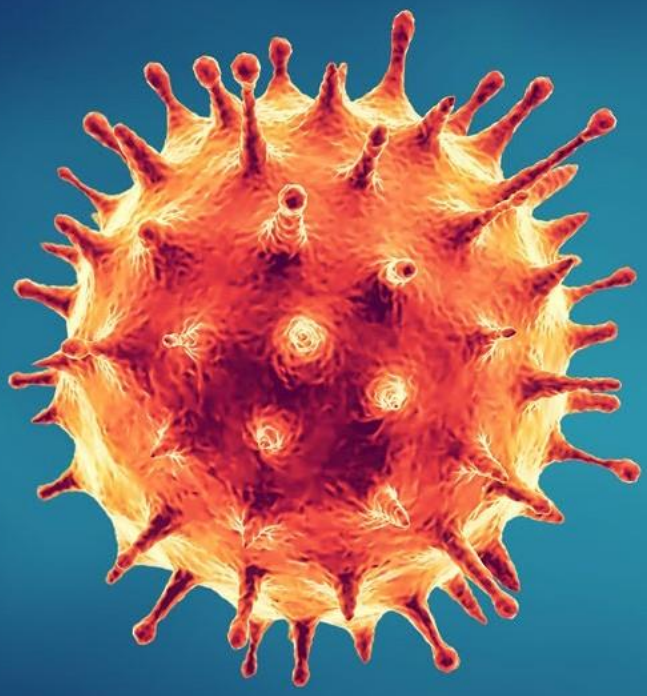
SYNTHESIS REPORT

by the French fire service on the management of the first phase



INTRODUCTION

The scale and intensity of the COVID-19 crisis has certainly put our emergency services system to the test, highlighting both strengths and weaknesses of our crisis management model.

It has acted as a magnifying glass by exacerbating the limitations – and indeed dysfunctions – of the current system that firefighters face on a daily basis. This report aims to analyse the management of the crisis and identify its shortcomings, highlight difficulties and inadequacies, and show how local adaptability has facilitated the success of territorial crisis management despite, in some places, the involvement of the fire service, which was against the wishes of the health authorities responsible for managing the crisis.

In its capacity as the representative body for some 250,000 emergency firefighters, the National Federation of French Firefighters (FNSPF) would like to highlight the role played by the fire and rescue services (SIS) in the operational response to this pandemic, with the aim of proposing any measures to improve these now recurrent events and the resilience of our country. The independent nature of the FNSPF means it has freedom of analysis and speech to assess the management of the crisis and evaluate its characteristics.

This reflection process was carried out following a broad consultation with the French fire service, which involved gathering information and experiences in order to capitalise on this data and draw conclusions. The general approach was to collect objective data from both the SIS and the FNSPF's internal bodies, including departmental and regional fire services, thematic and category-based committees, and working groups, before holding interviews with various institutional, associative and trade union players involved in the response to the crisis.

In creating this document, the FNSPF seeks to make recommendations to the managerial and governing bodies of the SIS, the civil protection supervisory authorities and the public authorities, in particular with regard to the establishment of a fully fledged concept for interministerial and interdepartmental crisis management.

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UNEXPECTED MANAGEMENT OF THE CRISIS AT NATIONAL LEVEL

A/ The question of concordance between policy and the regulatory framework

Generally speaking, it would appear that the texts and plans defining the organisation of national crisis management and the response to a pandemic were not applied during the first wave of the pandemic.

In accordance with the 2008 white paper on national defence and security, the Prime Minister entrusts, in principle, the operational management of a crisis to:

- the Minister of the Interior (MININT) when the crisis takes place on national territory
- the Minister for Foreign and European Affairs for external crises

The decision to entrust the management of the COVID-19 crisis to the Ministry for Solidarity and Health (MSS) stands in direct opposition to these provisions and goes against various other texts and guiding principles.

The Prime Minister's Circular no. 5567 SG of 2 January 2012 defines governmental organisation in the management of major crises. It stipulates that the MININT is responsible for anticipating and monitoring crises that may affect internal and civil protection, as well as for the operational management of crises in the territory of the Republic (Article L. 1142-2 of the Defence Code).

As part of its readiness to handle crisis management, it also has to ensure that government plans are transposed and implemented at a devolved level. According to the procedures set out in this circular, the minister responsible for health is responsible for 'organising and preparing the health system and the health resources needed to identify and prevent serious health threats, to protect the population against them, and to care for victims. They contribute to interministerial planning in the field of national defence and security with regard to its healthcare aspect' (Article L.1142-8 of the Defence Code). The 2011 national plan for prevention and control of the 'influenza pandemic', which resulted from the feedback collated after the 2009 H1N1 flu epidemic, reiterates this pre-emptive action attributed to the MININT and the prefects of the various zones and departments.[1]

Finally, the contingency planning resulting from Law no. 2004-811 of 13 August 2004 on the modernisation of civil protection entrusts the ORSEC[2] operational system with the permanent and sole responsibility for managing events that seriously affect the population. Specific provisions include the preparation of appropriate responses to health risks in the event of pandemics.

[1] National plan for prevention and control of the 'influenza pandemic' n° 850/SGDSN/PSE/PSN, October 2011. [2] Organisation of the civil protection response.

Even from a policy point of view, it is clear that the general approach is also far removed from the guiding principles. A major crisis is always, by its very nature, interministerial. If it is to be at all effective, a single director (or pilot), a single operations commander, and one or more technical advisers have to be involved in its management – just as they do for any relief intervention. However, these principles were not respected in the initial phase, which was characterised by a succession of decision-makers and crisis commanders. Furthermore, leadership of the crisis was entrusted to the technical adviser and agent (the health administration and ministry), even though there is nothing about its organisation and culture to suggest it could carry out this role effectively.

Crisis management is based on 3 main principles

- **A single point of leadership** (after taking into account all interministerial aspects).
- **Individual organisation within the territories:** in our country, this is traditionally provided by the prefects of zones and departments in charge of coordinating the state's territorial administrations, the response of local authorities, economic and social players, and so on.
- **The mobilisation of all forces that make territories resilient:** including elected local representatives, police forces, firefighters, health professionals, voluntary associations and social partners.

B/ The consequences of siloing national operations

The decision to differentiate health management from other necessities has led to not only the contravention of each of these principles, but also a level of organisation that is both atypical and variable over time. From 27 January to 17 March, the state's response was steered exclusively by the Directorate-General for Health (DGS). Subsequently, two parallel organisations coexist between the Ministries of Health and the Interior with two teams of staff and two chains of command, each with different expectations of cultural and territorial organisation.

In combination with the long line of crisis decision-makers[3] and whole host of future-planning and logistics cells in the ministries, this type of organisation has contributed to:

- Obscuring where strategic decisions are made
- Favouring 'silo' work by administrations rather than interministerial management. This situation has led in particular to limiting the ability of healthcare workers to access support measures (access to schools and crèches) and protection measures (masks, screening tests, etc.), as well as to the exclusion of firefighters, who are nevertheless working alongside them and also exposed to the virus.
- Complicating lines of communication and hindering the flow of information.

This situation is illustrated:

- On the one hand, by the late establishment on 17 March[4] of the Beauvau CIC[5], "a tool (on which the Prime Minister relies) for the political and strategic steering of government action in the field of major crisis management", where the Ministry of Health has also often been absent[6].
- On the other hand, by reducing the COGIC from this point onwards[7] to a monitoring and implementation role, although its involvement in the operational management of the crisis between January and 17 March would have been useful in order to take account of its multisectoral dimension.

The classification of this crisis as a health crisis, and the way it was managed by the MSS when it was also a systemic crisis on account of its intersectoral nature and its general impact on populations and society, highlighted two major shortcomings of the ministry in terms of crisis management.

First of all, this decision revealed the profound lack of interministerial culture within the Ministry of Health. Allowing a sectoral ministry to manage a cross-sectoral crisis resulted in a technical agent – however important this agent may be – to manage aspects of the crisis that were totally alien to their field of expertise, operational capacities, and institutional legitimacy. This has resulted in a lack of interministerial coordination, whether in the initial phase when each ministry mobilised its crisis cell and managed the consequences in its area of expertise, or after the mobilisation of the CIC, with the MSS regularly bypassing the unit and sending its updates directly to the Prime Minister and the President of the Republic.

Secondly, the management of the crisis by the MSS suffered greatly due to the lack of a future-planning culture within the ministry, as in the case of the destruction of the strategic stocks of masks built up after the H1N1 flu pandemic for reasons of budgetary control. This was in spite of several reports by the Inspectorate General of Administration (IGA) recommending logistical reinforcements in the face of pandemic risks, particularly with regard to FFP2 masks.

3 Prefect Salomon, then Prefect Thirion, Prefect Degos, Mr Castex, Mr Ribadeau-Dumas, and Prefect Robin.
4 The first 3 cases recorded in mainland France date back to 24 January, and stage 2 of the ORSAN REB plan – which aims to curb the spread of the virus within the country – was triggered on 29 February.
5 Interministerial crisis cell.
6 Prime Minister's Circular no. 5567 SG of 2 January 2012 on governmental organisation for major crisis management.
7 Operational Centre for Interministerial Crisis Management, DGSCGC, Ministry of the Interior.

This course of action by the MSS towards the fire service did not change during the crisis, as priority for wearing FFP2 masks was established for carers only. On the issue of masks, the ministry only seemed to be managing the shortage rather than the supply at every stage of the crisis. Generally speaking, those working in the field felt they had been given the raw end of the deal in terms of timescales – and even that was with some delay.

In line with the positioning of the Ministry of the Interior, the General Directorate for Civil Protection and Crisis Management (DGSCGC) seemed to be absent for the first few weeks, leaving the departmental fire and rescue services (SDIS) to respond without support or coordination.

Subsequently, as the MSS and its Operational Centre for the Reception and Regulation of Health and Social Emergencies (CORUSS) was not intended to manage interministerial crises nor equipped with the necessary tools, the decision was made to mobilise the Beauvau CIC, although it was unable to handle the information being fed back from the field. This duplication of the chain of command, which was precisely what the 2012 circular (more detail to follow) sought to avoid, has contributed to making the actions of our institutions both confusing and disjointed.

C/ Firefighters as an underused resource

Day in, day out, firefighters are the first on the scene for emergency rescue and care. They are the ones stepping in to help every 7 seconds, devoting 84% of their activity to providing emergency assistance (SUAP), which amounts to 4.13 million call-outs every year. This inevitably predisposed them to play a major role in this crisis with regard to the general population and the medicosocial system, particularly in retirement homes for the dependent elderly (EHPAD), which require assistance with tasks including screening, disinfecting and maintaining premises, bearing stretchers and distributing meals.

Nevertheless, the fire service was included to an insufficient extent – and sometimes even deliberately excluded – in the initial management of this healthcare crisis.

In this context, the fire service and its health and medical services (SSSM) have started to feel that the state does not afford them sufficient consideration or recognition. As a real symptom of these shortcomings, the first reflex of the central state in a situation of ‘sanitary warfare’ was to resort to the armies rather than to the expertise and resources of the fire services, perceived as more territorial players.

Firefighters have therefore not been included in the scope of national decisions concerning those considered to be ‘front-line’ players, particularly those involving access to priority childcare facilities, access to screening tests, and the recognition of COVID-19 contracted on duty as an occupational disease. The long silence on this last point, despite the recommendations of the National Academy of Medicine, remains particularly misunderstood and tainted with negative experiences.

The most serious shortcoming in this area, however, is undoubtedly the lack of personal protective equipment (PPE), the provision of which was centralised by the

MSS, while at the same time it was impossible for the SDIS to acquire it, forcing them to make urgent agreements between SDIS to exchange or pool existing stocks.

While the importance of the fire service's involvement in managing this crisis is gradually being recognised, it is becoming essential to ensure the necessary cooperation between healthcare and civil protection players in the management of health crises, and to guarantee equal treatment for fire services and healthcare personnel as pledged by the President of the Republic.

D/ Lack of coordination between crisis managers

The decision to entrust the Ministry of Health with the management of this crisis has meant giving a second-tier role to the players in the Ministry of the Interior, which is essentially responsible for the operational management of crises when they take place on national territory[8], and to the prefects of zones and departments, who are traditionally responsible for managing crises in the territories. This contradicts the national plan for prevention and control of the 'influenza pandemic' drawn up by the Secretariat-General for National Defence and Security (SGDSN).

More specifically, the prefects were not immediately placed at the heart of crisis management despite being the only players really able to open up operational dialogue with all stakeholders in the territories because of their role as architects of public action at local level.

During an influenza pandemic, however, the prefect's priority missions are:

- to maintain public order and security, distribute aid, offer civil protection, and perform judicial police missions
- to communicate with the public, provide information and open up dialogue
- to uphold the essential missions of the interministerial departmental directorates (DDI), either on their own or across departments, and prioritise the files needed to ensure:
  - continuity of services
  - care for the population, particularly those who are vulnerable
  - continuity of economic activities

Depending on the severity of the pandemic and the extent of its intersectoral consequences, the prefect decides in principle on the mobilisation of a monitoring cell together with the regional health authorities (ARS) or the departmental operational centre (COD), with representatives of the following present:

- the prefectural services (SIDPC[9], communication)
- the ARS
- the gendarmerie and the DDSP
- the SDIS

Decree no. 2010-224 of 4 March 2010 on the powers of zone prefects of defence and security specifies the responsibilities of each of these and structures the powers of the zone prefect. It contains important points that have not been applied for 10 years – notably the reinforcement of the interministerial defence and security zone headquarters (EMIZDS) by executives from the various ministries. Despite the circular issued by Xavier Bertrand, then Minister of Health, requesting the provision of a staff member from this ministry to the EMIZDS, no EMIZDS has benefited from this provision to date.

However, during the first phase of this crisis, the prefects of zones and departments were not systematically granted the place that should have been theirs.

In some territories, the prefects have taken over, but this is not the case across the board, leading the fire service to take on the epidemic wave with all the more force.

In a department particularly affected by the epidemic, it appears that the SDIS remained deprived of information throughout the crisis, its main source of intelligence turning out to be the Crisorsec digital application throughout the event.

Feedback from civil protection agents in the field reveals profound differences in the relationship between the SDIS and prefects or regional health agencies (ARS).

While in one department, we were surprised by the lack of interaction and cooperation with the ARS (one collective contact per week at the insistent request of the region's 8 SDIS), feedback from another states multiple and daily examples of trusting relationships with the ARS, the hospital centres and the urgent medical aid services (SAMU).

These differences from one department to another are undoubtedly a symptom of a lack of strategy and collective organisation at national level.

The members of the federal commission of departmental directors of fire and rescue services (DDSIS) and senior management thus indicate that prefects and the ARS do not share information as they should.

[8] Prime Minister's Circular no. 5567 SG of 2 January 2012 on governmental organisation for major crisis management.
[9] Interministerial service for defence and civil protection.

E/ Lack of communication at national level

A major grievance was raised by the SDIS and the departmental firefighters' unions regarding the lack of communication at the beginning of the crisis, which made it difficult to start managing the situation since information was shared only sparingly and open to interpretation by elected officials and directors. There is clear evidence that crisis management would have benefited from a single, more effective means of communication at national level to convey a common policy from national to local level[10].

With regard to acknowledging the role played by the fire service, the communication from the President of the Republic reflects the belated recognition of their role, since firefighters were not mentioned as front-line players from the outset. Similarly, their total omission in the Mulhouse speech on 25 March came as an unwelcome surprise to all fire services across France. This came at a time when the fire services, particularly those of the Haut-Rhin, were already largely mobilised in the territories feeling the strain and were preparing in the other departments for the arrival of the epidemic wave. It was perceived as a distinct lack of recognition, although it was fortunately corrected in the address to the French public on 13 April.

This shortcoming is symptomatic of the failure of the national political and administrative authorities to acknowledge the fire services among the real players in the management of this crisis from the outset. As a real manifestation of this isolation of the fire service, even in normal situations, the DDSIS do not have access to the Ministry of the Interior's collaborative bidding website (OCMI), despite this being available to any prefecture staff.

[10] Volunteer firefighters' committee, 29 April 2020

02

MISSION IMPOSSIBLE FOR THE DIRECTORATE-GENERAL FOR CIVIL PROTECTION AND CRISIS MANAGEMENT

A/ A DGSCGC largely sidelined from crisis management

The DGSCGC was largely absent from the management of the first phase of this crisis, except for 5 or 6 officers in the CIC, most of whom were assigned low-grade secretarial duties.

A party involved in the management of this crisis said they had noted a day during which, out of 76 people in the CIC, there were 5 firefighters to 12 gendarmes, despite the fact that the civil protection dimension of the crisis prevailed over its public order dimension.

In particular, the management of the crisis by the director of the fire service due to the DGSCGC's inability to attend for health reasons was the subject of strong and unanimous criticism:

- **Delay in taking into account the warnings** from the DDSIS of the Grand Est on the seriousness of the crisis until the epidemic had arrived in Île-de-France
- **Lack of national directives on the personal protective equipment policy**
- **Pressure on the DDSIS in territories feeling the strain** to lower the level of protection of their staff and bring it in line with that of healthcare workers in the face of a shortage situation
- **Absence of DGSCGC fire officers (then working remotely) alongside police cadets and students from the *École de guerre* in the management of the CIC.**

In addition to defining a national crisis-management policy, the DGSCGC should have anticipated the Ministry of the Interior's orders for the SDIS by being a driving force in the discussions on feasible missions and their limitations, the means to be acquired if necessary, and operational anticipation.

The DGSCGC was initially created in 2011 with the aim of preparing our country for the management of crises of all kinds and ensuring the implementation of necessary measures, supported by a continuum between crisis planning and action as well as the ongoing monitoring carried out by the COGIC and CIC (if mobilised). With this in mind, **it is now more relevant than ever to grant the DGSCGC the resources and the organisation to fulfil the very objectives for which it was conceived**.

In particular, a unanimous observation is emerging to deplore the **absence of the DGSCGC's health division** among the SDISs and their SSSMs in the management of this crisis.

The exclusive control of the MSS over all health issues has generated very little demand and extensive disengagement from the DGSCGC's health division, which is beyond belief.

In addition to the health advisory role of the Director General, he should still be a coordinating link in terms of his ability to lead the SSSM network, stimulate dialogue, compile good practices and produce an operational and active health policy. This would all be in conjunction with the DGSCGC offices concerned and would serve as a national guideline.

B/ COGIC reduced to an information monitoring and management centre

For its part, the operational centre for interministerial crisis management – or COGIC – is the armed wing of the DGSCGC. As a real tool for coordinating the interministerial defence and security zone headquarters (EMIZDS) and the operational centres of the other ministries, it demonstrated a high level of resilience during the first two months of the crisis.

As it turns out, however, **the COGIC was later reduced to a monitoring and information management centre**. **COGIC was also notably removed from operational management of the crisis**, which was nonetheless multisectoral, and reduced to implementing actions as soon as stage three of the 'influenza pandemic' plan was reached on 17 March – the date on which operational management was transferred to the CIC. This political decision has had several major consequences:

- A lack of the appropriate level of exploitation of the information provided by COGIC
- A lack of an informed operational opinion for the DGSCGC authorities
- An increase in the number of crisis management advisers
- Subpar crisis management despite a high level of civil protection response
- A frequent absence of an appropriate response to the needs identified by the heads of the EMIZDS (dengue and COVID-19 epidemics in Reunion Island, and tension over the supply of masks in the Oise region).

As a result, it was not possible to implement the necessary interministerial management of the crisis and each ministry armed itself on an autonomous basis.

C/ SDIS left to their own devices

Whereas in Italy, civil protection was simultaneously entrusted with crisis management and communication, the DGSCGC was not in a position to communicate with the general public. Also, and above all, it did not represent a strong enough presence for the SDISs, who were largely left to their own devices.

The fire service should have been seen as a force capable of anticipating and acting in the face of the health crisis.

It is also worth considering why the decision was made not to make use of the four operational and logistical support establishments (ESOL), whose logistical support constitutes the distribution of masks to those out in the field who are actively fighting the epidemic.

Firefighters have taken exception to the fact that they were not given the benefit of screening tests. The professional activity of some volunteer firefighters was also impacted by their participation in the fight against COVID-19.

03

SUCCESSFUL TERRITORIAL MANAGEMENT THANKS TO THE ADAPTABILITY OF LOCAL PLAYERS

A/ Local crisis management hindered by regional health authorities ignoring the fire service

The initial pre-eminence given to the general directors of the regional health authorities over the prefects of the departments has, in too many territories, led health agencies to claim to be managing this crisis alone during the first phase of the epidemic.

However, the administrative structures of the health service appeared to be complex and rigid.

Their verticality has led to the marginalisation of liberal medicine in relation to hospitals.

The territorial delegates of the regional health agencies (ARS) have all too often seemed to lack any decision-making capacity in an emergency.

The ARSs have only been able to do what they were designed for, which is to handle the management and administration of healthcare systems.

Totally unprepared to manage emergency situations, they seemed to be overrun with managing the number of places in hospital intensive care units, the requests for statistical feedback from *Santé Publique France*, and health data, which had to be shared (with prefects, elected representatives and the like) to coordinate the parties involved on a territorial basis.

Consequently, the ARSs have instructed their territorial delegates and hospital directors to put an end to all communication with departmental prefects, depriving the latter of the information needed to coordinate emergency operations (in retirement homes, for example).

For too long, they have forgotten about these retirement homes, leaving local authorities to deal with the large number of deaths among our elderly population[11] alone.

They have demonstrated that they were wholly unprepared to manage a crisis of this magnitude and lacking in the necessary culture to handle its operational management.

[11] In this context, see also *Sud-Ouest*, 30 May 2020 edition for the outburst by Dominique Bussereau, President of the *conseil departmental* of Charente-Maritime and the *Assemblée des departments de France*, after finding out through the press of the death of 16 retirement home residents in Tonnay-Charente, an establishment for which he was politically responsible!

B/ The adverse effects of administrative crisis management

First and foremost, **there has not been sufficient foresight at national or regional level**, particularly in terms of logistics (masks, gowns, hats, shoe covers, etc.). This lack of foresight has entailed the risk of capacity disruptions for the fire services, despite them being on the front line, although their close ties with local authorities and economic players in their territories have fortunately made this possible to overcome.

Secondly, the quest for autonomy of health agencies, convinced that they were capable of handling a crisis considered to be exclusively health-related on their own, led them to **avoid recourse to the fire service** as much as possible.

An example of this involves the refusal of an urgent medical aid service (SAMU), covered by its regional health agency, to recognise the skills of firefighter doctors. This resulted in the use of military medical helicopters rather than SDIS helicopters to relocate patients, leaving the helicopter belonging to the local SDIS for civil protection, armed by the health and medical services (SSSM), to ensure patient transfers to another region in an absurd paradox.

Generally speaking, monitoring the number of call-outs at the request of the SAMU for the four departments in the greater Paris region shows that the fire service was very much in demand at the start of the crisis from the beginning of March. This was to compensate for the disorganisation in the health sector, although it was gradually sidelined from mid-March onwards when the ARS began to call on approved civil protection associations (AASC). This highlights that the fire services were positioned on the front line at the start of the crisis before being replaced by voluntary workers from associations who were less well protected and less prepared. This proved detrimental to the unity of command of the civil protection players and their resources under the operational direction of the prefects.

Unfortunately, this movement has been largely favoured by the lack of consideration of AASCs by the fire and rescue services (SIS) in the response to the current risk.

This pre-eminence given to the ARSs has also led to a **desire to take hold of civil protection resources**, with attempts to achieve outcomes by enticing individual health professionals from the SSSM in the form of appeals to join the medical reserves rather than inviting them to join the SIS. The same phenomenon had already been observed in 2013 with the individual solicitation of firefighter doctors to become consulting physicians for urgent medical aid services.

Moreover, this prevalence of ARSs has discouraged exchanges with the SDISs and the inter-service sharing of work on preventative measures for their crisis cells, particularly with regard to potential capacity disruptions for the actors and/or resources involved.

Similarly, the lack of systematic mobilisation of the departmental operational centres (CODs) has been detrimental to interdepartmental coordination and work.

The relationship between ARSs and prefects at territorial level has not been the same in all regions. It has depended very much – too much, in fact! – on the people involved, particularly the territorial delegate of the ARS (DT ARS) and the pre-existing relationships between local players.

In departments where the relationship between the ARS and the prefects can be described as an *entente cordiale*, the SDISs were relatively free to manoeuvre as long as the ARS and the prefecture shared information.

In other departments, however, the prefect was notoriously kept away from discussions by the ARS.

Deprived of data on the foreseeable evolution of the situation, the prefect and the services placed under their operational direction therefore did not have the necessary tools to determine what approach to take in certain scenarios, such as the mobilisation of admissions structures upstream or downstream of hospital centres, opening of mortuary facilities, introduction of specific actions in retirement homes, and organisation of support for the population and non-hospital-based front-line staff (including private nurses and home helps).

As a result, the senatorial delegation to local authorities published an initial critical assessment of the coordination between local authorities and ARSs on 2 June 2020. This was subsequently shared by the national associations of elected representatives (AMF, ADF, *Régions de France*). Its president, Senator Jean-Marie Bockel, criticises the ARSs for being "too distant from the territories" and "ill-adapted to handle crisis situations" insofar as they do not involve local players in crisis management to a sufficient extent.

Generally speaking, and as has been successfully demonstrated by the subsequent management of the 'unlockdown', in which they were pivotal alongside the mayors, **the territorial management of this crisis would have benefited greatly from having a single steering committee from the outset comprising the prefects of the departments – the only authorities capable, together with the elected representatives, of ensuring the coordination of the players in the field, potentially with the support of the ARSs**.

C/ Health and medical emergency services – the cornerstone of the operational structure

As an essential tool for anticipating the spread of disease in this health crisis, the health and medical services (SSSMs) comprise some 12,230 members. Among them are various professionals and volunteers from the health sector (such as doctors, pharmacists, nurses, healthcare executives, psychologists and veterinarians) who combine their skills and are integrated into the world of the fire service. Their expertise benefits both the policies of the SIS and their authorities, with the aim of offering high-quality emergency support while also contributing to the protection and care of responders.

In the COVID-19 crisis, the SIS SSSMs ensured the continuity of supply management (such as personal protective equipment and oxygen) and provided integrated expertise enabling balanced exchanges with the various health organisations (ARS, SAMU, etc.).

This was particularly the case when it was necessary to take a stand on the choice of wearing FFP2 masks to guarantee the protection of operational personnel despite national recommendations. The SSSMs have played a leading role in the various actions described in the rest of this report, which have enabled the SISs to reconcile the continuity and adaptability of their missions.

At a time when 84% of their activity concerns emergency assistance transport (SUAP), the SISs must have integrated, multidisciplinary health expertise. This health expertise guarantees that the SISs have the capacity to control and manage the emergency support mission for people. It also provides relevant advice and critical analysis through an acculturated healthcare component.

Similarly, faced with a health crisis with a high human resource impact, the SISs, thanks to their SSSM, are able to monitor and analyse various medical data in a complex environment, enabling them to look ahead rather than suffer the consequences.

D/ Lack of personal protective equipment

In view of the difficulties raised by the SDIS in ensuring their own resilience and not risking contaminating the people rescued, **the question of the supply of personal protective equipment (PPE) is indicative of the segregation of the SDISs and their ability to adapt**.

It now appears that pre-existing stocks were not prepared to withstand such a crisis.

At the beginning of the crisis, the SDISs did not have an even distribution of PPE: while some had two weeks' worth of capacity without replenishment, existing stocks of masks meant it was possible to last a month in other

departments. Most of the SDISs have therefore had to rely on various donations that have made it possible to bridge the gap between two deliveries, for example.

The majority of supplies to French retailers come from Asia, a continent that had already been affected by the health crisis for more than two months when the epidemic first appeared in France. As a result, these supply channels quickly dried up in the face of increased demand from all those involved in the crisis.

From the very beginning of these supply tensions, **in-house pharmacies (PUIs)** have been studying day in, day out to establish all the possible ways of supplying the necessary health products in order to avoid any disruption, relying on the networks of current market partners, industrialists in the territories (often prioritised), SDISs and hospital pharmacists, or even new national and international suppliers.

That said, the SDISs had to face the problem of their orders being requisitioned by the state, which is covered in more detail below.

This meant they quickly turned to donors to make up for their PPE shortfall.

In addition to accepting spontaneous donations from companies in their department, the SDISs were proactive and decided to contact all entities likely to help them out, including schools, companies, shopping centres and various brands. This required thorough and meticulous research work, which finally bore fruit as several bodies responded to these calls for donations.

Aside from the supply of PPE, which could have been coordinated earlier at central level for SDISs, **instructions on the harmonisation of usage rules were expected** from the DGSCGC. The contradictory information between the concepts familiar to those involved and the recommendations of the health service, as well as the different responses put in place by the SDISs according to the extent of their stocks and the relative intensity of the crisis,

have created legitimate concerns among those involved and tensions in the field between health workers and the fire service.

Throughout the crisis, the inter-SDIS solidarity card – through pharmacists – has been essential in supplying masks to departments feeling the strain.

The SDIS in Oise, for example, received a donation of 5,000 tie-on surgical masks from SDIS 77 (donation of 3,000 masks) and SDIS 91 (2,000 masks) at the beginning of the crisis. SDIS 80 also organised the weekly ARS distribution platform starting on 26 March, which saw it share out 99,050 surgical masks and 2,500 FFP2 masks, which were received in Oise on 8 June. Thanks to this inter-SDIS solidarity, SDIS 60 was also able to play its part and on 20 March it offered 1,000 FFP2 masks and 3,000 surgical masks to SDISs 80, 62 and 02, and 500 FFP2 masks to the SDISs of the Bas-Rhin and Haut-Rhin regions along with surgical masks.

Difficulties were also encountered in supplying SDISs with oxygen and hydroalcoholic gel. Again, they had to be adaptable and rely on their relationships with local suppliers to source their own supplies.

E/ Measures for operational continuity and staff monitoring

As soon as the crisis began, the SDISs had to organise themselves to ensure the continuity of their public service in healthy sanitary conditions for their staff. As such, a number of human and organisational measures have been implemented. These can be found in Appendix 1.

By adapting the working schedules of the professionals and taking advantage of the high availability of volunteers, the fire service was able to bring the response potential up to the level of the operational demands. They faced the sharp increase (30% in March in Haut-Rhin) in the number of emergency call-outs for people linked to COVID-19, and demonstrated their high level of technical expertise for the benefit of the population.

All of the individual protection measures put in place by the SDISs have proved effective. To date, there is no evidence to suggest that the fire service is overly exposed to COVID-19, and the rate of penetration of the virus among firefighters – despite varying according to the area and their degree of exposure to the crisis[12] – is comparable to and does not exceed that of the population of the department concerned.

According to the Operational Centre for Interministerial Crisis Management (COGIC), 1,826 firefighters had tested positive for the virus as of 28 August, none of which were considered serious cases related to the service.

[12] 5% for SDIS 60, 15% for SDIS 68, figures to be interpreted with caution given the number of asymptomatic cases.

In order to protect their workforce, the SDISs have implemented various mechanisms in which the health and medical services (SSSMs) have played a major role.

In Haut-Rhin, the DDSIS emphasises the effectiveness of these measures, which have made it possible to protect SDIS staff despite the virulence of the virus within the department. While they intervened in a third of emergency assistance transport (SUAP) missions with suspected COVID-19 cases, no serious cases were reported among the staff.

F/ Technical innovations and administrative adaptation

Co-developed by the SDIS in Allier, an association and a start-up, a dedicated COVID-19 staff monitoring solution was born. Launched by SDIS 03, it was subsequently set up by their counterparts in the Yvelines, Seine-et-Marne and South Corsica

Thanks to this software based on artificial intelligence, each staff member was able to provide information on their own state of health on a daily basis, allowing the SSSM to have a precise and up-to-date view of which staff members were sick over the course of the day. As of 29 April, 1,316 staff members in the Yvelines were being monitored thanks to this application, 37 of whom were found to be positive.

This innovation has enabled these SDISs to not only acquire and keep a very precise and up-to-date picture of their staff members' health, but also maintain social links and optimise the medical time for following up with them. More than 7,000 staff members were monitored over the entire period.

With regard to the criteria for suspending suspected staff members or keeping them in employment, the SSSM for Yonne has appointed a professional doctor in charge of preventative medicine within the SDIS. Their role is to monitor each staff member suspected of coming into contact with COVID-19 and provide their medical expertise on the procedure to follow (isolation, shielding measures, etc.), in addition to determining whether or not they should remain in active service. Several administrative situations have made it possible to define whether or not the staff member should remain within the structure and – more specifically – the subjects at risk who were immediately (on medical advice) invited to stay at home.

In the most affected departments such as Haut-Rhin, the SDIS was led to ask its staff with a high risk of coming into contact with the virus to wear masks when dealing with the epidemic.

Screening tests, which were carried out almost systematically at the beginning of the crisis, later became difficult to obtain, which led to uncertainty and questions for the fire service. In the Val d'Oise, the SSSM was able to offer systematic PCR tests to its staff members from 23 March.

G/ Medical care for staff members

As it requested on 27 March from the Minister for Solidarity and Health, the FNSPF **appeals to the Government** to comply with the opinion of the National Academy of Medicine and to allow, as was already the case for the nursing staff with whom they work on a daily basis, **all active SARS- CoV-2 sufferers to be declared to have a 'service-related illness'. It is imperative to introduce special compensation as an occupational disease for firefighters who become infected on duty in order to avoid cumbersome and random protocols**.

The SSSMs are at the disposal of the SISs to provide support for staff, whether somatic or psychological. Health support for staff has been implemented in several ways. In Bas-Rhin, as soon as the first contact case was recorded by a professional firefighter, the SDIS set up a partnership scheme for professional fire officers and SSSM doctors.

The availability of psychological support for staff has been heavily publicised for SIS personnel. In Ain, a similar offering for the fire service has been developed by the SSSM, including two videos of the head physician explaining the epidemic and the necessary measures that have been taken. Instructions were also disseminated through posters and mailshots to volunteer and professional firefighters, as well as to administrative, technical and specialised personnel. In addition, audio-conferences were set up between the head physician and the on-call staff to answer queries, and a COVID-19 FAQ document was regularly updated. Finally, regular (weekly) status updates were organised with the trade unions and the departmental advisory committee of volunteer firefighters (CCDSPV). In addition to this effective communication, psychological support was offered to staff members, although this was not requested except at the alert processing centre (CTA) where a psychologist was involved.

In order to offer their staff effective and responsive psychological support, systems have been put in place by the SISs.

The Val d'Oise departmental fire service union has thus organised a solidarity system in which psychologist volunteer firefighters have been brought in to help the staff with stress management.

In a rescue centre in the Yonne, in addition to telephone contacts with psychologists, firefighters were able to benefit from a collective psychological support service while respecting social-distancing measures.

In the Val d'Oise, the psychology service consisted of a full-time administrative, technical and specialised staff member (PATS) and a volunteer firefighter, and it operated through the mediums of email and posters, but mainly via telephone and videoconferencing. Taking all sessions together, the psychologists came into contact with more than 350 members of staff (more than 300 firefighters, 50 PATS), which represents around 400 hours of interviews for 15% of the total staff. From the very beginning of the epidemic, psychologists joined the cell for monitoring sick or vulnerable workers, which

allowed them to immediately understand the psychological difficulties encountered by most of the workers. The main issues covered were trauma, exhaustion and depression.

The work carried out by psychologists has also focused on systematic support for all heads and deputies of fire and rescue centres (CIS) and services in order to anticipate problems related to self-isolation and/or working remotely, and to support any grief and trauma-related issues. This is made it possible to forge links between the services. The psychologists were also present at CTAs and CODISs with more than 30 informal interviews conducted. In addition, this presence at CODISs and the exchanges with the CODIS officer made it possible to propose five immediate actions of a post-operational psychological debriefing nature with the teams in the field.

In Oise, a cell has been set up to monitor the number of staff impacted by COVID-19. It brought together three types of staff (doctors, HR and the committee for health, safety and working conditions (CHSCT)) and facilitated the management of quarantining, social distancing and follow-ups with sick firefighters, with phone calls made by the doctors. In addition, and using a common monitoring tool, the in-house pharmacy (PUI) has made surgical masks available for symptomatic members of staff.

H/ Shortcomings in monitoring

A number of difficulties were raised:

- The lack of feedback from centre 15 or the ARS concerning the infected people evacuated by the SDIS made it impossible to cross-reference whether an infected firefighter had been involved in a call-out.
- It was difficult for the ARS to implement work stoppages among the SDIS staff.
- The lack of information on the access conditions surrounding the various government provisions generated a period of uncertainty lasting several weeks that raised fears of a significant financial impact for the SDIS and staff. The children of firefighters were belatedly granted the same rights as those of carers.

04

OPERATIONAL COMMITMENT AND SUPPORT FROM OTHER PARTIES

A/ SIS/SAMU coordination and support for CRRA-15

Feedback on the coordination between the SISs and the SAMUs differs according to the local situation and, more specifically, whether or not there is a common platform for receiving calls. As a result, **in the departments concerned, the common platform has made communication easier and absorbed peak call times** by allowing all emergency staff members to work together.

In the early stages of this crisis, the CRRA-15 call reception and control centres faced a real explosion in the number of calls they received, which impacted their response times significantly – particularly in the most affected departments.

The saturation of a CRRA-15 can have a twofold impact: the lack of a medical response for callers, causing de facto forwarding of calls to 18-112, and the lack of incoming assessments regarding emergency assistance for individuals.

The observed delays in accessing the CRRA-15s have increased significantly, particularly in the most affected departments and during the peak period. In one of the departments most affected by the health crisis, the average call waiting time of the CRRA-15, which was just over 1 minute before the COVID-19 outbreak, rose to 10 minutes 25 in March 2020, with 36% of calls answered in more than 5 minutes. The immediate consequence of this delay was that the SDIS found it difficult to answer 18-112 calls due to the sheer volume of emergency call handling operators (OTAU) at the CODIS waiting for the CRRA-15 to pick up so that they could transfer callers who, in most cases, had already hung up several minutes ago. In another severely affected department, up to 18 minutes of waiting time were recorded to transfer a report or a call to the CRRA-15.

> At the Paris SAMU on 13 March 2020, only 6% of calls were answered within a minute, and the maximum wait on 15 March was 12 minutes 40 seconds. Even as early as 25 February 2020, in a university hospital outside Île-de-France, 40% of calls to the emergency services were answered in over 2 minutes.

To compare this with Austria, for example, the longest waiting time for calls at the height of the crisis was 3 minutes 26 seconds on the non-urgent call line, with no waiting time observed on the urgent call line[13]!

Unlike its counterparts, France did not think ahead or learn lessons from previous health crises. All countries that set up

[13] Source: The European Emergency Number Association (EENA 112).

a non-emergency call number[14] that is distinct from the main emergency number indicate that this was very useful during the pandemic.

With this in mind, there can be no valid support for the argument of the unpredictability of the COVID-19 crisis.

Beyond the difficulty of transferring a caller to the CRRA-15, **the heads of equipment in the departments most affected found themselves in a situation of deadlock in the field with no response from the CRRA-15 to communicate an assessment of the situation**.

This communication, prescribed by the SIS-SAMU common reference system for the organisation of personal assistance and urgent medical aid, annexed to the decree of 24 April 2009 (simplified assessment – no medical contact), is a major obstacle to the ability of the SIS to deal with an ever-increasing number of victims, as resources are held up for quite some time while waiting the CRRA-15 can respond.

B/ Changes to procedures

In order to overcome the difficulties encountered by the CODIS and the heads of equipment in communicating the assessments to the emergency services, the fire services have had to demonstrate their adaptability from the moment this crisis began.

Faced with very long response times from the CRRA-15 for assessments from victim emergency support vehicles (VSAVs), and in order to free up the SIS operational resources more quickly, the fire service regularly intervened to compensate for the unavailability of the CRRA-15 in the most affected departments.

The health officers in the CODISs have proved to be very effective. They took charge of the VSAV assessment and decided whether or not to transport the victim in the event of a lack of response from the CRRA-15s.

To cope with the increase in calls, some SISs have reinforced their teams, particularly at weekends and on public holidays, and have mobilised their on-call staff as much as necessary.

Finally, when faced with call situations for COVID-19 that required special analysis, the SDIS favoured classifying the call into 4 categories (reference to the 10-digit info number for COVID-19, classification N1, classification N2, and DR commitment). This classification allowed the SAMU to benefit from triaged COVID-19 emergencies. To complete the system, an emergency call handling operator (OTAU) was stationed at the CRRA-15 to reclassify calls or engage the firefighters directly if necessary[15].

Similar measures have been taken in all other departments where the time taken for the SAMU to pick up has increased considerably.

Faced with this saturation of the emergency services observed in the first weeks of the crisis, many SISs set up **medical and paramedical coordination within departmental fire and rescue operational centres (CODIS)**, which made it possible:

- on the one hand, to provide support for the 18-112 operators with processing alerts
- on the other hand, to handle the assessments of victim emergency support vehicles (VSAVs) independently

Faced with this major problem, the refusal by the Director of the Prime Minister's Cabinet during the crisis[16] to transfer incoming 112 calls to the SIS in the 14 departments where they are received by the CRRAs[15] for technical reasons linked to the crisis will have to be reconsidered once the crisis is over.

C/ Multifaceted support for hospitals

Whenever possible, the SISs have also supported hospitals by providing medical equipment – including ventilators normally used by their health and medical services (SSSM). One SDIS even launched a campaign to collect ventilators from veterinarians within its department for the benefit of hospitals.

The SISs have also done what they can to ease the workload of hospitals in a number of other ways. For example, the fire service has regularly had to equip COVID-19 airlocks in order to facilitate the reception of victims at the hospital.

This support has taken many other forms, including the provision of secondary inter-hospital medical transport, the medicalisation of civil protection helicopters, health transport to combat the lack of private ambulances, and the implementation of screening centres.

Faced with a possible massive influx of patients leading to a breakdown in the care of victims, an SIS has set up a working group in collaboration with the town hall, the civil protection investigation and intervention unit (UIISC) and the hospital centre. In this context, a multidisciplinary team worked on a project to create a centre for regrouping victims in a multi-purpose conference and performance hall.

The conclusions drawn by this team, which pooled the skills needed to achieve this objective, led to the possibility of setting up this victim grouping centre at both technical and operational levels.

[14] 111 in the United Kingdom; 116 117 in Germany, Finland and Norway (source: EENA 112).

[15] Meeting of the FNSPF Volunteer Committee, 29 April 2020

[16] Letter from Mr Benoît Ribadeau-Dumas, then Director of the Prime Minister's Office, to Colonel Grégory Allione, President of the FNSPF, dated 10 April 2020.

This was very much welcomed by the hospital centre as a pre-hospital structure at a time when it was under great strain, although the main problem would have been the provision of medical staff (such as doctors, nurses and orderlies). The ARS was involved and participated in the scenario, in which the mobilisation of separate health workers could have been insufficient, so the use of national reinforcements (national health reserve or army health service) was envisaged. The mayor expressed his interest and his wish to include this project in his municipal safeguard plan. Fortunately, the centre did not have to be implemented; however, the study remains valid and can support the activation of the victim grouping centre at any time.

Here again, however, **the SDIS have regularly had to contend with a refusal to cooperate from hospitals and emergency services (SAMU)**.
One of them, for example, made a proposal on 26 March 2020 to its hospital centre to set up a support module for hospital structures (tents and advanced medical station (PMA) equipment) in an area heavily impacted by the health crisis. The SDIS received a negative response from the hospital centre (CH). The purpose of this module was to provide a triaged arrival at the hospital emergency room (COVID-19 / non-COVID-19), allowing victims to be taken care of quickly and thereby free up the victim emergency support vehicles (VSAVs) more quickly, while also allowing victims to wait in acceptable conditions.

D/ Support for retirement homes

The SISs have also provided assistance to the medicosocial sector, notably by carrying out assignments in retirement homes (EHPADs) such as providing screening tests for residents and carers, cleaning and disinfecting the premises, welcoming families, and maintaining social links with the elderly. In addition, the fire service regularly participated in the distribution of hydro-alcoholic gel or in the preparation of expert reports in the EHPADs concerning their organisation in terms of hygiene.

E/ Support for the general population

The actions taken by the SISs have been complemented by the voluntary commitment of the members of the associative network for the benefit of vulnerable populations on the basis of numerous local initiatives.

The departmental firefighters' unions have mobilised to ensure intergenerational solidarity in particular. With this in mind, measures have been taken to safeguard the health of former firefighters in certain departments and make sure that they are not struggling in certain ways (particularly with regard to the supply of basic necessities such as food and medicine).

The support groups also checked in with former firefighters and the families of wards to assess their needs. They have even been called upon to visit older people outside the network at the request of certain municipalities.

Fire service NGOs have also played an active role during this crisis. The International Emergency Firefighters association (PUI), for example, has worked together with French Popular Relief in Haute-Vienne to meet the needs of the population, whether by distributing food or raising awareness of good health practices.

In the same way, the international civil protection association (*Entraide protection civile internationale*) has provided assistance with activities such as distributing masks in communes, manufacturing masks, and supporting the elderly.

The fire services have therefore demonstrated their reactivity and adaptability to all events, as have the ambulatory health professionals and hospital staff including nurses and orderlies, to increase intensive care capacity and provide support to sick people.

CONCLUSION

Feedback from the field unanimously deplores a feeling of exclusion of the fire services from both the operational response and the management of the first phase of this crisis of an unprecedented scale.

This phenomenon is the product of the state's initial instinct to manage the crisis centrally by relying insufficiently on its own devolved bodies and decentralised means.

The decision to entrust the territorial management of this crisis to the ARSs, which lacked a culture in this area and fell outside the power of the prefects, led to the uneven, partial and uncoordinated mobilisation of territorial resources, creating a general feeling of complexity, dysfunction and a loss of efficiency.

As expressed by the FNSPF and the associations of elected representatives at the time, the failure to include the decentralised resources that represent not only the fire services but also local authorities in the management of the crisis at the outset has reduced our response capacity by a significant part of its human resources.

On the other hand, the decision made by the public authorities since the 'unlockdown' phase to entrust the management and coordination of public action to mayors and prefects of departments has demonstrated the relevance of making this partnership into the pillar of our crisis management system, which must be radically and sustainably transformed around four key ideas:

- **PROXIMITY**
- **ANTICIPATION**
- **INTERMINISTERIALITY**
- **TERRITORIALISATION**

10 proposals for interministerial and territorial crisis management.

1. **Definitively reassign the operational management of crises on national territory to the Ministry of the Interior.**

2. **Entrust the coordination of devolved services in the context of territorial crisis management to the departmental prefect alone, with particular regard to the forces of law and order as well as all civil protection and healthcare players.**

3. **Make the department the pivotal level of the territorial state and allow local authorities to deviate from the distribution of competences in recognised emergency situations.**

4. **Increase public awareness of major risks and entrust the French National Fire Officers Academy (ENSOSP) with the dissemination of a shared culture of civil protection between the various crisis management players with a view to building resilience.**

5. **Allow the fire service to carry out wider technical procedures under the responsibility of their head physician to facilitate earlier action and also contribute to domestic support in close collaboration with the healthcare professionals in the territories.**

6. **Strengthen the capacities and positioning of the healthcare and medical assistance services offered by the fire and rescue services.**

7. **Generalise the creation of departmental emergency call centres responding to the single interdepartmental emergency number of 112, with access to video protection and healthcare based on the European assistance number 116 117. This would also involve rethinking the coordination between the hospital and healthcare professionals in the regions in a bid to move away from directing everything to A&E.**

8. **Automatically recognise COVID-19 infections contracted by firefighters and, on a wider scale, all civil servants, volunteers and voluntary workers involved in civil protection missions as an occupational disease.**

9. **Introduce an ambitious policy for the development of volunteering through the adoption of a European directive in favour of civic and community engagement in all its forms.**

10. **Consolidate the operational response of proximity and solidarity of the territories through a dynamic climate of investment in support of fire and rescue services and operational means.**

APPENDIX

Human measures

1. Implementation of a departmental operation order, operational bulletins and instructions (such as the protection and cleaning of victim emergency support vehicles (VSAVs)).
2. Production of educational documents (such as videos of dressing and handling a victim).
3. Creation of diagrams for zoning rescue centres.
4. Delivery of meals to rescue centres on shifts.
5. Implementation of telephone lines to respond to employers and volunteer firefighters (SPV).
6. Development of useful information and resources (such as FAQs, answers on social networks, and infographics).
7. Delivery of vaccination campaigns for seasonal flu.
8. Reminder of the principle of washing clothes.
9. Feedback from chief veterinarians to all relief centres regarding the implementation of barrier measures.
10. Audit of SDIS psychologists in all rescue centres.
11. Reminders of hygiene regulations and social distancing measures through communications.
12. Information for staff on the need to report all acts of ostracism.
13. Drafting of departmental training continuity orders.
14. Taking into account the loss of a main job for some volunteer firefighters.
15. Daily monitoring of impacted staff members.

Organisational measures

1. Mobilisation of crisis cells at the beginning of the epidemic, followed by monitoring cells.
2. Recruitment of contract firefighters to ensure continuity of public services when necessary.
3. Modification of working time by way of a derogation to reduce staff turnover.
4. In the departments most affected, coordination with VSAVs dedicated to the transport of COVID-19 patients to reduce staff from three to two in order to limit the risk of contagion.
5. Overtime cap.
6. Implementation of cells to monitor the number of staff impacted together with the SSSM, human resources and the committee for health, safety and working conditions (CHSCT).
7. Two weeks' quarantine for firefighters coming in contact with a sick person without suitable protection
and for staff returning from high-risk areas.
8. Self-isolation for those in contact with people who have been in contact with infected parties.
9. Preventative monitoring and distancing of vulnerable people by SSSMs.
10. Postponement of holidays.
11. Limitation of face-to-face interactions to managerial positions.
12. Implementation of working from home as part of business continuity plans (BCP).
13. More consistent use of electronic signatures and electronic voting systems for elections.
14. Exchange forums between zones / SDIS / regional health authorities.
15. Launch of telemedicine follow-up consultations for firefighters impacted by the disease.
16. Limitation of the solicitation of volunteer firefighters working in the hospital environment.
17. Implementation of audio and video conferencing (for boards of directors, meetings between heads of centres, etc.).
18. Cancellation of internships and training courses.
19. Isolation of the alert processing centres and departmental fire and rescue operational centres (CTA-CODIS) and implementation of social distancing measures in the leadership teams and rescue centres.
20. Stationing of firefighter medics (ISP) at the CTAs to stabilise the flow of emergency assistance transport while the CRRA-15s were overburdened.
21. Implementation of BCPs, business recovery plans (BRP) and guides to ensure post-quarantine health and safety.
22. Presence of an officer at the departmental operational centres (COD).

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