

IN THE MATTER OF THE GRENFELL TOWER INQUIRY

**BEFORE SIR MARTIN MOORE-BICK, MS THOURIA ISTEPHAN AND MR ALI
AKBOR OBE**

MODULE 5: BSR TEAM 2 WRITTEN OPENING SUBMISSIONS

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INTRODUCTION AND OVERVIEW

1. At the time of writing Modules 1, 2 have concluded and Module 3 is well underway and as set out in those earlier modules the evidence presented before the Inquiry has been shocking. It will be no less so in Module 5.
2. Whether described as a series of missed opportunities, failures to learn lessons, apathy, a closed culture mindset within the LFB or just complacency, this tragedy was entirely predictable. What is painful for the BSRs is the fact that, given the evidence that was around years before, no proper action was taken to avoid the events that would unfold on the night of 14 June 2017.
3. There are many questions that Module 5 will have to consider. Some of them include; why was there a failure to learn the lessons from Lakanal House? What was the impact of Austerity and Cuts on this tragedy? Were there deficiencies in training? What led to this? How is it that there were inadequate Section 7(2)(d) visits, when it was clear that these could make a difference and forearm the fire service with the knowledge it needed to make a proper risk assessment? Why, with a modern fire service in the capital city of one of the wealthiest countries on this planet, was there such a wholesale communication failure between firefighters, with equipment that did not work or was unfit for its purpose? Why did evacuation not take place when there was significant external fire spread. Why was it not patently clear to the command and firefighters on the incident ground that Grenfell Tower was a failing building and that a stay put advice was not tenable?
4. Some of the answers to these questions may be easily found from the experts who have been instructed. However, some of the answers are not so as clear as to why the patently obvious was not addressed. But in our submission this module illustrates that lives could and should have been saved and this tragedy was far from unpredictable and certainly was not unavoidable.

LAKANAL HOUSE AND FAILURE TO LEARN LESSONS

“When you repeat a mistake, it is not a mistake anymore – it is a decision.” – Paulo Coehlo

5. The fire at Grenfell Tower was neither unprecedented nor unforeseeable.
6. On 3 July 2009, a faulty television caused a fire to break out in Flat 65 on the 9th floor of Lakanal House in Camberwell, south London. The building was a high-rise residential block – 42m tall, containing 98 flats and maisonettes spread over 14 floors. The fire spread via the exterior cladding made up of HPL composite panels, which were found to be non-compliant with Building Regulations.
7. Six people died in that fire, three of whom were children. Inquests were heard and at the conclusion the Assistant Deputy Coroner, Her Honour Frances Kirkham CBE sent Recommendations in a Rule 43 letter dated 28 March 2013 to Mr Ron Dobson, the London Fire Commissioner at the time {CWJ00000073}. These Recommendations covered s7(2)(d) visits, fire safety awareness for the public, Incident Commanders, Brigade Control, and communications at major incidents.
8. The Phase 1 Report found:

“It is self-evident that the conclusions in Section F6 of the LFB Lakanal Report were critical of the control room’s response to the Lakanal House fire. They were also strikingly prescient. Each of them applies with equal, if not greater, force to the Grenfell Tower fire. The evidence heard by the Inquiry at Phase 1 shows that, despite changes to certain LFB operational policies and the introduction of new training packages, few if any lessons were learnt by the LFB.¹”

9. The evidence concerning the LFB’s failure to learn the lessons of the Lakanal House fire will be heard across Modules 5 and 6. In Module 5 the Inquiry will hear how the LFB failed to implement recommendations relating to s(7)(2)(d) visits; Incident Command policies and procedures; and radio communications. The Inquiry will explore the failure to disseminate knowledge of these changes through appropriate training. In Module 6, the Inquiry will hear evidence about the changes to national guidance following Lakanal, and the LFB’s failure to fully incorporate these provisions into their own local policies; about the introduction of Fire Survival

¹ Phase 1 Report Volume IV 29.3

Guidance policy and the failure to regularly refresh the training of Control Staff on handling these important calls; and the missed opportunity to introduce fire safety measures in high-rise buildings through the retro-fitting of sprinklers.

10. The common themes in the failure to learn these lessons are a defensive culture within the LFB top tier management, who had battened down the hatches when faced with criticism from the Coroner's court and the DCLG following Lakanal; and a fire and rescue service whose workers were stretched to breaking point by chronic underfunding, staff shortages and threats of privatisation.

S7(2)(d) visits

11. The Coroner recommended that the LFB review its procedures for sharing information gained as a result of s7(2)(d) visits, familiarisation visits and home fire safety visits.
12. Assistant Commissioner David Brown was the Lead Officer responsible for implementing this Recommendation. We say his role is crucial in understanding why certain aspects of the LFB's fire safety inspection programme, most notably s7(2)(d) visits were so poor. Our clients want to know why the firefighters who attended Grenfell Tower for these visits weren't trained to do so. AC Brown was responsible for the 'Back2Basics' training programme and our clients question both the adequacy and effectiveness of this training.
13. The Inquiry is aware from our opening submissions in Module 3 that a number of home fire safety visits took place at Grenfell Tower, most recently 4 days before the fire. A number of our clients' loved ones were visited who were vulnerable, either through mobility issues or because they had very young children or elderly relatives. Despite this, no serious outstanding risks were identified. Why not?
14. The Inquiry will hear from firefighting expert and former Chief Fire Officer Steve McGuirk, who finds that the LFB's policies reflected national guidance but the policies were not being followed in practice due to a lack of training, understanding and performance management. He states that the LFB **did** identify training issues

regarding s7(2)(d) visits following Lakanal but failed to consider how the additional hazards of high-rise residential buildings altered the way that their s7(2)(d) duties needed to be discharged.

Incident Command

15. During the Lakanal House fire, there were six changes of Incident Commander with some serving as Incident Commander for brief periods. The narrative verdicts criticised the firefighting response for focusing resources on active firefighting rather than search and rescue.
16. Assistant Commissioner Andy Roe was the fourth officer to take on the role of Incident Commander on the night of the Grenfell Tower fire. Prior to his arrival, Station Manager Andrew Walton had served as Incident Commander for only a few minutes. The Phase 1 Report found that “Before the arrival of AC Roe the principal failure was one of command.²” Although AC Roe immediately recognised the need for total evacuation and revoked “stay put” within minutes of his arrival, by the time he arrived it was too late. The Phase 1 Report criticised the earlier Incident Commanders for continuing to attempt to fight the fire and not recognise the need for evacuation. The mistakes from Lakanal House were repeated. For our clients, a clear explanation is required as to why the mistakes of the not distant past were repeated and the lessons not learned.
17. The Coroner recommended that the LFB reviews its policies and procedures concerning Incident Command. She asked the LFB to consider whether it is effective for an Incident Commander to be closely tied to the mobilisation of the number or types of appliances attending an incident, and to consider whether a policy that may result in rapid and frequent changes of Incident Commander is effective.
18. We will hear evidence from Dr Sabrina Cohen-Hatton, who pioneered research into how to improve decision-making during major incidents. The Decision Control Process was incorporated into the National Operational Guidance on Incident Command in 2015.

² Phase 1 Report Part III: Conclusions, 28.8 (Volume 4)

19. Steve McGuirk’s evidence is that Dr Cohen-Hatton’s research was “significant”. Yet the LFB chose not to incorporate her model into their own local policies. Why was this so? Steve McGuirk states that they are the only FRS in the UK not to have adopted the newer approach. The HMICFRS report following their 2018 inspection of the LFB described this as “worrying”.
20. In Module 6, former Commissioner Dany Cotton will be asked to account for her decision not to incorporate the Decision Control Process into LFB’s policies. McGuirk invites the Inquiry to “*examine the manner in which the LFB considered the significance of the national research, and the means by which the LFB made their determination to retain the analytical model.*”³
21. Dr Cohen-Hatton faced resistance within the LFB as she attempted to convince them to adopt her model, and as she attempted to make improvements to Incident Command training. Our clients want to know the reasons behind this, and whether the missed opportunities to learn from her best practice contributed to the failures of command and control on the night of the fire. Ultimately, the Inquiry will have to ask the question: given these failures, were there deaths which could have been avoided? Were there lives that could have been saved?

Radio communications

22. Problems of radio coverage, interference and congestion affected the LFB response to the Lakanal House fire. As we will state later in this opening submission, we had a situation where a modern fire service could not communicate with each other. These problems were repeated on the night of the Grenfell Tower fire. The Inquiry will hear evidence from communications expert Professor Chris Johnson that there were missed opportunities to mitigate communications problems through training, guidance and site inspections.
23. The LFB’s Communications department drafted a response to the Coroner’s Rule 43 letter setting out proposals to address her recommendations. Johnson’s evidence is

³ Steve McGuirk Expert Report SMC00000046_0053, §135

that these were not actioned. The LFB's final response to the Coroner did not contain any of the Communications department's suggestions, and instead argued that communications problems could be overcome by increasing the number of channels. A training package was designed by Babcock to improve the use of radio equipment but this was never realised.

The why?

24. Our clients seek answers as to why the Coroner's recommendations following Lakanal House, which were clear and robust, were not followed. We intend to continue this thread into Module 6 to seek further transparency as to what the obstacles were to achieving effective implementation of these recommendations. This is essential if authorities are to confidently and correctly learn lessons and avert this lack of engagement and enforcement moving forward.

AUSTERITY AND CUTS

"Due to budget cuts the light at the end of the tunnel has been turned off" – Aaron Paul

25. In Phase 1 we submitted on behalf of our clients that:

"The LFB's response to Grenfell Tower was invariably affected by deregulation, outsourcing, budget cuts and a growing culture of the neglect of essential services. The devastating effect on fire safety calls for an urgent halt to deregulation of the LFB and input of resources into the services." {INQ00000551_0024} §6(i)

26. Four years after the fire, our clients renew this call.
27. Module 3 opened by stating that the Grenfell Tower fire was fuelled by an incendiary mix of power and profit over people. This culture permeated into the management of public services, including the emergency services.
28. In its Phase 1 Report, the Inquiry found failures of the LFB in relation to training and the implementation of policy. In order to understand these failures, the Inquiry needs

to understand the austerity agenda and programme of budget cuts and privatisation implemented by the Coalition government from 2010 onwards. Our clients agree with Matt Wrack, the General Secretary of the Fire Brigades Union when he said that:

“...the terrible loss of life at Grenfell Tower was ultimately caused by political decisions made at the highest level. For at least 40 years, policies relating to housing, local government, the fire and rescue services, research and other areas have been driven by an agenda of cuts, deregulation and privatisation.”⁴

Budget cuts and cuts to frontline services

29. Since Conservative-led governments came into office in 2010, almost 12,000 frontline firefighter jobs have been cut – one in five of the total firefighting force. Between 2010-11 and 2015-16, it is estimated that central funding to local fire and rescue services decreased by an average of 28% in real terms. Alongside central funding cuts, the London Fire Brigade faced swingeing cuts from Boris Johnson when he was Mayor of London. Johnson cut LFB’s budget by £150 million, closing 10 fire stations, removing 27 fire engines and cutting jobs by 1,242. Londoners experienced the real life consequences of Mayor Johnson’s cuts, which had fatal results. We draw the panel’s attention to a series of newspaper articles that charted the devastating effect of these measures⁵.

30. Of particular relevance to the failures in relation to Grenfell Tower are that, over the past decade, Control Room staff levels were reduced by 13% and staff engaged in inspection and enforcement have been cut by more than a quarter (26%).

31. A 2010 Report ‘Role of the Fire & Rescue Service (Delivery Models) Report’ {INQ00014640_0003} forewarned:

“The immediate and greatest challenge to the Fire & Rescue Service (FRS) is that of funding. Financial support from the Government is set to reduce by c.30% over the next four years [...] For many and perhaps most FRSs, these funding reductions will imperil their ability to carry out risk-based budgeting and implement their local

⁴ The Grenfell Tower Fire: A Crime Caused by Profit and Deregulation

⁵ See Schedule 1 to these submissions: BSR00000078.

Integrated Risk Management Plans (IRMPs), let alone play an effective part in the National Framework. When all the frills have been removed, every spare ounce of fat burned off, and every possible efficiency saving identified and implemented, there will remain only real cuts to the core service and a real increase in casualties and property loss.”

32. The Cabinet Office prepared a document dispelling the “myths” of austerity and cuts following the Grenfell Tower Fire⁶. They attempted to characterise the closure of fire stations and cuts to frontline jobs and control room staff as a falling demand on the service. Nothing could be further from the truth. The number of fire incidents reduced in recent years because of the shift in strategy from fire services from fire extinction to fire prevention. Firefighters are carrying out vital work in communities, including conducting Home Fire Safety Visits, s7(2)(d) visits, inspections and education programmes – being asked to do more with fewer resources.
33. In 2013, a Judicial Review was brought by 7 London Boroughs and an Individual C, against Boris Johnson the Mayor, the LFB Commissioner and Authority (03/10/13). The FBU, Secretary of state for Communities and Local Government and other London Boroughs were listed as interested parties. C sought an injunction prohibiting the LFB from carrying out any irrevocable steps preparatory to the closure of any fire station or the decommissioning of any fire appliance. This was refused, but the Authority and then Commissioner, Ron Dobson gave an assurance that, for the time being, they did not intend to take any irreversible steps to implement LSP5 and that they would give a minimum of 14 days’ notice should they intend to do so.
34. Part of the Commissioner’s argument against the claimant was that they were advocating an approach which looked at “the theoretical likelihood of a fire.” With cruel irony, if the LFB had been prepared to adopt an approach which looked at all eventualities, in theory the impact of certain materials and cladding on fire spread and direction, in theory the possibility of compartmentation breaches etc, we might have not seen and heard, the appalling lack of knowledge and training demonstrated in the Phase 1 evidence of operational firefighters.

⁶ CAB00005645

The years preceding the Grenfell Tower fire.

35. In the years leading up to the fire at Grenfell Tower, fires and fatalities were again on the rise: an inescapable consequence of austerity cuts. In one particularly brutal year, 2015, as the axe fell on Clerkenwell fire station, dating back to the 1870s and nine others, to save £28.8m; the LFB said in a statement at the time that changes, including the loss of 552 firefighters that year, were "inevitable". However, under the leadership of Ron Dobson as Commissioner, the LFB maintained, the service would not be affected. The cuts, which included the reduction in the number of fire engines by 14, would not affect the service it provided because the number of fires "has fallen by 50% over the last 10 years."
36. Such assurances from the LFB leadership proved to be hollow. The following year fire deaths across the capital had gone up by 20 per cent, according to figures released by the London Fire Brigade (LFB). In 2015-16 the number of fires attended and the number of fire-related fatalities both increased on the previous year: Fire and rescue services attended around 162,000 fires in England during 2015/16, 5% more than the 155,000 in 2014/15; and there were 303 fire-related fatalities in England during 2015/16, 39 more than 2014/15 and the highest figure since 2011/12.
37. RBKC Labour Councillor Pat Mason wrote to Ron Dobson in 2016, regarding the £6.4m LFB budget cut consultation.⁸ Following a £45m cut to the LFB budget in the last round, the Mayor of London sought a further £8.1m reduction for 2016-17. Cllr Mason was minded to support Option A in consultation - that returns 13 fire engines retained by Mayor Johnson back into service. Note this will mean that 2 fire rescue units, 5 aerial appliances and 2 operational support units would be alternately crewed. Whilst still not happy with the proposal for alternate crewing, Cllr Mason saw this as preferable to Option B – which was supported by Commissioner Ron Dobson because that option "makes no sense" to have 13 fire appliances parked up out of service. Cllr Mason also did not find the evidence credible that the LFB could continue to achieve the London-wide average attendance time target of 6 mins for the first fire engine and 8mins for the second.

⁷https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545927/fire-statistics-monitor-1516-hosb0916.pdf

⁸ RBK00036252

38. The FBU considered strike action during this period of time. They believed that there was a lack of leadership at the top and a lack of challenge to the Mayor and his agenda for cuts and deregulation.

39. In 2016, the incoming Mayor of London Sadiq Khan commissioned the Mayer review, which examined whether the LFB needed additional resources now or in the future, as well as its ability to effectively manage incidents such as a flood or terror attack.

40. Mr Mayer said it was:

"important that the current budget gap is not allowed to widen further".

41. He added:

"The service must continue to evolve and adjust to future challenges. Ring-fencing funds for potential major incidents and rehousing second appliances could make a big difference to the brigade's ability to maintain its readiness and resources to protect the capital, whatever the future may hold."

42. Our clients are clear in their assertions that Boris Johnson, when Mayor of London, had a cruel agenda of cutting the LFB budget, firefighter numbers and stations. This was a man who showed his contempt for fire safety and the lives of Londoners, when in the face of legitimate political debate and criticisms of his reckless policies told Labour Assembly member Andrew Dismore to: "Get Stuffed". His agenda directly impacted upon the LFB's ability to discharge its statutory duties as a Fire and Rescue Service. Sadly, the LFB leadership failed to provide an effective voice of opposition to this. In this regard they failed their own operational firefighters and Londoners. Our clients speak plainly; the link between cuts and austerity and fire safety being compromised and eroded is real.

Privatisation

43. As Fire and Rescue Services came under increasing pressure to deliver so-called “efficiency savings”, proposals were introduced for the outsourcing and privatisation of aspects of their functions.

Control emergency call-handling and mobilisation

44. The disastrous FiReControl project, which aimed to replace 46 local Fire and Rescue Services Control Rooms with 9 regional centres, was abandoned in December 2010 having cost £500 million. Amyas Morse, the head of the National Audit Office said: *“This is yet another example of a government IT project taking on a life of its own, absorbing ever-increasing resources without reaching its objectives. [...] It was approved on the basis of unrealistic estimates of costs and under-appreciation of the complexity of the IT involved and the project was hurriedly implemented and poorly managed.”*⁹
45. In 2012 under Mayor Boris Johnson’s leadership, the Greater London Authority awarded Capita a 10-year contract to take over the LFB’s control centre along with around 120 staff who would be transferred to the company. This proposal was vociferously opposed by the staff and their unions. The decision was reviewed following the departure of the Conservative Chair of LFEPA and instead an award was made to Capita for a contract replacing the existing ‘mobilising solution’ with VISION.
46. This was Capita’s first foray into essential frontline services. Capita had no prior experience of emergency call handling, and a poor track record of IT failures for public services: at the Criminal Records Bureau¹⁰ (now the Disclosure and Barring Service); Individual Learning Accounts¹¹ and school records system Sims¹². It was also fined £1 million for poor customer service in the initial stages of the congestion

⁹ <https://www.fbu.org.uk/blog/private-money-public-mayhem-0>

¹⁰ <https://www.computerweekly.com/feature/Series-of-mistakes-by-the-Criminal-Records-Bureau-led-to-failure-of-essential-system>

¹¹ <https://www.timeshighereducation.com/news/government-urged-to-ditch-capita-after-ila-failure/170259.article?storyCode=170259§ioncode=26>

¹² <https://www.information-age.com/capita-blamed-in-schools-data-loss-287036/>

charge¹³. These public relations fiascos led to Private Eye magazine giving them the moniker “Crapita”.

47. Principal Operations Manager Scott Hayward gives evidence that there was a significant delay to the delivery of VISION and that a significant amount of its functionality was untested before it went live in November 2015. In the first year after VISION was introduced, there were six occasions when the system failed and staff resorted to using pen and paper to record information and pass it to crews. Hayward cites the ‘resource implications of VISION’ as a reason why LFB Control failed to undertake FSG refresher training: No FSG refresher training took place in 2015 due to VISION training¹⁴.

48. Hayward explains that during the period when privatisation was considered, there was a block on recruiting further Control officers, which led to the Control Room being understaffed. This further exacerbated the problems with releasing staff for training, particularly FSG refresher training.

49. An FBU Report published in April 2017 warned that:

“Understaffing, excessive workloads, and imposed shift changes are causing intolerable stress and anxiety which is impacting both on the health and welfare of control staff and on public safety.”¹⁵

50. A 2016 review said that the Brigade could not sustain any more cuts after Johnson left office if it was to have sufficient resources to meet the challenges of the future and to keep Londoners safe. Further cuts of 15% to 2020 were set out in the Local Government Settlement. Despite the Grenfell Tower fire, no additional funding has been found for fire and rescue services. LFB cannot learn the lessons of Lakanal House and Grenfell Tower without the resources to implement the changes that are needed. Above all else, our clients don’t want any other families to go through what they have. Without proper funding, the past will repeat itself.

¹³ <http://news.bbc.co.uk/1/hi/england/london/3180492.stm>

¹⁴ Witness Statement of Scott Hayward {LFB00055191_0027}

¹⁵ Losing Control? Cuts, Closures and Challenges in UK Fire Controls (Fire Brigades Union, April 2017), p.2

Training

“Outsourcing or contracting out some of a fire service’s function is another way to part privatisation by the back door.” - David Wibberley.

51. After a procurement process, on 1 April 2012, Babcock Training Ltd was awarded the much coveted 25-year contract to provide training services for LFB. Babcock is a UK multinational corporation, with operations in the UK and Europe, Africa, America and Australia. It is a plc listed on the London Stock Exchange and features in the FTSE 250. According to its 2018 annual report:

‘We maintain, upgrade, operate and manage expensive infrastructure and essential equipment for a range of government bodies and private sector customers in the UK and internationally.

We provide them with better capability, reliability and availability of their critical assets, and in doing so, provide significant cost savings. We are a trusted partner who understands the critical role that our customers’ assets and infrastructure play in delivering their business; we share risk with them in delivering innovation and efficiency, and we share the benefits.’ (our emphasis)

52. The tone, ethos and language of private enterprise sits ill on a public body, tasked to save lives and protect the population of the Capital.

53. In the evidence he gave in Phase 1, SM Peter Johnson pulled no punches in relation to what he saw as serious and significant failings in the training provisions of Babcock and the IT system used by the LFB. {MET00013235_0004}:

“We never received any feedback from them, nor were the issues ever fixed. Ever since I joined the Command Units, the computer systems were outdated. Reporting issues with the Command Units would be a hard thing to do. Over a period of time we would speak with Babcock and our I.T department about all the issues on the Command Units, but they only really offered short term fixes sometimes blaming each other.”

54. In 2013, Peter Groves explained the official reasons behind the choice of Babcock International. This included: future cost avoidance, improved service effectiveness, efficient resource utilisation and revenue generation. Remove all this jargon and the

rationale is in fact very simple. Babcock offered cut-rate prices, for second-rate services.

55. The LFB leadership were blinded by the dazzling figure of £66m, which was Babcock's projected financial saving. This was the key to the appointment. Whenever the long-term needs of a public service such as proper investment in training, are placed on a financial balance sheet, there is always the real danger that short term "savings" will be prioritised over long-term investment. The true cost of this blinkered approach and mindset is the downgrading of fire safety.
56. For this inquiry to properly discharge its obligations and to answer the questions so many of our clients demand, those in charge of this decision need to be held accountable.
57. Why did the country's largest fire and rescue service outsource something as fundamental as training and equipment to a company with no experience or prior knowledge of this very specific and complex field of emergency services?
58. If as Peter Groves posited, the Chair of the Resources Committee did not believe that the LFB training was fit for purpose prior to Babcock's appointment, why not invest time, and resources into improving it? Why was there no funding for upgrading the LFB's own pre-existing training centres, resources and facilities? Why was existing expertise from those voices within the LFB who were critical of Babcock's appointment not listened to?
59. The fire safety of Londoners and the training of firefighters was far too important, literally a matter of life and death, to be put in the hands of novices, motivated by market forces rather than a commitment to protect and save lives.
60. Given the numerous failures highlighted by the Chair in the Phase 1 report relating to lack of adequate training, it is prudent to question the suitability of the LFB's contract with Babcock. As Babcock continue to delivery training services to the LFB pursuant to this contract, this issue is of considerable importance. Our clients are keen to understand why a vital emergency service was part-privatised, especially

after the failure of previous similar deals. It is not lost on our clients that there is similarity between drive for costs saving on the part of the LFB and the strategy used by those responsible for the refurbishment of Grenfell Tower. Once again, it appears to be a case of savings over safety.

61. The LFB leadership were warned by the FBU at the time about the risks of outsourcing training to Babcock. Peter Groves explains in his witness statement to the Metropolitan Police the relationship between the FBU and Babcock:

“Culturally, there were challenges around how LFB personnel engaged with Babcock. The Fire Brigades Union were not in favour of outsourcing. At the start we had issues with members refusing to be trained by a public sector entity. Even now, there are still people that believe that unless someone wears an LFB uniform, then they aren't credible”¹⁶.

62. The FBU were unequivocal about the outsourcing of training to Babcock. It would appear that the concerns of rank-and-file firefighters were not taken seriously. This inquiry should ask why?

INADEQUATE TRAINING

“By failing to prepare you are preparing to fail”- Benjamin Franklin

63. We know that firefighters and members of the FBU remained concerned about the delivery of training by Babcock for several years up until the fire at Grenfell Tower. They may still be unhappy with the quality of Babcock's training. Previously, firefighters raised concerns about the Babcock trainers' competency to provide the relevant training. There were also concerns about firefighter safety. On 06 August 2014, Jim Wennell (FBU) noted an ongoing matter of firefighter burns during training and 22 unreported cases which included allegations of bullying by Babcock trainers.¹⁷ Peter Groves describes in his police witness statement very strong feelings from LFB staff towards trainers¹⁸.

¹⁶ {MET00071103_0017}

¹⁷ {LFB00030567_0002}

¹⁸ {MET00071103_0017}

64. Peter Groves explained that there were difficulties at the beginning of the contract with Babcock:

“it took nearly four to five years to get settled with it... that first year was a very hard year for both LFB and Babcock. To switch something ‘off’ on the 31st of March and expect someone to take it all on from 1st April, was a big ask. The process was so truncated that it took nearly three years to imbed. It took until 2016 for the training to be fully imbedded and for delivery to be in a steady state”¹⁹.

65. Several performance and competence related issues with Babcock’s training delivery were raised in the first two years of the contract²⁰. It is unclear whether these issues were ever fully resolved.

66. In Phase 1, we were critical of the LFB’s overemphasis on computer-based training. This criticism remains. *Efficient resource utilisation* was one of the central reasons for outsourcing training to Babcock. The 2013 LFB report explained that this was to be realised by a greater use of computer-based training and a move away from “the need for *trainer facilitated delivery away from the workplace*”. The model of online and e-learning is simply not sufficiently effective in transferring information into knowledge, for a public fire and rescue service. There needs to be a return to a more practical based training regime, where the emphasis is on ensuring that the relevant skills, knowledge and information are inculcated into the firefighting body, rather than a preoccupation with profit margins and financial imperatives.

67. Our fears in Phase 1 that computer-based training could adequately replace real life and practical training have been proven by the expert report of Steve McGuirk²¹. McGuirk says:

“Without realism, though, it is difficult to induce the necessary pressure that characterises an emergency situation, and which helps personnel to understand the difference between initiative and freelancing, by having had the opportunity to practise and see for themselves the implications and impact of both... So, despite the difficulty, the need for realism remains an essential element of an operational training regime.”²²

¹⁹ {MET00071103_0016}

²⁰ {LFB00041281_0005}, {LFB00102150_0004 -0005, paras 12, 13 and 19}, {LFB00102163_0004 para 12} and {LFB00030567_0002 – para 2.6}

²¹ See [§ 108]

²² {SMC00000046_0046}, paras 119-120.

68. McGuirk further contends that realism has become more important in the light of the “falling activity phenomenon” – the reduction in operational incidents: “*the only way of trying to address this loss of live exposure is by the creation of more realism in training events...*” From a lay person’s perspective, it seems obvious that theoretical and computer-based training is not sufficient. The Inquiry knows that Babcock built facilities for the LFB in Beckton and Park Royal, pursuant to the contract, but the Inquiry must investigate how these sites were used, for whom, and for how often.

69. It is not the intention of these submissions to primarily criticise Babcock for the **content** of the training material provided to the LFB, as this content was signed off and approved by the relevant people within the LFB. In Peter Groves’ statement he describes the role of LFB and Babcock as “*ultimately, it's the LFB's job to provide the Statement of Training Requirement (SOTR) and Babcock deliver it*”²³. The Inquiry’s decision not to call any Babcock witnesses in this Module is regrettable, as this would have allowed the Inquiry to dig deeper into the adequacy of their training and the manner in which it was devised. However, we invite the Inquiry in the absence of such evidence to rely on the evidence given from the LFB’s perspective.

70. Before the Grenfell fire there were deficiencies with the LFB’s training programmes. However, our ability to conclusively assess the adequacy of the training provided by Babcock is limited by the fact that at the time of writing his expert report, Steve McGuirk has not had sight of all the relevant training materials²⁴. When Mr McGuirk has been able to review the full disclosure of training materials, we will be able to comment more fully and so will do so in our closing submissions.

²³ {MET00071103_0006}

²⁴ {SMC00000046_0055} paras 143 – 144.

Incident Command Training

71. Phase 1 highlighted deficiencies in the LFB's training prior to the fire. Perhaps most egregiously, in the case of incident command training. The Phase 1 report concluded that:

“Once it was clear that the fire had spread out of control, that compartmentation had extensively failed, but that evacuation remained possible, a decision should have been made to evacuate the tower... before AC Roe assumed command, none of the incident commanders had been able to conceive the possibility of mass compartmentation failure and the consequent need to consider, and then order, a total evacuation of the building. There came a point when it was, or should have been, reasonably obvious that operational responses to individual FSG calls were, or were likely to be, ineffective and that the stairs would remain passable for only a limited period of time. In those circumstances, it was, or should have been, obvious that only a supervised mass evacuation would minimise the number of casualties... Before AC Roe assumed command, none of the incident commanders had, for a variety of reasons, effectively seized control of the situation... The absence of an operational evacuation plan was a major omission in the LFB's preparation for a fire at a building such as Grenfell Tower, but, since there was no attempt to carry out a managed evacuation of the building, it is less significant than the absence of any training for incident commanders in how to recognise the need for evacuation. That absence in turn reflects a failure to recognise the risk of fire taking hold on the outside of modern buildings. Several LFB witnesses said in one way or another that they did not understand what was happening as the fire spread up the building and that buildings “should not behave like that”. That reflected a failure to educate firefighters in the dangers associated with combustible cladding systems... That failure is surprising, given the long history of fires involving cladding on high-rise buildings both in this country and abroad, a history of which some senior figures within the LFB were aware.”²⁵

72. On the night of the fire, there was an inadequate application of the incident command procedures set out in the LFB's policies PN238²⁶ and PN342.
73. Alarming, Michael Dowden, the first incident commander on site at Grenfell Tower on the night of the fire, when asked about abandoning the stay put policy told the Inquiry that he could not “remember any time that I had actually been on a training course that would facilitate that.”²⁷ This is consistent with Commissioner Andy Roe's statement that there was no explicit guidance or direction in any of the

²⁵ Phase 1 Report Part III: Conclusions, 28.5-8 + 27.9-10, (Volume 4

²⁶ {LFB00000164}

²⁷ Transcript Day 9, 25 June 2018, page 35 lines 1-3.

LFB's policies or training as to when and how stay put should be withdrawn and alternative strategies followed.

74. Mr McGuirk agrees with the Chairman's findings that there were several failures of incident command on the night, which he has attributed to, inter alia, the falling activity phenomenon.²⁸ McGuirk describes the "falling activity phenomenon" regarding incident commanders as the reduction in level of live exposure of likely incident commanders to all incidents; incident commanders tending to be in predominantly managerial rather than operational roles; lack of operationally focused fire research; limited learning by applying procedures to reality; and a sense of complacency in relation to the risk posed by fires. As discussed above, McGuirk points to the importance of realistic training to address this issue²⁹.

75. Citing research undertaken by Dr Sabrina Cohen-Hatton from August 2015, McGuirk notes that due to the decline in attendance at operational incidents, it is highly unlikely that there will be sufficient opportunity to practise and develop the full range of skills necessary for incident command. The research concluded that simulation is only a partial solution and it would not be advisable to replace more realistic exercises completely with computer simulations, but to use a combination of the two.

76. The response of the incident commanders on the night of the fire at Grenfell Tower, prior to AC Roe's take over, demonstrated a lack of understanding and assessment of risk and poor decision-making which was reflective of a lack of training and application of the relevant policies. This lack of preparedness is inexcusable given the Lakanal House fire and subsequent inquest. The Coroner in the Lakanal House inquest recommended further training for incident commanders with a particular focus on the use of the dynamic risk management model and other management tools to enable incident commanders to analyse a situation, the need to recognise when to escalate attendance by more experienced incident commanders and the need to anticipate that a fire might behave in a manner inconsistent with the

²⁸ {SMC00000046_0046-0054} paras 121 -141.

²⁹ {SMC00000046_0047-0050} paras 123-126.

compartmentation principle. The LFB recognised the need to address these recommendations³⁰, but this was clearly not followed through adequately.

77. McGuirk concludes that the LFB incident command training did not prepare personnel for the potential need to evacuate a high-rise building with no pre-existing evacuation plan. It is unclear how Babcock was able to confirm to the LFB in 2014³¹ that it had satisfied all of the Coroner's recommendations with regard to incident command, save for the potential to make more use of high-rise incident-related scenarios in training. This is contradicted by Gordon Reynolds' claim that "*the LFB have never requested Babcock to design any training packages with the specific purpose of compartmentalisation failure.*"³² This is an issue the Inquiry should explore in this module, to see what lessons can be learned with an eye to prevention.

78. A key failure of incident commanders on the night of the Grenfell Fire was the failure to carry out a dynamic risk assessment early enough. It is unclear why, given that the LFB hosted the drafting of the Incident Command National Operational Guidance ("NOG")³³. This guidance was never incorporated into the LFB policy or training. Steve McGuirk notes that: "*the LFB are the only FRS in the UK not to have adopted the newer approach [of DCP as per the NOG]*"³⁴.

79. Our clients are alarmed by the fact the LFB has been described as one of the worst forces in the UK by Her Majesty's Inspector of Constabulary and Fire and Rescue Services ("HMICFRS") in reports since the fire at Grenfell Tower. The 2018/ 2019 report highlighted concerns about the quality of training for incident commanders. It says:

*"the brigade's operational policies and procedures are comprehensive, but they don't fully reflect national operational guidance (NOG), even for risk-critical areas such as incident command. This is worrying, especially since it is coupled with the need to improve the maintenance of competence of all its incident commanders and emergency drivers through training and assessment. This needs immediate attention."*³⁵

³⁰ {LFB00051027_0001}

³¹ {LFB00116678_0002}

³² {BAB00000074_0009}, para 51.

³³ {LFB00118213_0002}, para 11.

³⁴ {SMC00000046_0053}, para 135.

³⁵ <https://www.justiceinspectorates.gov.uk/hmicfrs/frs-assessment/frs-2018/london/>

80. We share the concerns of both McGuirk and HMICFRS and invite the Inquiry to investigate why the LFB did not to incorporate the NOG into policy and practice prior to the fire at Grenfell Tower. This LFB failure constitutes a major failure, and one that held foreseeable risks which have nothing to do with the benefit of hindsight.

81. Professor Torero in his Expert Report to the Inquiry was also critical of the LFB's operational command structure and its impact on the ability to carry out dynamic risk assessments. He states:

*“the Grenfell Tower Fire showed that the London Fire Brigade does not have an adequate operational command structure that allows information and orders to flow effectively, such that commanding officers may use the former to conduct a proper dynamic risk assessment, and use the latter to change strategy in accordance with this assessment. Departing from a well-established protocol, such as the “stay-put” strategy would have only been possible following a comprehensive dynamic risk assessment carried out by a suitably competent individual, and enacted via a strict command structure. It is important to add, that this is a two-way process by which an adequate command structure is also underpinned by the capacity to deliver an adequate dynamic risk assessment. The structure and policies of the London Fire Brigade are currently not conducive to the recruitment, education and training of professionals capable of conducting a comprehensive dynamic risk assessment under conditions as complex as the Grenfell Tower Fire.”*³⁶ Professor Torero also said: *“currently, the prevailing culture of the Fire and Rescue Services only assigns value to plan execution and tools and training associated to following predefined protocols.”*³⁷

82. These criticisms go to the very heart of the LFB's existence and need to be addressed in an open and honest way if the institution is to learn lessons from the Grenfell Tower fire. If such a culture has been fostered at the LFB, it means that a radical overhaul of the institution is needed.

83. The picture relating to the LFB's training about the dangers of cladding is similar. The Phase 1 report concluded that:

³⁶ {JTOR00000002_0004}, lines 90-99.

³⁷ {JTOR00000002_0025}, lines 860-861.

“the otherwise experienced incident commanders and senior officers attending the fire had received no training in the particular dangers associated with combustible cladding, even though some senior officers were aware of similar fires that had occurred in other countries, and of the fact that construction materials and methods of construction were being used in high-rise building facades with a limited understanding of their behaviour and performance in a fire”³⁸ ...The failure to train firefighters in how best to fight cladding fires was the inevitable consequence of the LFB’s institutional failure to inform its firefighters about the risks they present.”³⁹

84. The then Commissioner’s oral evidence before the Inquiry highlighted the scale of the problem: the LFB would not develop a training package to respond to “*something that simply shouldn’t happen*”⁴⁰.

85. Tellingly, in an email from Keeley Foster to Ron Dobson in September 2016 attaching a draft presentation for a Fire Summit the following month, Ms Foster asked whether the presentation “*should include growing concerns over the cladding of buildings?*” The email linked to an article which detailed external spread through cladding & insulation products.⁴¹ This email illustrates that those at the top of the LFB were well aware of these issues and potential for catastrophic fires in high-rise buildings.

86. There is evidence to suggest that LFB knew that there was more than a negligible risk of a serious fire in a high-rise building with a cladding system.⁴² At the very least, the LFB ought to have known about the risks posed by combustible cladding due to an awareness of cladding fires in the UK and abroad. The Chairman concluded in the Phase 1 report that:

“Notwithstanding this history of fires involving cladding systems, the LFB’s experience and assessment of the Shepherd’s Court fire in August 2016 and the letter to the Chief Executives of the London boroughs, very few (if any) of the incident commanders or senior officers who attended the fire at Grenfell Tower were aware of the risks posed by exterior cladding. Certainly, none of them had received any training in recognising or assessing risks of that kind or in the steps that should be taken in response to a fire in the envelope of a high-rise building.”⁴³

³⁸ Vol 1 Chapter 2, para 2.18(a).

³⁹ Vol 4 Chapter 27, para 27.20.

⁴⁰ Transcript Phase 1 Day 50, 27 September 2018, page 52 line 11.

⁴¹ {LFB00070069}

⁴² Vol 4 Ch 27 Para 27.9 & 27.18.

⁴³ Vol 4 Ch 27 para 27.14.

87. Professor Torero reinforced this view: *“given the recent history of large façade fires, the evolution of the fire at Grenfell Tower was foreseeable and that there was awareness within the London Fire Brigade of these fires and their potential consequences.”*⁴⁴ The Inquiry heard evidence during Phase 1 about the “Tall Building Façades” presentation from 2016⁴⁵ which discussed previous cladding fires, mechanisms of external fire spread, regulations, the Shepherd’s Court fire, and the need to understand what products are used in a façade system. The oral evidence in this Module needs to explore why this presentation was only shown to a few senior officers.
88. It is surprising that although the LFB thought the risk serious enough to write to local councils in April 2017 urging them to *“consider carefully your arrangements for specifying, monitoring and approving all aspects of future replacement and improvement to building facades and construction of new buildings for which you are responsible”*⁴⁶, it did not think it important enough to 1) copy this letter to watch commanders or 2) make training firefighters about the risks of combustible cladding a priority. The oral evidence in Module 5 will hopefully shed further light on who within the LFB was aware of the dangers of combustible cladding.
89. Module 6 will look to uncover any inadequacies in the LFB policies prior to the Grenfell Tower fire surrounding cladding and high-rise fires. There are, for example, serious questions to be asked about the provision or lack thereof in GRA 3.2 and PN 633 for the specific risks associated with cladding. For the purposes of Module 5, it does not yet need to be determined whether the policies adequately provided for cladding fires. The history of cladding fires in the UK and abroad was such that, regardless of the adequacy of existing policy, cladding should have featured prominently in LFB training. Instead, there appears to have been an assumption that compartmentation would work. This assumption arguably led the LFB to not treat the dangers of combustible cladding with the appropriate emphasis it needed. This underemphasis had deadly consequences and can be considered another notable failure.

⁴⁴ {JTOR00000002, p.3 lines 55-57.

⁴⁵ {LFB00003521}

⁴⁶ LFB00032307

90. Respectfully, this Module's oral evidence, needs to explore why the two learning packages designed by Babcock under TCAP 0212; 'Highly Insulated Buildings for Station-based Staff' and 'Highly Insulated Buildings for Station Managers', were not released prior to the fire at Grenfell Tower. It would appear from the disclosure so far that the packages were approved by the LFB but were not released⁴⁷ in October 2015 due to "*significant and long-term issues surrounding LFB's IT infrastructure*".⁴⁸ The IT issues are detailed in the TCAP document: the pilot for the TCAP was ready by January 2016, but essentially the package could not function because the Brigade started using a new version of internet explorer in January 2015 which was not compatible with Big Learning and the ICT department could only support a 2MB internet link. These issues continued until all computer terminals were replaced with the current model in 2017⁴⁹. Given that the training slides make reference to cladding and specifically to thermal insulation boards as a modern method of construction,⁵⁰ it is important that the Inquiry digs deeper into why this training wasn't released. Why were the aforementioned IT issues not resolved before the fire at Grenfell Tower? Why was this issue not deemed important enough to necessitate an urgent solution? Why didn't they simply print it out?
91. Professor Torero points to a wider issue within the LFB that led to this inadequate training about cladding fires. Professor Torero argued that:

"...firefighter training is clearly insufficient to understand the intricacies of modern buildings and in particular all potential forms of behaviour in the event of a fire... The lack of technical knowledge on building performance is further reinforced by years of training and tradition that also favours direct interaction with the fire...At the core of these failures is a profound misunderstanding of risk within modern buildings created by inadequate education and training...It can be established that the training provided to members of the LFB was not adequate to understand the complexities of modern buildings, in particular high-rise buildings....There is a strong disregard for training and education pertaining to building behaviour. It is clear that the inadequacy of training and education crosses through all ranks of the LFB."

⁵¹,"

⁴⁷ MET00040010 pg 14 and

⁴⁸ BAB00000075, para 27

⁴⁹ LFB00102213_16

⁵⁰ See: BAB00000075, BAB00000016, BAB00000013, BAB00000009

⁵¹ JTOR00000002, pages 18 and 23

92. If it is established that this summation accurately describes the culture within the LFB, then significant change is needed, urgently, in order to save lives and prevent future tragedies like Grenfell.

Section 7(2) (d)

“I wouldn’t change anything we did on the night.” – Dany Cotton

93. During her phase 1 evidence Dany Cotton, the then LFB commissioner, when repeatedly pressed regarding the LFB’s preparedness for a high-rise cladding fire, made her now infamous remarks that it would have been impossible to prepare for this because the way the building behaved was so unexpected; and ***“I wouldn’t develop a training package for a space shuttle landing on the Shard.”*** Despite weeks of evidence from other firefighters about a lack of breathing apparatus, broken radio communications, a delay in ordering an evacuation and an absence of previous checks on the building; to the bemusement and distress of many present and those watching and listening; she confidently stated: ***“I wouldn’t change anything we did on the night.”***
94. Not only were these crass and insensitive comments deeply hurtful and disrespectful to the bereaved families, residents and survivors, who are still waiting for her to take the opportunity to apologise for her words; they were plainly wrong. Perhaps Ms. Cotton, who will return to give evidence in the next module no. 6, will avail herself of the opportunity to rectify the situation.
95. What has become abundantly clear is that those in the upper echelons of the LFB management seemed unable or unwilling to grapple with some very uncomfortable truths about the organisation and the need for serious change. For the LFB as a public service to function effectively, its policies and training must be based upon a firm foundation of knowledge and information. That is what underpins **Section 7(2)(d) of the Fire and Rescue Services Act 2004**. Hand in hand with that it must also be recognised that such a foundation must be reinforced with proper funding and allocation of resources.

96. It is vital to contextualise all the topics in Module 5. The triumvirate of mindset, training and cuts, pervades throughout and their collective impact on the operational performance and efficacy of the LFB management, cannot and should not be underestimated.

Legislative Framework and Policy

97. Section 1(1)(d) of the Fire Services Act 1947 was the precursor to s.7(2)(d) visits. It was a narrow obligation which required the obtaining of a few pieces of general information specified in the legislation for firefighting purpose, i.e. information related to the character of the building and buildings in the area; water supplies, the means of access and other material details, including local circumstances. However, the relevant Manual of Firemanship identified a basic principle that knowledge of the station ground is the first requirement of successful firefighting.
98. Without the knowledge and information about the character of the building, the locale, the environment and buildings in the area, any subsequent firefighting operation will be compromised. Everything flows from this knowledge and therefore its accuracy, detail and comprehensiveness is key.
99. Section 7(2)(d) of the Fire and Rescue Services Act 2004 provides that fire and rescue authorities must make arrangements for obtaining information for the purposes of (a) extinguishing fires in its area; and (b) protecting life and property in the event of fires in its area.
100. One thing that the LFB cannot be criticised for is a lack of policies. The organisation is awash with them and unsurprisingly there are 4 policies relevant to s7(2)(d) familiarisation visits:
- (i) **GRA 3.2** Firefighting Fires – In High Rise Buildings – Introduced Feb 2014.
 - (ii) **PN800**: Management of Operational Risk Information – details the risk assessment process that should be utilised in order to establish whether a premises requires visiting and describes the methodology for recording the data on the operational risk database (ORD).

- (iii) **PN 633:** Policy Note on high-rise firefighting – The specific information that crews are required to collect at high-rise premises is set out in PN633 as well as the procedure for search, rescue and firefighting operations at high-rise buildings.
- (iv) **Provision of Operational Risk Information System (PORIS)** – guidance for the management of operational risk.

Principles behind s7(2)(d) familiarisation visits

101. As well as the information gleaned from these visits providing immediate data for operational firefighting, s7(2)(d) visits allow the fire and rescue authority to obtain the information necessary to inform fundamental aspects of their planning process, contingency planning, evacuation and all aspects of the operational response.
102. Between 9th June 2006 and 21st September 2006 there was a “gap analysis” of the provisional guidelines set out by the CFOA Operations Working Group following its review of Generic Risk Assessment 3.2: Firefighting in High Rise Buildings and the high-rise policy at the time (Operational Note 193, Revision 2). The report observed in relation to s7(2)(d) visits:
- *“There are various building layouts and design and that there is a potential of significant risk in the event of a serious fire. Effective pre-planning and ‘operational intelligence’ have a significant effect on successful operations.”*
 - Operational personnel with ‘high rise buildings’ should be familiar with the guidance contained in ‘GRA 3.2 Fighting Fires – in High Rise Buildings’ and high-rise procedures’.
 - That the policy made no mention of the importance of the Ops Information Folder or the need for essential information to be exchanged between LFB directorates.
103. The groundwork was laid, the issues were clear, what was now required were the objectives and aims. A seminal tragedy provided the perfect opportunity for the LFB to identify, review and modify its policy, training and practice. That tragedy was the Lakanal House Fire.

Lakanal and Beyond.

104. It was repeatedly said that in the wake of the Lakanal House Fire, lessons would be learnt. It is a phrase so often used (and abused) after tragedies and disasters, that its meaning has become diminished and treated with often justifiable skepticism. It is a phrase that is very easy to utter in the aftermath of a disaster, when the public gaze is still bright and handwringing and platitudes are plentiful. It is a phrase which sadly history has often shown to be hollow. Far from being learnt, lessons are ignored, disregarded and failings ultimately repeated. However, we must cling to the belief that it does not have to be that way. Our families want to see proper reflection and a recognition that improvements and changes are needed. If organisations and individuals actually understand their own history and take that forward with a bold and resolute mindset, change can be affected. As the writer Maya Angelou astutely noted: *"History, despite its wrenching pain, cannot be unlived, but if faced with courage, need not be lived again."*

105. Following the Lakanal fire there were myriad reports, working groups and policy initiatives. Perhaps the following highlight the momentum that Lakanal generated:

(i) DAC Kevin Hughes produced a report comparing GRA 3.2 (2008 version) to the London Fire Brigade Policy 633 (published in Nov 2008). This report was discussed at the Lakanal Board meeting on 7th January 2010: High Rise Firefighting. The report noted:

- that the GRA guidance is more detailed than Policy 633 and the LFB policy is less explicit on the development of contingency plans;
- the need to systemise the process of information-sharing between building owners to the LFB, as owners do not have a legal requirement to share information and, when they do, it is on an ad hoc basis;
- provision of a check-list for crews to use when attending other incidents;
- the expectation that *"if the RRO was being adhered to, LFB would expect fire risk assessments to be maintained for all these buildings and if a lift was not working it would not be an unreasonable expectation for the responsible person to notify the Fire Brigade"*;

- it is an unrealistic expectation of the GRA to have sufficient information on all building stock in London thus it may be better to produce a generic guidance on high rise buildings and the variety of layouts in order to familiarise crews with the features of these buildings.
- (ii) Operational News Issue 20 (November 2011), ran an article titled: **“High Rise Firefighting”**. Revisiting the topic of pre-planning, the article noted that any high-rise building should be subject to s7(2)(d) visits and during which: *“crews should be looking out for defects or modifications which may compromise the buildings inherent fire safety features. These checks should include damaged self-closing doors which would allow smoke travel, pipe runs not fire stopped and missing or damaged rising mains. Defects should be reported to borough management fire safety teams using form FSR-A020-a2b(rev 2)”*
- (iii) Policy 633, which was updated in 2012 set out the procedure for search, rescue and firefighting operations at high-rise buildings with Section 4 referring to gathering operational intelligence in accordance with PN800. Appendix 1 sets out a list of 22 specific items that operational crews must consider when they conduct s7(2)(d). Crucially, the list of items to be considered during a s7(2)(d) visit identifies **‘cladding systems’** as an example of **“building construction features”** which must be considered whereas PN633 is silent on cladding. However, PN633 does suggest considering the likelihood and impact of fire spread beyond the compartment of origin and any building features which may promote rapid/abnormal fire spread.
- (iv) The LFB Policy 800 which was introduced in 2012 set out the 5-stage process for gathering and managing operational risk information:
- Stage 1: Identification of premises that might potentially give rise to hazards and risks.
 - Stage 2: Initial site analysis.
 - Stage 3: Information gathering by a site visit.
 - Stage 4: Risk assessments – which requires a premises risk assessment (PRA).
 - Stage 5: Completing the Operational Risk Database (ORD)
- (v) Meanwhile, PORIS introduced a more sophisticated risk information management system, within which it was now necessary to collect and evaluate a greater range of information in order to carry out a more precise analysis of the level of risk, applying a set Risk Matrix to six specific risk groups (including firefighters).

The Inquiry expert Steve McGuirk has opined that the PORIS guidance effectively redefined the s7(2)(d) duty.

(vi) GRA3.2 was yet another policy document which referred to the collection of operational risk information under s7(2)(d) as a “**key control measure**” that underpins pre-planning for fires in high-rise buildings.

106. So far, so good. A flurry of activity emphasising and re-emphasising the importance of familiarisation visits and all that flows from them.

107. In response to the Lakanal recommendations, the Lakanal House Working Group sought to create an inspection regime targeted at high priority buildings. In 2013, DAC Tom George noted that there were 7,000 premises on the ORD and there should be more. In response Borough Commander Elwell provided a report specifically addressing how the s7(2)(d) process could be improved. Although DAC George and Brown found the report “interesting” they were looking for a prescriptive list. In 2014, DAC Brown created a list of the types of premises that were high priority, and high-rise residential buildings were on the list. However, this list was never incorporated into LFB Policy. In his witness statement [LFB00083884], at paragraph 74 DAC Tom George explained that he did not think *“that creating a highly prescriptive inspection regime targeted at high priority buildings that fall within a banding system would be achievable, in that it would be virtually impossible for crews to visit (and undertake a meaningful inspection) such a significant number of premises, especially for inner London stations.”*

108. However, this rather neatly illustrates a recurring theme: missed opportunities to implement meaningful change and rectify systemic failings. The systems were identified. The failings highlighted. Aims and objectives were announced. Reports and suggestions were produced. But at that final hurdle, the decision makers stumble and the necessary changes were ultimately not carried over the finishing line.

109. Policy documents and guidance are only as good as the training of personnel, the transferring of information into knowledge and the ability to implement this in practice.

110. These LFB policies, guidance and articles were in the LFB domain for over **5 years before** the Grenfell Fire. That makes the Phase 1 evidence from firefighters of all ranks, wherein they spoke of how the system of familiarisation visits had fallen into disrepute, and showed a complete dearth of knowledge and awareness of cladding fires, compartmentation breaches, contingency and evacuation planning; even more perplexing but inexcusable.

Grenfell Tower and Familiarisation Visits

111. Where a premises has been entered onto the ORD, station personnel are required to visit the premises and undertake a s7(2)(d) visit and ensure the information on the ORD is correct. The ORD is used to “record significant hazards/risks, including less obvious hazards and unique control measures in place as well as any particular tactical plans or command and control procedures required. All risk-critical information will be fed to the MDT and thus be available for the appliance commander and crews to access on route.”

112. Grenfell Tower was categorised as medium to low-risk, and was subject to s7(2)(d) visits once every three years. A number of s7(2)(d) familiarisation visits were conducted at Grenfell Tower but the evidence from Phase 1 operational firefighters makes it clear that the visits were superficial and failed to gather valuable information. The Phase 1 report has made findings: Vol 1 Ch33 para 33.11, Vol 4 Ch 27 para 27.25, Vol 4 Ch 27 para 27.28-29, Vol 2 Ch10 para 10.21/ Vol 4 Ch 27 para 27.30 and identified failings, made recommendations and foreshadowed the issues to be investigated in this module.

113. Our families need those questions answered and more:

- Why had the system of familiarisation visits been allowed to fall into disrepute? We use the word “allowed” on purpose, because had there been a political will and imperative on the part of the decision-makers and LFB management, this decline could have been averted and indeed reversed.

- Why was the training so poor? This is especially so in light of the fact that lack of training had been identified as early as the two reviews / gap analysis, and in the post-Lakanal soul searching period.
- Was the training model appropriate for an organisation such as the LFB?
- Considering the developments in construction techniques, materials and practices should s. 7 (2) (d) visits be conducted by suitably qualified professionals in addition to fire crews?
- Cladding fires were not some dark secret withheld from firefighters. The information was there to be read, digested and understood. Why were so few at the top aware of it, and why had this knowledge not trickled down the ranks?
- Why was there not closer liaison between the LFB and KCTMO?
- Why were crews not alert to the lack of information on the ORD, since this would have been a potential indicator that the visits were not being conducted correctly?
- Had the visits been carried out systematically and comprehensively by properly trained firefighters, collating the relevant information; would that have made a material difference to the outcomes?

The Future

114. Best practices. The LFB can and should learn from their counterparts around the country.

- West Yorkshire FRS use a thematic approach to s7(2)(d) visits, including a topic talk on specific issues commonly found in premises in that theme.
- Greater Manchester FRS use a nominated Operational Single Point of Contact who is responsible for ensuring information is collected and entered onto the appropriate risk database. They also require that each operational watch is provided with a nominated fire safety officer, whose role is to address any fire safety issues or enquiries that crews may have.

115. There are numerous branches of the LFB who carry out and should be carrying out tasks and operations which complement s.7 (2) (d) familiarisation visits. One obvious branch is the Home Fire Safety Visits, the purpose of which is two-fold:

providing advice and eliciting information. The LFB staff will identify where the risks occurring in the home lie and provide advice to the resident on how to reduce or eliminate them. They will test the smoke alarms or install smoke alarms where necessary.

(i) The LFB have 4 policies relevant to Home Fire Safety Visits:

1. PN 741: Home Fire Safety Visits – principles, referrals and visits.
2. PN 742: Home Fire Safety Visits – Grouped Risk – how P1 postcodes are identified.
3. PN 743: Home Fire Safety Visits – Individual Risk – how P1 individuals are identified.
4. PN 744: Home Fire Safety Visits – Carrying out the visit – explains the procedures for carrying out the visit and when a Serious Outstanding Risk referral needs to be made.

(ii) PN 741 states that LFB staff will:

- *“provide an appropriate and agreed plan for the resident’s escape and the escape of the others they live with, should an accidental fire occur in their home”*
- *“provide the resident with a personalised escape plan, tailored to their ability and to the circumstances of their environment.”*

(iii) Grenfell Tower was within a P1 postcode, and was subject to the following home fire safety visits from 2005 to the time of the fire:

- 26 March 2007
- 17 March 2008
- 19 March 2008
- 20 June 2013
- 13 August 2014
- 12-13 January 2016
- 2 February 2016
- 18 April 2016
- 10 June 2017

(v) The following individual home fire safety visits were also carried out:

- Maryam Adam – 6 August 2015 (web request)
- Joseph Daniels – 12 April 2016 (“SAP referral”)

No serious outstanding risks were identified as a result of any of the home fire safety visits over the 12-year period.

116. The valuable information here concerning PEEPs and individual residents obviously impacts upon incident command, operational firefighting evacuation planning and contingency planning. It is self-evident that this is information that those carrying out s.7(2) (d) visits would and should factor into their findings and investigations.

COMMUNICATIONS FAILURES

“Silence is golden when it’s called for. Silence can be deadly when it’s not called for”

— Meryl Runion

117. So, this Inquiry may well ask the important question as a starting position, well, what is indisputable? It is this, that the capital’s fire service, which should have been a world leader in firefighting given the UK’s resources, encounters a situation at Grenfell which was not remarkable to its personnel – where its own firefighters could not speak with one another during a critical lifesaving operation.

118. It is known that on that fateful night of the Grenfell fire, communication within the LFB broke down. The ability of firefighters to speak to each other, the bridgehead and/or the Incident Commander was severely compromised. In the 21st Century vital information from FSG calls was left to paper notes being passed by runners to the Bridgehead. Numerous firefighters complained about their radio system not working. Firefighter Ricky Nuttall said that “all radio communications were an absolute nightmare” {MET00012561}. There were issues with the fitting of radios, which led some firefighters to rely on partners’ radios to work. There seemed to be no pairing of firefighters with those of who had a radio fitted for the BA systems.

119. Former Commissioner Dany Cotton recognised in Phase 1 that firefighters had problems with the Breathing Apparatus Radio Interface Equipment ("BARIE") on the night of the fire, resulting in multiple occasions where communication was lost. The FSG system collapsed, unable to cope with the volume of data, and still reliant even at senior levels on paper and white boards. At the Bridgehead, a wall was utilised for the calls. As the fire took hold communications were totally overwhelmed. The telephone operators were unable to process FSG calls in a timely manner and to ensure that the proper advice was given in respect of the stay put policy when this changed. At times the majority of communications system failed, and firefighters resorted to pen and paper or the information was not passed at all. In the modern world with all the technology that was potentially available to a modern firefighting authority in a great metropolis in one of the wealthiest boroughs in the UK not only is this unbelievable, it is totally unacceptable. Communication failures at Grenfell Tower occurred from the very start of the incident to the very end.

120. A common issue identified was that the firefighters tasked with rescue to a particular flat would encounter a casualty in the stairwell en route and assist that casualty to safety. The inability to communicate with the bridgehead meant that another crew would not be dispatched to the original flat until the previous team had arrived back at the Bridgehead. This caused considerable delay, and in many cases FSG calls were not actioned repeatedly.

121. The Inquiry's Phase 1 Report noted:

"Given the inevitably chaotic circumstances, the unreliability of communications between the bridgehead and firefighters and the absence of instantly available replacement crews, the consequence of the strategy pursued by successive incident commanders was that occupants who might have been rescued were not.... The difficulties with communications significantly limited the efficiency of search and rescue operations inside the tower " {phase 1 report Vol IV, 28.111-130}

122. We respectfully agree.

123. We also agree with Professor Johnson that the failure of communication on the night of the fire:

- 1) Placed the lives of residents at risk; it became increasingly hard to sustain the 'stay put' policy when vital information from FSG calls could not be passed onto the BA teams already committed within the Tower. Residents' lives were also placed at risk by the undermined mutual situation awareness both of the firefighters in the building and of senior personnel directing operations; which made it hard to ensure that sufficient resources were deployed in time to prevent loss of life.
- 2) Potentially placed the lives of firefighters at risk. On the night of the fire, it was difficult to know if the loss of communications from teams relying on BARIE sets was the result of signal loss, network congestion or injury to those firefighters.

124. Professor Johnson {CWJ00000119_0018} comments on the issues that are caused by low powered radios which (2.5.9) lead to "widespread and sustained loss of situation awareness"⁵².

125. The issues also include:

- i. Confusion.
- ii. Incomplete communications.
- iii. Panic and fear.
- iv. Loss of organisational control.
- v. Lack of feedback from the fire scene to Control; and
- vi. Wasted time.

126. The failure in communication on the night of the fire was not unforeseeable. Once again, there was policy that reflected the importance of communication, but this was not translated into effective training and resourcing. LFB Policy 488 on Incident Communications says that "effective communications are the key to success. A reliable communications network is essential for safe operation at incidents and fundamental for securing the level of command required to manage operational

⁵² The lack of effective fireground communications on the night of the Grenfell Tower fire undermined mutual 'situation awareness': "Situational awareness is one of the overriding factors associated with understanding the operational environment, decision making, and operations command and control during periods where large amounts of information are needed and are critical to the successful outcome of a task. Endsley defined situational awareness as follows: 'the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future' (Endsley 1988). In simpler terms, situational awareness refers to the degree of accuracy by which one's perception of his current environment mirrors reality (Naval Aviation Schools Command 2004)... " {_0033}

resources effectively” {CWJ00000119_0029}. With such an unequivocal policy, serious questions need to be asked about how the LFB found itself in such an underequipped and vulnerable position on the night of the fire.

127. Following the terror attack in London on 7th July 2005, in which failed radio equipment was a significant hindrance to the rescue mission, a report was produced which recommended that:

The Metropolitan Police Service, London Fire Brigade and London Ambulance Service provide us with an update on the rollout of digital radio systems within their services in November 2006, May 2007 and November 2007, so that we can monitor progress towards full implementation of TETRA based radio communications across London's emergency services.

We would draw this recommendation, and others aimed at the London Fire Brigade and Metropolitan Police Service respectively, to the attention of the London Fire and Emergency Planning Authority and the Metropolitan Police Authority.⁵³

128. Only the MPS and LAS updated their radios for the majority of their staff.

129. The issue of failed radios at serious incidents also featured in the rescue response following the attacks on New York on 11th September 2001. Radios used by the New York Fire Department, Port Authority Police and New York Police Department during the rescue effort, were similar in description to the radios used by the London Fire Brigade at Grenfell. The rescue effort on 9/11 was hampered by the inability of its radios to function properly.⁵⁴ The failings at both of these incidents should have, but clearly did not, give the LFB pause for thought. There was an opportunity for reflection and a chance to remedy what was foretold.

130. In this regard, the Phase 1 Report noted:

"It is equally plain that it was well known⁵⁵ within the LFB that BARIE sets performed badly in concrete high-rise buildings. Given that knowledge, greater efforts should have been made to establish and maintain effective communications inside the tower on the night."(Phase 1 report Volume IV 28.131).

⁵³ https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/archives/assembly-reports-7july-report.pdf

⁵⁴ <https://fas.org/irp/offdocs/911comm-sec9.pdf>

⁵⁵ "LFB staff were aware that propagation issues affected the use of BARIE sets in high-rise concrete buildings; concerns were raised by • the HSE after the Shirley Tower fire; • the Coroner's recommendations after the Lakanal House fire; • the Local Government Association's 2015 Fire Peer Challenge • and by a CLG incident ground communications study" Professor Johnson {CWJ00000119_0019}.

131. General Risk Assessment 3.2 sets out the operational guidance in place at the time. This guidance provided for contingency planning in the event that communication went down.

132. The guidance material identifies at Page 7 that:

“High rise incidents may create difficulties with lines of communication and radio reception.

The scene of operations may be a considerable distance from the access level and point of command. Building construction may cause radio reception ‘blind spots’ and affect radio based breathing apparatus telemetry systems.”

133. At page 31 that:

“Where appropriate and available, the Incident Commander must consider the use of alternative radio channels to manage the volume of radio traffic. Where there are communication difficulties, specialist equipment, such as a leaky feeder radio cable, Airwave radios or repeater equipment, can be used and the Incident Commander should also consider the use of internal or mobile telephones, public address systems or loudhailers to communicate with building occupants.

When radio communications with any team committed to the incident are lost, it must not automatically be assumed that any loss of communications is associated with transmission difficulties caused by the building. Every effort should be made to re-establish communications as quickly as possible.

If there is an unexpected or sustained loss of radio communications, an assessment of risk should be undertaken to consider whether breathing apparatus emergency procedures should be initiated and emergency teams deployed. Factors such as significant deterioration of circumstances should inform this risk assessment and communication with any nearby teams may also assist.”

134. Despite these warnings, there appears to be little or no initial and or continuation training for the operation of radios. There appears to be no policy, procedure or training to mitigate the loss of radio communications on the fire ground other than a leaky feeder policy.

Extending the signal

135. During the fire and in order to attempt to boost the radio signal “leaky feeder units” were deployed. Marcus Johnson, Matthew Cook and Andrew O’Loughlin refer to bringing sets into Grenfell Tower to assist with extending the range of the telemetry⁵⁶. Although Andrew O’Loughlin records the deployment of a leaky feeder, he comments that it did not improve the radio either inside or outside.

136. In the post-fire review the LFB’s view was that: “the requirement to deploy the Brigade’s radio repeater and leaky feeder capability probably wasn’t required at this incident as the radio communication issues experienced at the Grenfell Tower fire were primarily caused by the sheer volume of radio traffic being generated”.⁵⁷

137. Airwave radios can operate on a Direct Method of Operation and use a talk-through, which means as long as you can reach another radio, they can form a chain to allow the radios to communicate to the far end. No airwave appears to have been deployed into the Tower.

Mobile phones

138. There is no evidence that LFB issue mobile phones were used within the Tower. Although Marcio Gomes⁵⁸ describes the mobile signal as significantly degraded post-renovation, such that he was unable to communicate without moving towards the windows when using a mobile phone, we do know that during the fire he was able to speak to Control on his mobile phone as he went down the staircases from floor to floor with his family.

139. Mobile phones work in a different way and have about the same power as the radios the firefighters were using. However, at the far end there is a filter, which allows a poor signal to be usable. The base station is transmitting at 100w. The same is for the Airwave (main radio) not used on the fire ground. The BA crews have very

⁵⁶ {MET00010921}, {MET00005528}, {MET00005213}

⁵⁷ Grenfell Tower Fire Preliminary Report ([london-fire.gov.uk](https://www.london-fire.gov.uk)) at page 82

⁵⁸ {IWS00001078_0011} §57

low power (1w) radios to allow them to be intrinsically safe as well as their handhelds at (5w) with no base station.

140. Professor Johnson commented regarding the Grenfell Tower itself that:

“The structure of the building is also likely to have limited signal propagation. This, in turn, added to congestion and interference once teams came back within range, because they then competed for the available bandwidth to pass on information that could not be communicated when they were higher in the building.”⁵⁹

141. The LFB carried out its own radio tests after the fire, although noting that “when these tests were undertaken the fabric of the building was substantially altered from the night of the fire”⁶⁰.

142. Adam Tear – a solicitor at Howe and Co. with particular experience of communications – conducted basic mobile telephone signal mapping on his visit to the Tower. He found that at the bridgehead there was an actual loss of mobile phone signal, which may be to do with its particular location next to the lifts. The floor set up was very different to the floors above, there was therefore a larger amount of concrete it appears between the Bridgehead and the first floor than there would have been between the fourth and fifth floor.

143. All of the glass was removed from the lower floors, and there was a lot of scaffolding in place which meant that it was almost impossible to get an accurate picture and some floors had lost walls which again may have distorted the results. The signal strength measured in decibels by Mr Tear, for mobile phones, varied as follows:

Floor	Decibels	Signal Strength
2 nd	120	No signal
3 rd	119	No workable signal
4 th	112	Very poor

⁵⁹ {CWJ00000119_0019}

⁶⁰ [Grenfell Tower Fire Preliminary Report \(london-fire.gov.uk\)](https://www.london-fire.gov.uk/grenfell-tower-fire-preliminary-report/) at page 80

5 th	115	Very poor
8 th	109	Poor
13 th	87	Good
14 th	100	Poor
16 th	100	Poor
18 th	88	Good
19 th	100	Poor
20 th	98	Average
21 st	95	Average

144. Outside at the base of the tower the signal was around -95 an average strength.
As a guide the readings above would appear on a mobile phone as:

- **-50 to -79 dBm**, generally considered as a very good signal (**4 to 5 bars**).
- **-80 to -89 dBm**, generally considered good signal (**3 to 4 bars**).
- **-90 to -99 dBm**, generally considered average signal (**2 to 3 bars**).
- **-100 to -109 dBm**, generally considered poor signal (**1 to 2 bars**).
- **-110 to -120 dBm**, generally considered very poor signal (**0 to 1 bar**).

On the night of the fire

145. Radios used by the firefighters on the night of the fire operated on the UHF frequency, which is heavily affected once radios move out of line of sight. This means that, the greater the obstructions between the transmitting and receiving stations, the less signal can arrive at the receiving station.

146. It seems impossible to avoid the conclusion that cost saving/cutting influenced the LFB's decision not to upgrade its communication equipment earlier. In Phase 1, Ricky Nuttall said: *"I know there's better equipment out there and I understand it's all about cost but in this situation cost shouldn't come into it."*⁶¹

⁶¹ MET00012561

147. Radios used on the night of the fire were operated on simplex, and so only one person could talk at a time. This means that even if a firefighter is communicating a relatively routine message (so long as this is more powerful) this will block the communication from another firefighter on the same channel and or cut out that call. The person with the strongest signal will generally be the person closest or with least obstructions.
148. The radios acted on one Channel at a time, so a commander on Channel 1 would not hear an FSG on Channel 3, nor the BA crews on Channel 6.
149. There were issues with the radio fit, including loss of air when transmitting, and losing the earpiece and not being able to refit this afterwards.
150. Not all firefighters on the night had a radio fitted and therefore paired firefighters had to rely upon their colleague in order to communicate. It is unclear if any attempt was made at the Bridgehead to check who had what, and if there was any “radio check” prior to deployment from the Bridgehead.
151. Radio communications were not controlled by a central station such as the Bridgehead and so there was no management of the volume of traffic by managing the calls nor was there a limit on routine traffic in order to prioritise life and death messages. This potentially meant messages were lost and never received.
152. No Airwave⁶² technology appears to have been deployed into the Tower. Airwave sets were used by senior commanders, but these could not connect with the radio sets used by the firefighters on the fire ground. There appears to be no radio operator assigned to monitor this radio for the fire ground.
153. No LFB service issue mobile phones with priority sim cards (i.e., taking priority over civilian users) were issued to firefighters within the Tower and such a system was not activated.

⁶² “Delays in the replacement of Airwave have left LFB staff dependent on what is a legacy communications infrastructure that is not well integrated with more recent digital information sources” {CWJ00000119_0026}.

154. The Inquiry will need to investigate whether the LFB has a culture of 'making do' with existing technology, as Professor Johnson argued in his expert report. Professor Johnson argued that the LFB has a culture of 'making do' with legacy information technologies that increased risks to the public and to their staff during the Grenfell Tower fire. Johnson queries why so many procurement activities have stalled, making firefighters rely on obsolete technologies over prolonged timescales. We suggest that this is another example of poorly managed outsourcing and pressures from sustained budget cuts.

155. Many innovative proposals from LFB staff were dismissed, including but not limited to the failure to add text messaging to Airwave; the failure to integrate multimedia input (e.g. from mobile telephones onto Mobile Data Terminals ('MDTs')); and the failure of LFB to integrate/link with the MPS/LAS CAD system.

156. Professor Johnson does not offer a definitive remedy for the widespread failures and technological shortcomings of the equipment employed by the LFB. It is clear that the state of the LFB's communications manifest at the time of the fire was inadequate and ineffectual. It is equally clear that there are technological solutions to the endemic safety critical problem of signal attenuation. Large buildings should be surveyed and bespoke solutions developed, tested and proved in real time. There is no technological reason why with the appropriate distribution of communications equipment and leaky feeders strategically cited around a building that communication within a building should not be practicable.

157. The LFB did not have an adequate contingency or resilience procedure that anticipated communication failure. Nor did they have a procedure on how to reinstate communications. Given that the LFB will have known about these issues before the Grenfell fire, this level of unpreparedness is unacceptable. One would have anticipated on a basic risk-assessment basis that there should have been a procedure in place addressing how to reinstate communications once they were lost. We invite the Inquiry to consider:

- a) What form should such a procedure should take.
- b) Whether there was a lack of rigour associated with the s.7(2)(d) visits covering

communication assessment.

- c) Whether the assessment of a FRSs' communications resilience should be an integral part of s. 7(2)(d) visits.
- d) Whether there should be regular assessment of built-up area buildings by expert/trained firefighters to consider communications within their area of responsibility.
- e) Whether planning applications should be considered, prior to approval, by expert firefighters trained to report on communications black spots prior to approval.

158. Johnson argues that cultural change is needed to overcome organisational barriers to innovation. This cultural change should extend beyond the procurement of individual fireground communications to the adoption of a systemic approach where organisational attitudes, technical innovation and individual behaviours are based around the aspiration to become a world leading Fire and Rescue Service.

EVACUATION

159. Following Mr Kebede's 999 call at 00:54:29 the Control room received the first 999 call from a resident inside the tower, at 01:21:24, to whom stay put advice was given. The call was from Naomi Li in flat 195 on the 22nd floor who reported that she could smell smoke but that there was no smoke coming into her flat. CRO Adams told her that the fire brigade was in attendance that that she should stay in her flat and call back if the situation changed.⁶³ By then the control room had received other calls from outside the tower who were told that the brigade was in attendance.

160. Between 1:24 and 01:30, the control room had received 20 calls from people trapped inside Grenfell tower. By 01:30 there was significant external fire spread and it should have been patently clear to the command and firefighters on the incident ground that Grenfell Tower was a failing building and that a stay put advice was not tenable. A dynamic risk assessment of the unfolding circumstances ought to have resulted in a decision at that stage that it was necessary to evacuate the entire

⁶³ Phase 1 Report page 370

building. Between 01:15 and 01:29:59 77 people had self-evacuated, which demonstrated that the stairs had capacity for a total evacuation.⁶⁴

161. The control room had received a high volume of calls from people inside the tower reporting the effects of heat and smoke within their flats, some of which had multiple occupants, between 01:21:24 and 02:35.

162. Notwithstanding the blindingly obvious, the LFB defended the “stay put” strategy in the face of an obviously failing building. It is of note that the revocation of the stay put advice was from the control room⁶⁵ and not the incident ground, although Commissioner Andy Roe (then DAC) made the call minutes after assuming the role of Incident Commander at 02:43, saying that it was “absolutely unsustainable” by then. The fate of those who died was however already sealed.

163. Critically, the LFB failed to identify that an external fire had breached compartmentation – one of the fundamental assumptions backing a stay put strategy. The LFB’s response to the fire and crucially the maintenance of stay put demonstrated an inadequate operational command structure.

164. Deviation from stay put should have been a live consideration and at the forefront of the command’s risk assessment and high-rise firefighting strategy. GRA3.2 specifies that high-rise firefighting training must include:

“evacuation and casualty removal tactics. Incident Commanders should understand when a partial or full evacuation strategy might become necessary in a residential high rise building where a “stay put” policy is normally in place”.

165. The Inquiry’s Phase 1 report concluded that an effective evacuation of Grenfell Tower would have necessitated informing occupants to leave with the assistance of fire-fighters and deploying fire fighters to inform occupants that they must leave and to assist them in doing so, however there was neither policy, training or a recognised method for carrying out an evacuation. Accordingly recommending, inter alia, that there be national guidelines for carrying out partial or total evacuations

⁶⁴ Phase 1 report page 1429 & BLAS0000019 19.6.71

⁶⁵ DAC Fenton and SOM Smith said the decision to revoke the stay put advice was made on the basis of the nature of the length of the FSG calls, the limited information they had received from the incident ground that crew could not get above floor 15 and SOM’s experience of Lakanal House Fire. [Phase 1 Report page 1608]

of high-rise buildings and that fire and rescue services develop policies for partial and total evacuation of high-rise residential buildings and training in support.

166. Our clients have welcomed this recommendation and would invite the Inquiry to direct further position statements from the LFB as to the measures taken in response to the Inquiry's Phase 1 recommendations. In particular, our clients would wish to know what steps have been taken to implement evacuation strategies.

167. Our clients have pressing questions as to the rationale for a disparity of high-rise firefighting strategies and training across Fire Safety and Rescue Services.

168. Kent Fire and Rescue Service's approach to high-rise fire firefighting is markedly different from the LFB, the former having developed decision-making tools and training around an awareness of "rescue and evacuation" strategies.

169. RICE, (Rescue Intervention, Containment, Evacuation) mnemonic was developed in January 2011 by 3 members of the Kent FRS High Rise Task Force including Dr Paul Grimwood.⁶⁶ Firefighters are trained to recognise a "failing building" where an emergency evacuation is required because of the progression of fire growth beyond to the capability of internal firefighting capabilities provided or the available resources on-scene or the construction itself or associated signs of building systems failure.

170. Dr Grimwood has emphasised that RICE is a command decision making tool, primarily used to alleviate command stress and prompt a predetermined rapid analytical thought-process, where local or total building evacuation may be given earlier consideration (prior to firefighting intervention). The model can be applied to all multi-storey building types covering a variable range of occupancies and is not specific to just very tall buildings.⁶⁷

171. The evacuation component of RICE recognises the need to have a clear stairway to enable occupants to leave a building at any point in relatively safe conditions. It also recognises the need to balance a decision to evacuate a corridor,

⁶⁶ RICE was a development of "ICE" (Intervention, Containment and Evacuation)

⁶⁷ KFR00000040_0005

floor, stairwell or total building against the risk of leaving them in situ whilst firefighting is undertaken where the “stay put” advice is in place. Consideration is given to delaying firefighting advice whilst evacuation of that area or zone is evacuated.

172. Unlike the LFB, Kent’s FRS envisages the probability of the need to reverse stay put and the concept of stairwell protection, which is a feature of Kent FRS, high-rise firefighting strategy focuses on securing and maintaining vertical egress routes during firefighting operations so that residents are able to leave at any point if they feel unsafe. This natural decanting of occupants goes some way to assisting any later reversal of a stay put strategy placed on the building by the responsible person(s). This also facilitates/enables total evacuation of a building to be undertaken, with constant efforts directed at protecting at least one vertical access and egress route.⁶⁸

173. The RICE model and Kents FRS’s evacuation and rescue approach to high-rise firefighting was known to the LFB and Dr Grimwood was involved in discussions with DAC Peter Cowup of the LFB in September 2011 as part of discussions around updating GRA 3.2. Questions around these discussions will be properly put to Dr Grimwood in this module and will invariably be picked up with Peter Cowup in the LFB section on Module 6.

174. The obvious questions which arise are:

- Was Kent FRS’s approach to evacuation and dynamic risk assessment, where a stay put strategy is in place, shared with the LFB?
- Why wasn’t RICE / similar decision-making model incorporated into the LFB’s decision making tool for high-rise firefighting strategy?
- Should the RICE / similar decision-making tool and training packages be adopted by the LFB?
- Should a national policy/ framework mirror the RICE / similar decision-making tool?

⁶⁸ KFR00000040_0008

175. The looming question, must of course be whether and the extent to which, political directives and factors other than safety guided the LFB's strategy.

CONCLUSION

“Hindsight should not be used to excuse that which was reasonably foreseeable all along.”
(Anonymous)

176. Conan Doyle once said “It is easy to be wise after the event” but this quote has absolutely no place or no applicability here because this is not a case of critics being wise in hindsight. The LFB should have been much wiser before the Grenfell fire. But this organisation chose to be otherwise. We state clearly and unequivocally that, in this case, accordingly, this Inquiry should not allow the concept of Hindsight to be used to excuse that which was reasonably foreseeable all along.

177. Grenfell was avoidable.

178. The overall message from Module 5 is that there were failures at every level, unforgivable or inexcusable failures or mistakes. For example:

- Why the Coroner's recommendations following Lakanal House, which were clear and robust, were not followed?
- Why the LFB failed to follow its own policies?
- Why there were inadequate familiarisation visits and the statutory guidance under s.7(2)(d) was ignored?
- Why essential communication failed? Why the technology was inadequate?
- When it was known by the firefighters command that they were dealing with extensive fire spread in a failing building, why was there not a reset and the building evacuated in accordance with policy and guidelines.
- Why did the LFB fail to challenge its training providers on the adequacy of the course material?
- Why did the training not properly equip the firefighters with the skills they required?

179. What were the underlying causes of these failures; was it arrogance, a fixed mind-set, a culture of just making do, incompetence, the effect of austerity or a combination of some or all the above which created a toxic and deadly mixture which made Grenfell a predictable and deadly incident which would inevitably happen?
180. The sad thing is, the Grenfell tragedy was not inevitable. The course of this incident could have been changed and so many lives were needlessly lost.
181. It is important that this Inquiry stresses that, following this tragedy, lessons will be learnt and heeded this time around.

Leslie Thomas QC
Sam Stein QC (Communications Failures)
Allison Munroe QC
Thalia Maragh
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