GRENFELL TOWER INQUIRY

MODULE 5 & 6A CLOSING WRITTEN STATEMENT ON BEHALF OF BSR REPRESENTED BY BHATT MURPHY, BINDMANS, HICKMAN & ROSE AND HODGE JONES & ALLEN SOLICITORS

PART I: INTRODUCTION

[A.] SIX UNCONTESTED FAILURES

1.1. The difficult truth remains that the London Fire Brigade ('LFB') was brave at Grenfell Tower, but it failed in fundamental respects that contributed to loss of life and revealed serious shortcomings in the quality of its service. Those failures were (1) firefighter ignorance of catastrophic construction risks known to the organisation, (2) incompetency in premises risk assessments, (3) weaknesses of incident command management, (4) absence of developed high rise residential evacuation doctrine and practice, (5) tolerance of inadequate fire ground communications, and (6) incapacity of the Control room to cope with a complex incident. All of these failures were foreshadowed by the Lakanal House fire in 2009, and the long standing arrested development of organisational learning and modernisation that should have taken place in the UK Fire and Rescue Services ('FRS') before the Grenfell Tower fire, but did not. No witness to the Inquiry has seriously denied that these deficiencies were preventable failures, but several witnesses have found it hard to explain why they were allowed to occur.

[B.] UNDERLYING CAUSES

1.2. The lack of consensus within FRSs and government about the underlying causes of the LFB failures at Grenfell Tower, and why they persist, makes it all the more essential for the Inquiry to endeavour to report on and make recommendations about them. Those deeper causes concern (1) governance, (2) culture, (3) education, (4) health and safety compliance, and (5) accountability. The lack of sufficient accountability, by way of external oversight and investigation, for over a decade before the fire is a fault that lies with successive governments, but particularly the Conservative-led governments after 2010. Central government combined policies of deregulation, localism and austerity without sufficiently appreciating the lack of resilience within UK FRS to meet the known risk of tall building construction catastrophe. The remaining part of Module 6 must consider that aspect of state responsibility for the LFB's shortcomings.

1.3. This statement considers the deeper features of the failures of the LFB [**PART II**] and their underlying organisational explanation [**PART III**]. [1]

[1] For potential failure in the use of water, see Team 1 M5 Supplemental Opening Statement {BSR00000080} and for role of Central Government, the Inquiry has indicated that these submissions can be supplemented at the end of Module 6 part 2.

PART II: FAILURES

[A.] CATASTROPHIC CONSTRUCTION RISK

2.1. OVERVIEW: The failure to transfer information about the catastrophic risk of cladding fires both across and down the organisation, when that information was known about in isolated parts of the LFB, is the foundational failure upon which all others ultimately rest. Had the issue been collectively acknowledged across all LFB departments then it would have acted as a drive to deal with the other related faults. This foremost contribution of the LFB to the Grenfell Tower disaster involves a classic system error of failure to collectively take into account reasonably obtainable information. The failure was vertical in terms of not informing and educating station personnel, but it was also horizontal in terms of management not acknowledging the issue as a joint responsibility across its various service directorates.

2.2. RISKS OF MODERN CONSTRUCTION METHODS: Since the turn of the century, fire related guidance and policy has recognised that features of façade building design, including its constituent materials, could facilitate rapid external fire spread: in other words, a cladding fire. The risk was identified by the Parliamentary Select Committee in 1999,[2] the second edition of BR135 in 2003,[3] the GRA 3.2 national risk assessments of 2008[4] and 2014,[5] the Local Government Association ('LGA') Guide of 2011,[6] the DCLG PORIS Guidance of 2012[7] and the National Operational Guidance ('NOG') on Fires in the Built Environment of 2014.[8]

2.3. CORPORATE KNOWLEDGE: Not surprisingly therefore in March 2010 the LFB submitted to the Greater London Assembly, a study of tall and timber framed buildings that warned of "*new Innovative Construction Products and Techniques (ICPT)... probably most prevalent in the residential sector*", including increasing use of polymeric materials that "*can provide a route for fire to spread by bypassing cavity barriers or fire stopping*

---

[2] {LFB00032774/2-4 §§5, 10, 13 and 18-19}, Oral Evidence {CLG00019484 §§7, 32, 36}, Written Evidence {CLG00019484/5 §1.1 and §2.1}
[3] BR 135 2nd Edition {CLG00019023/9}, Martin {CLG00019469/35 §105}
[4] *GRA 3.2 High Rise Firefighting* (September 2008) {LFB00089157/8}
[5] *GRA 3.2 Fighting fires - In high rise buildings* (February 2014) {LFB00001255/18-19}
[6] LGA *Fire safety in purpose-built blocks of flats* (2011) ('LGA Guide') {LFB00118893/111 §72}
[7] DCLG and CFRA *Fire and Rescue Service, Operational Guidance, Operational Risk Information* ('PORIS') (2012) {LFB00091784/85}
[8] {LFB00024174/25 and 27}

measures". This issue was said to be relevant to external walls and cladding systems.[9] By that stage, at least, the Inquiry should conclude that the LFB's Fire Safety Department and, indeed, other senior officers in the LFB were aware of (a) the fire risks associated with insulated panel systems and cladding systems in the modern built environment, and (b) the operational risk not only of potential rapid and unusual fire spread but also of station officers being unaware of that when attending an incident.[10]

2.4. LAKANAL HOUSE: The legacy of the Lakanal House fire in July 2009, which led to the death of six residents, ought to have brought about a transformation of firefighting competency in relation to cladding construction risks, but it failed to do so.[11] The coronial recommendations issued at the conclusion of the inquest in March 2013 advised the Secretary of State to ensure that his Department review Requirement B4 of Approved Document B ('ADB') to the Building Regulations ('BR') "*with particular regard to the spread of fire over the external envelope of the building and the circumstances in which attention should be paid to whether proposed work might reduce existing fire protection*".[12] In a separate letter the Commissioner of the LFB was recommended to ensure that incident commanders in particular were given enhanced training "*to anticipate that a fire might behave in a manner inconsistent with the compartmentation principle*".[13] These two points, singularly and jointly, capture the foreseeability of catastrophic risk, which the LFB did not sufficiently institutionalise within its ranks in the years before Grenfell Tower.

2.5. COMMUNICATIONS WITH GOVERNMENT: Prior to the coronial recommendations, Commissioner Dobson wrote twice to DCLG about matters relating to external fire spread aggravated by non-compliant wall panels. In December 2009, he informed Sir Ken Knight, the Government's Chief Fire Rescue Adviser ('CFRA'), that external wall panels were a cause of rapid and abnormal fire spread at Lakanal House. As the panels in question were available from more than one supplier, he recommended that local authorities be advised of the point as there was a risk of repetition.[14] In December 2012, the Commissioner wrote to Brandon Lewis, Minister for Fire Services, recommending as a result of the further

---

[9] {LFB00108144/7 §§28-30}
[10] Dexter {T179/3/25-4/20}
[11] For recognition that it ought to have been a seminal organisation event for the organisation and was treated as such, see Dobson {LFB00032157/4 §11} {T210/73/1-74/22} {T210/79/3-9}, Cotton {T208/23/16-24/22}, Reason {T181/36/18-37/9}
[12] Kirkham-Pickles (28 March 2013) {HOM00045865/3}
[13] Kirkham-Dobson (28 March 2013) {LFB00032158/3} (i.e. the so-called 'Rule 43' letter)
[14] Dobson-Knight (14 December 2009) {LFB00104291/2}: see further Dobson {T210/122/20-123/11}

Brigade learning from the Lakanal House fire that additional guidance be given in relation to Requirement B4 of ADB, "*particularly with regards to the spread of fire over the external envelope of the building*", and not least because "*such a fire, particularly in tall buildings, has the potential to affect multiply* [sic] *storeys simultaneously, thus making firefighting more difficult*".[15] The Commissioner's correspondence with Government shows outward facing emphasis on weakness in the regulatory framework, but it was never accompanied by sufficient action to ensure transfer of that knowledge about cladding system fires internally within the organisation.[16] The Commissioner should have realised this was essential, not least because he believed that the government at the time would be politically reluctant to facilitate change,[17] and accepted, as any emergency service must, that the LFB still had responsibility for addressing the issues on the ground.[18]

2.6. KNOWLEDGE TRANSFER: Merely to recognise external cladding as a construction risk – with its range of implications for other fire protections in a high rise building – was not enough. There had to be an effective transfer of knowledge of the risk from the LFB's fire safety specialists to station based firefighters.[19] It was the latter who needed to be sufficiently competent to conduct both premises risk assessment to prevent or prepare for fire and dynamic risk assessment during the course of emergency operational response.[20] In its own investigation of Lakanal House, the LFB had identified that fire could rapidly and unusually spread downwards and laterally across the external face of a building. The Lakanal House Coroner was informed by the LFB that its personnel were already learning about such matters,[21] but this learning did not happen. Although from 2011 onwards the various editions of the LFB high rise policy PN633 did required firefighters visiting premises to ensure familiarity with any building construction features that could potentially promote rapid abnormal fire spread,[22] it is clear that they were not informed of the construction features to look for. Correspondingly, incident commanders and other

[15] Dobson-Lewis (11 December 2012) {LFB00032154/1 and 6}
[16] Dobson {T211/6/12-7/13} (for acceptance of the point during his evidence)
[17] Dobson {T210/150/25-152/10}
[18] Dobson {T211/4/16-24}, Dexter {T179/80/16-18}: see Dobson's regret for not pushing the matter further with Government {T212/62/4-18}
[19] Cotton {T209/219/13-220/12} {T210/21/16-23/3} {T210/41/21-24}, Roe {T212/158/1-10}, Dexter {T179/39/22-43/13}
[20] Circular 18/2009 {HOM00023213/5 §4.2}, Dobson {T210/112/3-113/25}
[21] Kirkham-Dobson (28 March 2013) {LFB00032158/2}
[22] PN633 (2011) Appendix 1 {LFB00102306/15} reproduced in PN633 (2014) {LFB00102305/13} and PN633 (2015) {LFB00001256/19}

operational responders were not educated in cladding fires as a known hazard that could pose profound risk to tall buildings.

2.7. FAILURE TO EDUCATE: The failure to educate, or inform, on the issue is truly extraordinary. Neither the Lakanal Case Study, nor the various incident command exercises produced as part of the Lakanal House Action Plan, ever prepared operational firefighters to know about, let alone effectively respond to, a rapid external fire spread or extensive breach of compartmentation.[23] GRA 3.2 (2014) assumed in terms that training and competency would develop "*knowledge, skills and understanding for firefighters on the impact of fire on the building's construction*" and "*recognition of the signs and symptoms of...risk of rapid and unpredictable fire spread and the adoption of appropriate tactics to mitigate these*".[24] There was then no training on the 2015 amended version of PN633.[25] In fact, the standard high rise training content dated back to 2011.[26] The LFB failure to educate its station based firefighters is all the more inexcusable because, in the two years before the Grenfell Tower fire, the Fire Safety Department trained itself about the risk of cladding fires,[27] wrote to local authorities about the risk,[28] and even participated in external conference advice on the issue.[29]

2.8. ATHERSTONE RESPONSE: The closest that the LFB got to training station personnel on modern construction risk was the initiative in response to the fire at Atherstone-on-Stour and the recommendation for more general education on highly insulted buildings and risk of rapid spread of fire.[30] Having seen the Warwickshire FRS Report on Atherstone, the senior figures responsible for operational assurance recommended a similar general package to the Operational Directorates Co-Ordination Board ('ODCB'), and in doing so noted its relevance to high rise buildings, with additional recognition that firefighters had

---

[23] Reason {T180/192/6-193/22} {T180/196/4-9} {T180/205/16-206/24} {T181/128/21-129/21}, Cotton {T209/37/10-20}, Roe {T212/152/18-153/6} {T212/155/2-17}

[24] {LFB00001255/21-22}

[25] FOOTNOTE 161 BELOW

[26] Groves {T177/146/5-148/15} (identifying training packages dating back to 2011 and 2014 of precisely the same content) and {T177/158/10-15} (confirming that the Back-2-Basics borough package of 2016 was no different in content)

[27] {LFB00032916} {LFB00069812/3} {LFB00024232/1}; and for context Green {LFB00032917/1-2 §§3-4}, Seal {LFB00032316/8 §38}

[28] Daly-Johnson 'Tall Buildings – External Fire Spread' (6 April 2017) {CST00002633}

[29] Hughes 'Firefighting in Tall Buildings' (June 2017) {LFB00024271/6-7, 11}, Daly {T183/152/18-160/20}, Roe {T213/34/20-35/5}

[30] {INQ00014765/68 and 78} and {INQ00014766/180 §337} *Cf.* Cotton {T209/158/21–159/9} {T209/171/9-17} {T209/175/12–176/14} who initially tried to suggest that the recommendation was limited to the specific facts of that fire, but eventually accepted that it was meant to be further reaching. Reason {T181/160/13-161/21} accepted that the addressing the BRE criticism of training as overly focussed on compartment firefighting, especially in the residential premises setting, was "*downright essential*"

been previously trained to overly rely on compartmentation.[31] The Operational News ('Ops News') article that appeared in January 2016 under AC Cowup's supervision was supposed to warn firefighters about the dangers of assuming that compartmentation would hold, or necessarily prevent rapid fire spread. The published piece though did not do that.[32] The Babcock training prepared in response to TCAP 0212, commissioned by DAC Ellis and Operational Assurance, under the supervision of (then) AC Cotton, would have referred to thermal insulation panels, which were increasingly used for external cladding, and described their combustible qualities, and appearance.[33] Its aim was to create greater depth to station firefighter knowledge than presently available in training as it was no longer "*sufficient [just] to talk about rapid fire spread and or unusual fire spread through voids/cavities etc*." without better understanding.[34] The training was never provided because of internet service difficulties relating to video content of training packages.[35] No one made alternative arrangements to teach the package given that the relevant content of the training on modern construction methods and insulation materials did not rely on video delivery.[36] Later delivery of the package seems to have dropped between Operational Policy, Operational Assurance and Babcock, notwithstanding that all those stakeholders knew that this was missing education for station personnel.[37] Cotton accepted that it was a significant failure not to teach the package, but was unable to identify who was responsible for that not being done.[38]

2.9. CULTURAL DISCONNECT: The disconnect between fire safety and operational firefighting appears to be one of the longest standing and deep-rooted problems that FRS generally, and LFB specifically, face. Commissioner Dobson, who joined the LFB in 1979, identified the issue well before he led the service from 2009 to 2016 and singled out his lack of

---

[31] Reason-Cotton-Ellis-Bevan email (27 November 2014) {LFB00088107/1-2}, Ellis Report to ODCB (March 2015) {LFB00084395/4-5 §2}, ODCB decision (16 March 2015) {LFB00040619/1 §3} requiring Cowup to lead on the issue {LFB00040619/3}

[32] {LFB00061482/5} *Cf.* the article made a passing reference to NOG publication on fires on the built environment, which included reference to cladding fire risks, but there was little evidence that the NOG guidance was known around the LFB or expressly translated into the training: Cotton {T209/219/1-18}

[33] {BAB00000016/7}

[34] {LFB00102213/5}

[35] {LFB00102213/16}, Groves {T177/175/15-180/18}. As to corporate knowledge of the IT problem see Reason {T182/68/10-69/20} {T182/72/22-73/15} {T182/77/9-80/14}

[36] Cotton {T209/204/16-205/6}, Groves {T177/180/19-25}

[37] Groves {T177/183/7-184/9}

[38] Cotton {T209/206/13-207/7} (OA was "*commissioning department*"), Brown {T187/79/18-87/2} {T187/82/11-83/17} (Director of Operations was the "*client*")

success in removing the problem as one of his principal regrets.[39] Sir Ken Knight, who led the LFB from 2003 to 2009, having become a firefighter in 1966, told DCLG colleagues at the conclusion of the Lakanal House inquest in 2013 that *"over successive major fatalities/fires for as long as I remember* [citing Dudgeon's Wharf in 1969, through to Atherstone in 2007 and Lakanal in 2009]*...there has shown to be a potential dis-link between fire safety intelligence and operational planning"*.[40] The disconnect appears to have two mutually reinforcing cultural aspects. First, firefighters are not necessarily predisposed to view construction and related fire safety issues as core to their identity as emergency responders.[41] Second, senior officers remain ambivalent about what they can reliably expect their rank and file to understand.[42] Familiarisation with building design and the capacity to identify building failure was written into high rise firefighting policy and assumed at national risk assessment level. Yet most of the LFB leadership doubted the capacity of station firefighters to master the rudiments; and when put to the test at Grenfell Tower almost all of the operational officers attending were unable to comprehend what was happening.[43]

2.10. MANAGERIAL DISCONNECT: There was also a horizontal disconnect about construction risk that operated within and across the different LFB service directorates. It was suggested that Fire Safety remained in a silo,[44] albeit within LFB's management structure there were a number of silos.[45] With respect to Fire Safety, however, there were aggravating inferiority complexes. Operational firefighters were dominant in the organisation but insecure in their understanding of the science of fire.[46] Fire Safety had the capacity to understand the science but insufficient self-esteem in the organisation to be sufficiently forceful in ensuring it acquired and shared the requisite knowledge.[47]

---

[39] Dobson {T210/107-109/16} {T210/111/3-8} {T211/40/1-42/7} {T212/57/1-14} {T212/60/22-61/6}: and see further Dexter {T179/134/2-20}
[40] Knight-Holland-Upton-Britzman (2 April 2013) {INQ00014669/2}
[41] Daly {MET00077774/12}, McGuirk {SMC00000046/29-30 §67} {T190/58/11-59/3}, Baigent {JTO00000002/9 §1.1.1 pp 83-90 §§5.3.1, 5.4.2, 5.4.6}: further PART II [B.] §2.21 and Part III [B.] §3.10 BELOW
[42] Daly {T183/138/6-139/11}
[43] PART II [B.] §2.20 BELOW
[44] Cotton {T210/22/5-23/3}
[45] Roe {T212/158/11-160/12} {T213/23/10-25/11}: further PART III [A.] §3.4 BELOW
[46] Dobson {T210/108/7-17} (the "*big beast*") {T210/144/11-19} (reached Commissioner rank without ever serving as a "*specialist*" in fire safety): see further McGuirk {T190/109/10-110/12} (Fire Safety needed a big seat at the management table) but {T190/110/13-111/1} (operational officers required more technical knowledge)
[47] Daly {MET00077774/12} {T184/118/22-120/11}, Groves {T177/188/15-190/5} (Fire Safety was not as closely involved on the training process as Operational Policy and Assurance), Dexter {T179/96/22-

That was the context for Fire Safety teaching itself about cladding fires, but keeping the rest of the organisation in comparative ignorance. However, the lack of joined up thinking was more basic. Many of the leading officers that the Inquiry has heard from did not see, or know about, Commissioner Dobson's correspondence with Government.[48] Several key figures did not sufficiently appreciate the doubts that had been raised about the stability of the regulatory system, [49] or recognise that the fires at Lakanal House and Shepherd's Court foreshadowed the risk of whole building cladding fires.[50] The present Commissioner *now* accepts both of these things should have been shared and has unequivocally conceded that the knowledge existed within Fire Safety but was not extended across the organisation.[51]

2.11. MISPLACED OPTIMISM: Both Fire Safety and senior leadership unreasonably assumed that documented international examples of cladding fires could not happen in England because of the strength of its regulatory system.[52] The assumption was made on an ad hoc basis without systematically studying the evidence of the foreign fires, including their regulatory context, or seeking national FRS or Government intervention to do so.[53] Of itself that was unreasonable. Some of the regulatory framework would have been similar, but in any event the cause of non-compliant cladding systems, including their design, constituent materials, and effect on compartmentation, would have been of obvious relevance to global high rise fire safety, including that in London.[54] This misplaced optimism is all the more inexcusable as it is in such stark contrast to Commissioner Dobson's letters to Government in 2009 and 2012 calling attention to the weakness of the domestic regulatory system, and the range of papers produced by DC Dexter between 2013 and 2014, which challenged the preconception that building

---

97/1}(international fires were never raised by Fire Safety before the ODCB), Daly {T183/38/2-39/1} (fire safety did not tend to feedback on training) {T183/202/18-21} (protection was not always high up on the agenda)

[48] Daly {T183/71/9-10}, Cowup {T195/48/13-24}{T196/36/16-37/4}, Roe {T212/142/11-19} {T212/144/7-145/9} {T212/148/2-8}, Dexter {T179/31/14-32/7} [*Cf.* Dobson {T210/123/12-124/21} who did not ensure Dexter was informed upon promotion]

[49] Cotton {T210/3/18-4/7} {T210/4/22-5/1} {T210/6/2-13} {T210/15/23-16/24}, Cowup {T196/38/10-39/10}

[50] Reason {T180/197/9-198/18}, Brown {T186/40/23-41}, Daly {T184/49/5-52/7}, Utting {T198/22/21-23/67}

[51] Roe {T212/147/12-21} {T213/5/18-6/5} {T213/10/14-11/19} {T213/20/23-22/6} {T213/23/3-9} {T213/28/12-24} *Cf.* M6 Opening Statement on behalf of the Commissioner {LFB00123263/2 §§4 and 6}

[52] Daly {MET00077774/3} {T183/135/12-136/9} {T183/141/13-142/2} {T183/144/16-22}, Seal {LFB00032316/11 §46}: and see also Cowup {LFB00032784/7 §§26-31}, Cotton {T209/231/18-232/11}

[53] Daly {T183/164/9-166/20} {T183/183/19-185/5}, Dexter {T179/96/22-97/19}, Reason {T182/102/8-25}, Dobson {T211/33/4-35/25} {T211/53/8-55/21}

[54] E.g. Lacrosse Tower fire, Melbourne, Australia (2014), Daly {T183/175/7-177/12} and The Address Tower, Dubai, UAE (2015), Daly {T183/183/4-184/7}

failure was rare and doubted both the competency and capacity of those in the public and private sector responsible for building regulation and fire safety compliance.[55]

2.12. FAILURE OF FORESIGHT: By August 2016, the Fire Safety Directorate was registering doubt about fire safety enforcement and, in particular, whether Stay Put could be relied upon as a strategy without first establishing whether compartmentation was effective.[56] The combination of combustible cladding and weak compartmentation is what has the potential to create a tall building fire disaster. In candour, the best that AC Daly could say is that by 2016, after the Shepherd's Court fire, his department was still only "*poking*" at the issue, but in continuing disconnect with the rest of the organisation.[57] No one confronted the obvious: that the difference between combustible cladding on windows as opposed to the whole of the building, was simply one of scale.[58] No one combined the known risks of cladding and the instability of regulated building compartmentation to register that an operational disaster was waiting to happen. The previous and current Commissioners accepted that this should have been done and acknowledged that the failure lay in deficient information sharing within the organisation.[59] Instead, many of the senior management complacently contented themselves when told of international high rise whole-building infernos that such fires "*could never happen*" here[60] at the very point when something should *and could* have been done to prepare for the risk that they might. The fact that the scale of the fire construction catastrophe at Grenfell Tower was unprecedented in UK firefighting history can be no consolation for the truth that its danger was foreseeable to the LFB.

---

[55] Dexter {T179/115/1-118/10} {T179/176/14-177/10}: and see generally Dexter {LFB00032239/6} (September 2013) (citing figures of 82 incidents *"involving a structural fire safety failure"* between 1 September 2010 and 31 August 2013 i.e. post Lakanal House including 6 buildings of 4-9 storeys and 7 buildings of 10 or more storeys), Dobson {LFB00086201/1} (December 2013) (summarising the shortcomings of Building Control and assessments conducted under the RRO), and Dexter and Reason {LFB00032749/2 §6(i) and §6(viii)} (11 July 2014) (emphasising the ongoing disputes as to the interpretation of the RRO and the consequential risks arising): for further summary of the position see Dexter {LFB00040774/1-2}, Dexter {T180/64/24-67/13-69/22}. As to the longer term appreciation of the problem, see Turek-Dobson (15 April 2010) {LFB00025654/13-14}, Dobson {T210/135/13-136/9}

[56] Performance Management Report (August 2016) {LFB00120301/2-3 and 7}, Daly {T184/70/10-71/19}

[57] Daly {T183/178/9-17} *Cf.* Dobson {T211/49/15-50/7}

[58] Daly {T184/49/5-52/7}, Roe {T212/80/18-81/11} {T213/13/4-19}, Dobson {T212/56/4-24}

[59] Dobson {T211/39/8-25} {T211/99/19-100/19}, Roe {T212/86/16-87/24} {T212/90/1-9}, Cotton {T210/19/4-20/10} {T210/20/20-21/14} {T210/21/15-22/3}: like her predecessor, Cotton wrote letters to Government to try to tighten the regulations without sufficiently considering the operational consequences of what she was writing about: Cotton {T210/25/21-26/1} {T210/26/21-27/15}

[60] Dobson {T211/38/3-39/7}, Cotton {T208/51/9-22} {T209/233/17-234/5} {T210/15/23-16/24}, Daly {MET00077774/3} {T183/135/12-136/9} {T183/141/13-142/2} {T183/144/16-22}, Reason {T182/105/25-107/6}

[B.] PREMISES RISK ASSESSMENT

2.13. OVERVIEW: From Lakanal House to Grenfell Tower, the LFB remained in breach of its premises risk assessment duties under statute, guidance and policy and resistant to fully acknowledging its weakness in this area, let alone discharging its obligations. The complexity of modern design and the volume of buildings under its jurisdiction created a significant challenge in London, but the LFB should have known that it was failing to rise to the challenge and considered the consequences in terms of risk to operational firefighters and the public. Its failure in pre-planning was directly causative of the extent of the fatalities at Grenfell Tower.

2.14. LAW AND POLICY: FRSs are under a statutory duty contained in s.7(2)(d) of the Fire and Rescue Services Act 2004 ('FRSA') to assess premises both to protect life and property from fire *and* prepare to respond to those threats when fire arises.[61] The continuing characterisation of the statutory duty as 'familiarisation visits' is a misnomer, not only because the duty requires composite risk assessment of a building, as well as familiarisation with it, but because station visits should be just one aspect of a dedicated project of information gathering, desktop updating and assurance, and where necessary expert inspection, fused together to protect both the health and safety of firefighters and the public.[62] Guidance from the Health and Safety Executive ('HSE') made it clear from 2010 onwards that the collection and accessibility of risk critical information, including construction hazards, was an essential function of pre-planning for operational incidents.[63] The Government's PORIS Guidance in 2012 provided that the information gathering duty under FRSA 2004 s.7(2)(d) extended to:[64] (a) hazard identification and risk assessment; (b) monitoring and measurement of performance; (c) competency of the personnel; (d) the overriding value of having accurate, timely and relevant information; and (e) the need for input from non-operational professionals regarding building construction, building systems, manufacturing processes. The data capture fields listed in Appendix C to PORIS required details of the "*construction type*" of a building including any cladding materials and internal linings as well as "*occupancy risks*" concerning *"restricted mobility*", "*limited comprehension*", "*arrangements for assistance in evacuation*" and "*children aged 6 and*

---

[61] Fire and Rescue Services Act 2004, s.7(2)(d) reads with section 7(1)(a) and (b)
[62] Roe {T213/106/2-108/4}, Dexter {T180/37/13-40/8}, Dobson {T211/194/25-197/10}
[63] HSE *The Management of Health and Safety in the GB Fire and Rescue Service* (October 2010) {CWJ00000022/23-24}
[64] CFRA and DCLG *Fire and Rescue Services, Operational Guidance, Guidance on Operational Risk Information ('PORIS')* (2012) {LFB00091784 §§5.7, 5.9, 9.5, 9.9, 9.10,}

below".[65] From 2011, the LFB high rise policy PN633 was deliberately expanded in Appendix 1 to include 22 matters to be considered during s.7(2)(d) visits, which included construction features that could promote rapid abnormal fire spread.[66] The revised version of GRA 3.2 in 2014 equally placed importance on the discipline of pre-planning, both in terms of comprehending construction hazards that could promote rapid external fire spread or breach of compartmentation, and (unlike the local policies) expressly cited "*cladding systems*" as one such hazard.[67]

2.15. SYSTEMIC FLAW: What the Phase 1 report described as the "*woefully inadequate*" entries on the Operational Risk Database ('ORD') for Grenfell Tower[68] were not an isolated phenomenon. Commissioner Roe, who became AC for Fire Stations in December 2017, told the Inquiry that a full audit of the entire LFB database had discovered a range of "*inconsistencies, poor information*" and a "*misunderstanding about risk*" necessitating a mass education program. Of 8,000 high rise buildings assessed since the Grenfell Tower fire, 1,107 have been recorded to not safely maintain Stay Put.[69] It is testimony to the extent to which the LFB abdicated its responsibility on ORD entries for years that both of Roe's predecessors responsible for s.7(2)(d) visits inaccurately described the Grenfell entries as atypical.[70] Indeed for reasons conveyed to them in a paper by GM Elwell in 2013 (see below §2.19) they should have known of the risk that poor standards could be more widespread.

2.16. VOLUME: The Brigade's approach to its task was complicated by the volume of buildings in London and the consequential tension between quantity and quality. DC Dexter described the effect of the Regulatory Reform (Fire Safety) Order 2005 ('RRO') coming into force as meaning that the LFB moved from being responsible for 350,000 to an estimated 700,000 premises.[71] As to high rise buildings, senior figures considered it LFB policy to endeavour to assess *all* sites in London on a renewed basis.[72] An express requirement to do that was communicated in an email from AC Brown to all stations in

---

[65] PORIS Guidance {LFB00091784/80, 84-85}
[66] As to the potential origins of PN633 Appendix 1 in the 2011 version {LFB00102306/15} see Hughes Gap Analysis identifying that the planning section was particularly in need of development (23 November 2009) {LFB00104255/9-10}
[67] GRA 3.2 (2014) {LFB00001255/16-20}
[68] Phase 1 Report {Vol IV §27.31}, ORD {LFB00003116}
[69] Roe {T213/108/6-109/13}
[70] Brown {T186/201/18-202/25}, George {T205/184/17-186/9} {T205/202/13-16}
[71] Dexter {T179/177/11-180/2}
[72] Brown {T186/62/13-64/16}, George {T205/183/21-184/11}, Dobson {T211/197/12-198/8}

April 2009 and the version of PN633 at the time of the Lakanal House fire required that station personnel "*be familiar with all high rise buildings on their ground*" (emphasis added).[73] A draft text for PN633 in 2010 would have required the same.[74] However the duty was not written into the amended version of PN633 in 2011, or subsequent versions of the policy, and the accompanying Ops News article in November 2011 required s.7(2)(d) visits only to take place at buildings that posed a "*particular risk*".[75] Those responsible for information managing the ORD assumed that AC Brown's 2009 requirement of stations to assess "*every*" high rise building meant only if there were "*unusual or very difficult circumstances*" associated with the block. They plainly regarded the diktat as aspirational, because there was "*no time to visit them all and it would be of very little value anyway*".[76] This confusion and (at the very least) inconsistent messaging over policy was never subject to formal decision making process at corporate management level; and neither Brown nor Dobson accepted that they had countenanced a change of policy to cover *all* high rise buildings, or been asked to do so.[77] Contrary to expectations that premises visits should be a service priority, available figures from October 2017 show that the LFB had only assessed 1,700 of the estimated 6,900 high rise buildings in London.[78]

2.17. LAKANAL HOUSE: The fire in Southwark in 2009 should have been a lesson in the perils of an underassessed building. The local authority was in breach of numerous duties under the RRO, including not having conducted a fire risk assessment.[79] None of the breaches had been established in the LFB's s.7(2)(d) inspections of the building, or by other information gathering requirements. The attending local stations assumed from previous visits and experience of incidents at the building that any fire would be contained within flats long enough for arriving crews to bring it under control.[80] Collection of data by the LFB in its broader investigation of the fire showed the service to be exposed by an unstable regulatory system across London which caused it to pursue outward facing initiatives with both central and local government.[81] Commissioner Dobson knew all these things at the time, but told

---

[73] Brown email (20 April 2009) {LFB00032161/2} {T186/59/13-60/17}, PN633 (2008) {LFB00102307/4 §3.1}
[74] Draft PN633 (2010) {LFB00039485/4 §3.1}, Cowup Email (1 August 2010) {LFB00082695}
[75] Ops News 20 (November 2011) {LFB00003561}
[76] Eustace email (22 August 2012) {LFB00095342/1} *Cf.* Brown {T186/89/3-96/7} and Brown [draft] email (13 November 2012) {LFB00113599}, Brown {T186/128/9-130/5} and {T186/133/1-21}
[77] *Cf.* Brown {T186/69/11-70/24}, Dobson {T211/220/1-20} (accepting the figure as a failure of leadership)
[78] Lakanal House Assurance Review (2018) {LFB00004801/28}, Brown {T186/54/16-55/19}
[79] For the inquest findings, see *R (Southwark LB) v LFEPA* [2016] EWHC 1701 (Admin) §§37-38: for the inquisition forms, see {TMO10038818} {TMO10038820} {TMO10038821} {TMO10038819} {TMO10038817} {TMO10038822}
[80] {LFB00028723/6-7 §§3.1.2-3.1.6} {p. 8 §3.3.2} and conclusions {pp 12-13 §§3.4-3.5}
[81] PART II [A] §2.5 §2.11 and FOOTNOTE 55 ABOVE

the inquest that it was not possible to even "*imagine*" pre-planning beyond certain assumptions about compartmentation and regulatory compliance.[82] As Lakanal occurred before the introduction of the ORD or Mobile Data Terminal ('MDT') systems, the major focus of the inquest was the faults in sharing basic information with the fireground, rather than the broader issues of s.7(2)(d) compliance; or the extent to which the LFB needed to be more driven in its efforts to pre-plan for building failure.[83] The coronial recommendations advised the LFB to develop its procedures for sharing premises information with the incident commanders, whereas the reply of Commissioner Dobson committed more broadly to collating and collecting information by reviewing policy for assessments, prioritising the number of ORD entries for high rise buildings, and setting corporate targets for s.7(2)(d) assessments.[84] Neither the inquest nor the subsequent correspondence on its recommendations appear to have studied the national PORIS guidelines, which had been issued in April 2012.

2.18. PORIS ASSURANCE: All efforts to improve the premises risk assessment system after the Lakanal inquest were compromised by the mistaken assurance that the Brigade was in essential compliance with PORIS guidelines when it plainly was not.[85] AC Brown told the Corporate Management Board ('CMB') in February 2013 that the LFB's "*robust*" premises information gathering system was "*largely in compliance*" with its duties under the PORIS guidelines and that it was not considered "*necessary or practical to make significant adjustments to current arrangements*".[86] Similar assurances were provided to the Lakanal House Working Group in September 2013.[87] As a means of definitively embedding PORIS compliance, it was recommended to the CMB that Operational Assurance conduct an audit/review on the "*consistency with which stations identify sites/buildings that might present an operational risk or hazard*".[88] The review was ordered, but did not take place.[89] It was similarly recommended that work be done on integrating the ORD and Fire Safety ('FARYNOR') databases, but this was abandoned as a project because incident firefighters were deemed unlikely to read detailed information. No thought was given to designing MDT entries that information could be presented in core headlines and the sub-categories

---

[82] Dobson {LFB00000717/4 §8} {CWJ00000010/115/8-17} {T211/10/13-11/15}
[83] *Cf.* Dobson {T211/11/16-12/21}
[84] Dobson-Kirkham (23 May 2013) {LFB00042089/4} {LFB00034062/7-8}, Dobson {T211/192/11-194/14}
[85] For a broader failure of PORIS to embed across the country, see McGuirk {T190/18/5-19/1} {T190/26/4-11}
[86] Brown (27 February 2013) {LFB00091785/20 §33}, Brown {T186/139/25-142/10} {T186/143/24-144/8}
[87] Report to LHWG (30 September 2013) {LFB00032162/2-3}, Brown {LFB00032166/8-9 §20}
[88] {LFB00091785/2 §(g)}
[89] Cotton-Bevan (1 December 2017) {LFB00041365/1}, Brown {T186/152/18-154/9}

(e.g. occupancy profile), to be looked at depending on the nature of the fire.[90] PORIS required a system for monitoring and measuring the content of premises information on a regular basis, but until Grenfell Tower there was no mandatory system in place to check the content of the ORD entries other than at the initiative of individual station managers.[91] PORIS also required a systematic approach to occupancy risk, including whether residents were mobility impaired or otherwise vulnerable; and although the risks were mentioned in PN800, LFB practices did not focus on the investigation of those matters as part of the s.7(2)(d) process, or require it as necessary ORD content.[92]

2.19. ELWELL'S PAPER: The paper produced by GM Elwell in December 2013 showed the declaration of PORIS compliance to be unsafe and recommended changes that went considerably beyond the Lakanal Action Plan. The thrust of the paper was its questioning of the capacity and the competency of the station staff to carry out s.7(2)(d) visits that would produce meaningful data or develop professional tactical plans.[93] It underscored shortcomings in not having adequate face-to-face briefing and training, as well as the overload facing the central London stations, whereas other stations and watches were unable to release staff under present shift arrangements. The result was "*a number of sub-standard*" entries on the ORD system. The force of Elwell's analysis was that he was the lead officer responsible for the relevant Service Standard 7 and contingency planning and his views would have reflected the insights of other Borough Commanders.[94] Yet when pressed on the individual recommendations on training and resources AC Brown found it hard to accept the warts-and-all reality that underpinned them; or to let go of his reductionist focus on quantity over quality.[95] The Paper contained the informed evidence that neither the Lakanal inquest nor its internal reviews were ever to consider. The effect of AC Brown rejecting the proposals (and sending George back to work on inspection prioritisation[96]) is that the fundamental inadequacies that had been identified by Elwell and

---

[90] {LFB00091785/13} *Cf.* Brown {T187/43/20-44/15}, Dobson {T211/211/7 – 214/25}
[91] {LFB00091784/21 §5.9} *Cf.* Brown {T186/49/14-51/16} (citing only individual SM discretion)
[92] {LFB00091784/80} {LFB00000705/1} *Cf.* Brown {T187/88/21-89/18}: see further McGuirk {T190/46/7-48/11}, Grimwood {T188/40/10-41/18}, both of whom envisaged some greater burden of enquiry
[93] Elwell (11 December 2013) {LFB00032825}
[94] Brown {T186/179/4-181/1}, George {T205/200/1-22} {T206/2/25-3/11}
[95] On Recs 2-3, Brown {T186/191/21-195/15} (*Cf.* George {T205/206/16-208/9}); on Rec. 5, Brown {T186/195/16-200/5} (*Cf.* George {T205/208/10-209/3} {T205/210/17-211/23}; on Rec 6, Brown {T186/200/7-201/16} {T186/203/1-203/8} (*Cf.* George {T206/3/14-4/8} {T206/4/9-5/11}); on Rec. 7 Brown {T187/24/5-25/18}: and see George {T206/9/3-11/21} (dealing with the feasibility of implementation), {T206/22/16-24/10} (on the extent to which the rejection of Elwell's was prioritised quantity of assessments over quality) (*Cf.* George {T206/7/12-22})
[96] Brown {T186/190/19-191/6}, George {T206/14/5-15/6}

further inadequacies that would have been identified had the recommendations been actioned, were never addressed.[97]

2.20. TRAINING: In the meantime, no one was being trained to anything other than the most rudimentary standards in terms of site visits and ORD entries. Aside from the failure to incorporate construction risk in the operational firefighting curriculum (see PART 1 [A] ABOVE), the Computer Based Training ('CBT') produced by Babcock for stations on s.7(2)(d) and PN800 in 2013 made no reference to the 22 items listed in Appendix 1 to PN633 and did not advise on how to actually complete a risk assessment.[98] Equally, no mention was made of the features of Appendix 3 of PN800 which required the ORD to refer to "*modern methods of construction*". Neither the slides nor the training notes contemplated that stations would contact the responsible person under the RRO to obtain additional information.[99] As in many other instances, the delivery of the Babcock package relied on watch managers to provide the training when they themselves were not trained on how to train. AC Brown's answer to these assorted criticisms was that the stages of assessment contained in PN800 made it clear what to do and all other necessary learning arose from being on the job.[100] Mr McGuirk found no evidence that stations trained for PORIS and especially the details of Appendix C, even though crews carrying out visits were now required to move away from collecting relatively limited information for firefighting, and become "*more rounded risk assessors*".[101] The outcome was that none of the North Kensington firefighters recalled being trained on how to carry out s.7(2)(d) visits and Elwell's criticism about substandard entries received no effective training solution in the three and half years before the Grenfell Tower fire.[102]

2.21. COMPETENCY: The extraordinary – worst of all worlds – situation that prevailed before the fire is as follows: (1) law and policy over several years required stations to consider construction features of buildings as part of their s.7(2)(d) visits, (2) senior officers did not believe average station firefighters had the technical aptitude to carry out that task, and (3)

---

[97] Dexter {T211/216/13-16}, Roe {T213/110/1-111/8}
[98] {BAB00000056}, Brown {T186/120/12-122/24}, Dobson {T212/7/10-8/21}
[99] {LFB00000705/19} *Cf.* the training notes (and not the slides) {BAB00000058/7-8} includes the Appendix 1 proforma information templates which do refer to building specific risks associated with modern methods of construction, but there is no training text or prompt to trainers on what to look for
[100] Brown {T186/123/13-124/15}
[101] McGuirk {T190/33/11-25} {T190/36/21-37/6}: see further Grimwood {T188/19/13-20/19} {T188/114/19-115/4}
[102] Rickets {T51/78/3} {T51/76/23} {T51/77/5}, Davis {T51/154/25-155/22}, Cotton [Phase 1] {T50/40/15-19}, GTIRT Preliminary Report {LFB00054565/30 §§128-133}, Dobson {T212/7/10-8/21}

aside from the undelivered package conceived in the aftermath of the Atherstone report, nothing was done either to enhance station crew competency through training, or to delegate the task to competent others.[103] Added to this, it was known that there was a cultural tendency amongst firefighters to undervalue both the non-heroic and paperwork sides of prevention and protection work.[104] It was also understood that information sharing between the station ORD facility and Fire Safety inspections, and *vice versa*, was "*patchy*" and did not work well; a point best understood by the continuing lack of integration between operational and fire safety departments.[105] These matters were allowed to lie because of the long term failure to translate knowledge of catastrophic cladding risk across the organisation, such that AC Brown (as the principal responsible officer for ORD content and Third Officer in the Brigade) declared that it was "*never on* [his] *radar*" that crews visiting a building should ever consider cladding as part of a risk assessment.[106]

2.22. INAPTITUDE MYTH: Against the grain of LFB leadership who did nothing to correct the firefighters' aptitude deficit that they now diagnose, Professor Torero argues that crews absolutely should and could have been trained to follow simple instructions to identify cladding, including establishing the product details of materials, and to pass the information up the fire safety chain to deliver the appropriate analysis and messaging to attending crews in the event of fire.[107] McGuirk agrees that the phenomenon of buildings being clad as something for firefighters to consider was not new; it could be expected for crews to understand that there were risks involved with insulated panels, without needing a detailed knowledge of the particular cladding system used at Grenfell, and for them to make enquires with the Responsible Person as to the materials used.[108] No one in the LFB's higher management has seriously argued otherwise, and as suggested in an email by Rita Dexter to Graham Ellis in relation to insulation materials, these kinds of things are not "*rocket science*".[109] The aptitude issue on premises risk assessment lay far more with management that unfairly exposed station crews by failing to develop broader

---

[103] Cotton [Phase 1] {T50/86/2-22}, Dexter {T180/36/15-37/9}, Brown {T186/30/18-21} {T186/32/23-33/18} {T186/38/11-20}, George {T205/193/17-194/9}, Dobson {T211/207/4-209/6}, Roe {T213/118/8-119/19}
[104] FOOTNOTE 41 ABOVE
[105] Daly {T183/46/6-47/11}, Brown {T187/36/23-37/10} {T187/38/13-25} {T187/39/3-18}, George {T205/191/8-25}
[106] Brown {T186/40/16-21} {T186/45/19-46/20}: see also George {T205/193/6-195/15}
[107] Torero {T191/71/19-72/23}
[108] McGuirk {T190/50/19-51/10} {T190/52/8-11} {T190/55/13-23}
[109] Dobson {T212/58/22-59/16}: see further, Dexter-Ellis email (11 March 2014) {LFB00084762/2} Dexter {T180/55/20-57/6}

organisational competency and strategies to comply with PORIS and to realise a solution before the disaster occurred.[110]

2.23. SINGLE POINT FAILURE MODE: Professor Torero, however, pushes the matter further, because external cladding posed what he terms a 'single point' existential threat to buildings, and prior assessment that failed to warn of this was a danger to high rise fireground responses like no other. Effective incident command in these circumstances was only ever as good as the provision of information on the cladding, because once ignited a cladding fire has the potential to cascade across all parts of the building (compartments, doors, egress) to make all other action extremely difficult.[111] The failure of fire safety specialists to educate their organisation – including proactively researching the nature of materials being used in the cladding systems on London buildings – set the incident responders up to fail.[112] The full extent of the system failure is underscored by AC Brown telling the Inquiry that as he could not expect crews to assess construction risks "*in depth*", including the risk posed by cladding, then the necessary safeguards were (1) the BR and RRO regime, even though the LFB knew the regime to be unstable; or (2) the Fire Safety audits, which in the case of Grenfell Tower, referred to a building "*constructed of brick and concrete*" with no mention of cladding at all.[113] Unwittingly, the analysis of the witness reveals the full circle of failure.

2.24. FATAL CONTRIBUTION: The systemic flaws in the LFB approach to its statutory duty of premises assessment undoubtedly contributed to the number of fatalities at Grenfell Tower. The most significant failing was that the introduction of the cladding onto Grenfell Tower produced no enquiry by the LFB at any time. The potential hazard constituting Torero's 'single point failure mode' was constructed into the building and the fire safety strategy took no account of it. Assuming (which was not the case here) competency and training of premises assessors merely to record that potential hazard and an incident commander to register its significance, WM Dowden could have known shortly after 01.15 am that the cladding fire that confronted him was an existential threat to compartmentation such as to render reliance on a Stay Put strategy untenable. At that stage, the challenges associated with emergency evacuation could well have been aided by incident command and control room access to much more precise data on occupancy, including disability and

[110] Torero {T191/73/14-23} {T191/76/16-23} {T191/77/9-15}
[111] Torero {T191/57/13-17} {T191/62/13-67/1}
[112] Torero {T191/66/14-69/21}
[113] Brown {T186/34/12-37/11}, Fire safety audit on Grenfell Tower (3 November 2016) {LFB00000144/1}

vulnerability. These things did not happen because for several years the LFB remained in breach of its pre-planning duties under statute, guidance and policy, and resistant to fully acknowledging or acting to rectify its weakness in this area, let alone discharging those duties.

[C.] INCIDENT COMMAND MANAGEMENT

2.25. OVERVIEW: Fatal fires in the first decade of the century revealed that the capacity of incident command management to respond to unexpected operational events was insecure. Its known weaknesses were (a) declining experience due to fewer fires, (b) understanding of modern construction hazards, (c) awareness of psychological fallibility in decision making, and (d) willingness to exercise operational discretion contrary or supplementary to policy. On all of these matters, LFB training was deficient, delayed, and in breach of the actions identified in the aftermath of Lakanal House. Consequently, incident command at Grenfell Tower was ineffective for the majority of the LFB attendance. As Commissioner Roe would later put it, "*People were caught in the headlights*".[114]

2.26. HEALTH AND SAFETY INITIATIVE: The issuing by the HSE of the guidance '*Striking the Balance between operational and health and safety duties in the* [FRS]' (March 2010) should have been seen as a warning of the regulatory consequences for failing to secure adequate incident command management. It identified the risk of sudden unexpected or unexperienced dangers at incidents, which required development in the psychology, knowledge and preparation of commanders, through training and the provision of information on hazards, risks and control measures.[115] Additional DCLG advice issued in 2013 endorsed the *Striking the Balance* analysis, adding that command training and management needed to learn 'human factor' aspects of decision making: to be both "*sufficiently flexible to allow the Incident Commander to exercise discretion on the resources and the procedures required to resolve the emergency*" and to comprehend the "*human and individual characteristics that influence the behaviour of teams and individuals.*"[116]

---

[114] The Guardian *We let Grenfell Tower residents down, says London fire chief* (1 September 2020) {INQ00015028/3}

[115] {LFB00118237/2 and 4}: see also HSE *Management of Health and Safety in the GB Fire and Rescue Service* (October 2010) {CWJ00000022/23-24}

[116] DCLG *Fire and Rescue Authorities: Health, safety, and welfare framework for the operational environment* (June 2013) {SMC00000012/23 §7.3 and 32 §9}

2.27. DECLINING AND NARROWING EXPERIENCE: The Chief Fire Officers Association ('CFOA') responded to *Striking the Balance* with a program to reform incident command. One of its main concerns was the decline in command experience due to fewer fires.[117] The decline was long term, as was the dilemma of how to remain resilient and resourced when there are fewer emergencies.[118] The LFB understood the problem, and Babcock advised it on the same.[119] It was dangerous to therefore assume that incident commanders could learn about responding to breach of compartmentation and rapid external fire spread on the job, because there was a risk that they might not encounter it. Moreover, as the preponderance of high rise fires remained contained within compartments, such fires would likely form the experience and default assumption of most crews upon attendance, unless methodically trained to assume otherwise.

2.28. LAKANAL HOUSE: Contrary to the response to the Lakanal House coronial recommendation and the design specification for incident command training contained in the LFB's post-Inquest TCAPs, there was never any enhanced training "*to anticipate that a fire might behave in a manner inconsistent with the compartmentation principle*".[120] The bespoke Lakanal House training (finalised two years after its commissioning and seven years after the actual fire), as well as the related command exercises, never told crews the actual story of what went wrong operationally at the incident, and too readily recounted policy without explaining how to technically and psychologically apply it to unexpected fire spread and collapse of compartmentation.[121] This represented a failure to assure that intended training had properly been embedded.[122] As a result, WM Dowden was completely exposed on the night of the fire. He spent the period before 02.00 assuming a remaining potential to conduct compartment firefighting, with the notion that rescue could be limited to only those affected by fire, when he should have quickly recognised it was to no avail. Commissioner Roe has made it clear to the Inquiry that this was the consequence of failing to transfer

---

[117] CFOA *The Future of Incident Command* (July 2015) {LFB00118236/24-26} (citing *Striking the Balance* {LFB00118237/4})
[118] White Paper (June 2003) {HOM00000584/26 §3.24}, Knight Report {HOM00000023/4-5 and 11-12} McGuirk {SMC00000046/47-50 §§123-126}
[119] Peer Review Self-Assessment (January 2015) {LFB00032341/9-10, 25, 34], Babcock Report (July 2013) {LFB00102216/4, 12 and 25} Cohen-Hatton (16 December 2015) {LFB00118212/5}: see Roe {T212/98/20-21} ("*the less you attend, the more you've got to train*")
[120] Dobson-Kirkham (23 May 2013) {LFB00042089/5-6}: see further {LFB00034062/22} {LFB00003716/5}
[121] Cotton {T208/175/2-179/11} {T208/186/24-191/5} {T208/191/22-195/23}
[122] Cotton {T208/201/25-202/25} {T208/204/3-24} {T208/232/11-235/25} {T209/17/8-19/11}, Reason {T181/31/23-32/5} {T181/91/15-104/3} {T181/128/21-129/21}

policy and known risk into training.[123] The failure was corporate and managerial, not personal to the attending crews, and especially not the initial incident commander.

2.29. HUMAN FACTOR AWARENESS: As anticipated by *Striking the Balance*, all the incident commanders at Grenfell Tower made errors in the face of unexpected danger and under extreme pressure. Without the training to identify a cladding fire, they could not compute the risk of whole building failure.[124] Instead, they fell back on pre-existing experience rather than adapt in response to novelty. The NOG program and CFOA had both recognised in policy development between 2013 and 2015 that psychological, as well as technical, training was necessary to avert such error.[125] Efforts were made to transfer techniques into decision making, including an understanding of the mental traps of cognitive bias and primed recognition, together with "*decision controls*" for checking perception before acting upon it.[126] The evidence of Dr Cohen-Hatton suggests that the reform program did not find a comprehending or progressive learning environment in the LFB.[127] Commissioner Roe, who came from a military background, was also struck by the lack of non-technical training for making decisions under shocking emergency conditions, when compared either to combat engagement, or policing.[128] As with other aspects of innovation, the LFB-Babcock process was slow; but this was compounded by the fact that, like the LFB itself, Babcock did not have the subject matter experts in human factor training.[129] Despite therefore HSE requirements and the drive of a national program, human factor awareness would feature minimally in the Babcock curriculum.[130]

2.30. DECISION MAKING MODELS: The failure to adopt the national Decision Control Policy ('DCP') in place of the long standing Decision Making Model ('DMM') is particularly indicative of the inertia and resistance that the LFB faces in change making.[131] The two models are strikingly different because the DMM normatively (and incorrectly) assumes a

---

[123] Roe {T212/88/8-89/23}
[124] *Cf.* Kent FRS IC Training from 2010/2011 onwards: Grimwood {KFR00000057/12-33}
[125] Cohen-Hatton {T184/162/2-163/1}
[126] CFOA *Future of Incident Command* (August 2015) {LFB00118236/8-11}, NOG *Foundation for Incident Command* (2015) {SMC00000045/8} (itemising non-technical factors that required teaching), Butler (19 November 2013) {LFB00030072/59-61}, McGuirk {T190/74/10-75/8}
[127] Cohen-Hatton {T185/88/2-90/10} {T185/178/9-179/20}; and the concerted resistance to DCP *without* in depth analysis: {LFB00110678/1-2} {T185/51/17-53/8} {T185/76/23-83/12} {T185/93/21-94/10}
[128] Roe {T212/96/16-98/8} {T212/99/20-101/19}: see further McGuirk {T190/181/9-22}
[129] Butler {LFB00110668/1-3}, Cohen-Hatton {LFB00110671/2-3 §§3, 7} {LFB00110669/2-3}, Cohen-Hatton {T185/75/10-76/22}
[130] Babcock Powerpoint *Incident Command Situational Awareness* {LFB00003805/6 and 10}, Training Notes {BAB00000042/15-18} *Cf.* Groves {MET00071103/24} and Roe {T212/100/20-10119} (accepting the significance of the training gap)
[131] NOG {SMC00000023/18-19} *Cf.* PN341 (2018) {LFB00012838}

rational and reflexive decision making process, whereas the DCP regards that assumption as part of the problem, and guides the decision maker to review reflexive assumptions before acting.[132] The DMM does not describe the way that people actually think in a real world emergency environment, and research shows that it is not used, even when users claim to rely on it.[133] Dr Cohen-Hatton's combined understanding of academia, national policy and LFB operational training, confirmed to her that the DMM existed in the LFB as more of a retrospective tool to explain why things had been done, than a second nature aid to contemporaneous decision making during incidents.[134]

2.31. REJECTION OF DCP: The formal reasons given by Operational Assurance not to adopt the national guidance were unsustainable.[135] DCP has been verified by empirical research and had been adopted nationally as well as by JESIP.[136] Of equal importance, long term research had undermined the DMM as a decision making tool because of its lack of controls to prevent bias recognition, or other natural decision making errors. It was said that the DCP did not have an Equality Impact Assessment ('EIA'), but aside from never seeking one and ignoring the rebuttal opinion from Cardiff University that the DCP provided far greater "*scaffolding*" for decision making of those with dyslexia,[137] the DMM has also never been the subject of an EIA, nor has it otherwise ever been established as a safe decision making tool beyond its broader management organisational origins in the 1950s.[138] The dominant motive for push back on the reform was its perception that it was too much too soon for a Brigade that was struggling to train incident commanders on the basics, let alone matters that were entirely new to operational thinking.[139] Commissioner Roe continues to contend for a hybrid model, after the DCP has been adopted across all other services for some time; but even if there was a compelling case for hybrid revision, which has not been disclosed to the Inquiry, it continues to be the case that the LFB has still not comprehensively revised its decision making model, when all other FRSs have.[140]

---

[132] Cohen-Hatton {T184/159/13-20} {T184/163/8-170/25} {T185/6/6-9/24}: see further Team 1 M5 Opening Statement {BSR00000079/33 §§7.3-7.6}
[133] For the academic critique, see {LFB00118236/12-14}, Cohen-Hatton {T184/171/15-174/7}; and for Cardiff University research projects, see Cohen-Hatton {T184/179/12-180/17} {T184/208/9-224/25} (summarising Study (1), {LFB00110667}) and {T185/23/7-36/20} (summarising Study (2), {LFB00110674})
[134] Cohen-Hatton {T184/191/21-192/24} {T184/194/5-195/24}
[135] Cotton {LFB00118213/7 §§33-34}, Ellis {LFB00118230/8-9 §§41-42}, Drawbridge {LFB00110672/2}
[136] Cohen-Hatton {T185/54/6-60/20}
[137] Cohen-Hatton {T185/60/22-64/23} {T185/67/2-68/20} (regarding dyslexia {LFB00110677/4})
[138] Cohen-Hatton {T184/221/14-19} (DMM not designed with the psychology of incident command in mind)
[139] Cotton {T209/111/13-113/20} {T209/115/3-116/7} {T209/122/24-123/19}, Ellis {LFB00118230/3-4 §17-19, 37-39}
[140] Roe {T213/64/22-67/9} {T213/71/9-72/19}, HMCIFRS {INQ00014795}

2.32. TRAINING AND REVALIDATION: The Inquiry now knows that the training of incident commanders was truly poor in terms of technical learning on construction risks and non-technical learning on the psychology of human error. Both of these features had traditionally not been taught to station firefighters. As a result, Babcock lacked subject matter experts in either of them; more broadly like the Brigade it trained, Babcock simply lacked sufficiently trained incident command experts.[141] As a result the training suffered as regards the content deficiencies outlined in the proceeding sections. There was also a terrible problem in delay:[142] only the lower levels of commanders were revalidated, not the middle managers,[143] and even then the actual number of those revalidated was unacceptably low in the period before the Grenfell Tower fire.[144] Cumulatively these delays and gaps meant that incident commanders were grossly unprepared psychologically and technically for what faced them in June 2017, despite seven years of notice from the HSE that they were required to be so prepared. When asked of her knowledge of the HSE requirements directly relevant to operational assurance, Commissioner Cotton (who worked in the area from 2012 onwards and led it at directorial level from 2015), said she was aware of the document but not its detail, otherwise relied on her health and safety advisers to consider its implications, and that no internal auditing was ever conducted to consider whether the LFB was in compliance with the guidance.[145] It plainly was not.

2.33. OPERATIONAL DISCRETION: Against the backdrop of *Striking the Balance*, and a number of inquest recommendations,[146] the NOG guidelines underscored the important command capacity to carry out "*unusual, orthodox or innovative action*" where risk so justified.[147] At Grenfell Tower the most obvious orthodoxy that was not jettisoned quickly when it should have been, was Stay Put. The inability to even contemplate doing so contrasted with policies that at least anticipated revoking Stay Put when events required. Yet with no practical guidance on how to conduct evacuation, the incident commanders could not envisage its practice. Later in the incident only one BA crew deliberately acted to provide

---

[141] Ellis {LFB00118230/15 §§69, 71}, Groves {T177/47/16-52/11}, Reason {T181/30/16-23}, Cotton {T208/205/21-206/3} {T209/97/21-99/8}
[142] Cotton {T209/76/5-80/16}
[143] i.e. anyone above Group Manager level
[144] Cohen-Hatton {LFB00110660/17 §§62-63} {LFB00118194/3 §10} {T185/168/19-170/15}
[145] Cotton {T210/46/1-5} {T210/49/12-50/7}
[146] For inquests that highlighted the dangers of rigidly following policy, see {LFB00102414/49 §§218-228} (7 July Bombings) and {LFB00102311/57-59} (Galston Mine): see further, Cowup {LFB00032783/16-18}
[147] NOG {SMC00000023/24-25}, NOG *Foundation of Incident Command* {SMC00000045/15}, CFOA *Future of Incident Command* {LFB00118236/10-11, 32-33}: note all cross-referring to the 'decision controls' [DCP]

firefighter BA sets to residents, when there were copious unused devices on site.[148] That practice should have gone on throughout the night, but several of the senior observers at the Grenfell fireground could not countenance the action when asked during their Phase 1 evidence.[149]

2.34. DECISION INERTIA: Discretionary judgement in workplaces of inherent risk is a complex matter to teach, but in recognising the danger of decision inertia when policy did not provide an answer, the LFB failed to properly educate its staff.[150] There remained deep seated reticence within FRSs, from management and union, over when and how to divert from policy.[151] Cultural aversion to any subsequent criticism in performance review or otherwise was a well-established problem.[152] It would also have been known that operational discretion did not enjoy unequivocal support amongst senior management, with some fearing its potential for "*freelancing*" and as a "*'charter' for unconventional conduct*".[153] However, without embedded learning on the DCP,[154] it was challenging psychologically for any responder to think differently, precisely because emergency and trauma generate primed recognition and habit as opposed to innovation and creativity. In failing to teach the psychology of incident command, the LFB failed to provide its commanders with a reflexive means of adapting policy and practice to save life.

[D.] EVACUATION DOCTRINE AND PRACTICE

2.35. OVERVIEW: Of all the gaps in LFB doctrine and practice before the Grenfell Tower fire, the absence of any consideration on how to facilitate an emergency high rise residential evacuation once it was known that Stay Put was untenable was most significant in terms of contributing to loss of life. The gap was undoubtedly a blind spot. The policies mentioned the potential for evacuation. Human behaviour in fire is such that people will leave a building once aware of a fire regardless of their proximity to it. The complexity of modern design and the instability of the regulatory system made it dangerous to rely on compartmentation without recourse to alternative responses when it failed. Despite this,

---

[148] McGuirk {SMC00000046/37 §89}
[149] O'Loughlin {T48/118/14-119/5} {T48/120/9}, Cotton {T50/176/9-177/12}
[150] Roe {T212/104/18-25}, Cohen-Hatton {T184/199/22-201/2}, McGuirk {T190/113/11-116/13} {SMC00000046/44-45 §113}
[151] Cowup {LFB00032783/16 §3.6.10} {T195/96/13-97/5}: see FBU criticism {LFB00098600/17}
[152] HMICFRS 2018/19 {SMC00000011/22}, Cohen-Hatton {T184/204/21-207/15} {T185/130/2-9} {T185/131/19-132/10}, Cotton {T208/40/3-41/6}, Dexter {T178/91/8-92/12}, Roe {T212/107/15-108/16}
[153] {LFB00067818/4} (memo summarising AC Brown's view)
[154] Operational Discretion was developed to be carried out by using reflexive decision controls, as particularly underscored in *Future of Incident Command* {LFB00118236/32-33}

residential evacuation as a concept in LFB operations remained intuitive, rooted in the image of the heroic firefighter, and subject to orthodox suspicion about the risk of the panicking crowd.

2.36. HIGH RISE POLICY: Despite the policy anticipating the potential for evacuation of residents where widespread breach of compartmentation made Stay Put untenable, the Brigade completely failed to prepare commanders and crews for such a scenario.[155] The LFB have accepted the failure,[156] but found it difficult to explain such is the depth of omission. The long and convoluted consultation that led to the revised GRA 3.2 in 2014 formulated a requirement for incident commanders to consider the need to reverse Stay Put; and (importantly) to develop training and competency on the issue. However, these key changes on Stay Put came from civil servants intervening to enforce DCLG's undertaking to the Lakanal Coroner.[157] Very little prior input on the issue came from the LFB or the national FRS.[158] Those in the LFB's Operational Policy department who drafted the national and local documents, did not consult upon or even think through the practical implications of the policy change.[159] Lakanal House training packages did not teach incident commanders about residential evacuation.[160] There was also no Station training on the revised PN633 to explain what had changed or developed and why.[161] As Cowup would put it, evacuation was a "*blind spot*", both for the LFB, but probably the whole of the country; so much so that it could be identified as an operational option by the policies, but without any additional guidance about how to go about it.[162]

2.37. ORTHODOXY: The explanation of the blind spot (or what the Inquiry has characterised as an 'article of faith') can be found in certain orthodoxies in incident response. Firefighters did carry out "*intuitive*" evacuations, based on experience rather than following any taught method.[163] It was part of a broader tendency in high rise firefighting before Grenfell Tower

---

[155] GRA 3.2 (2014) {LFB00001255/19-22}, PN633 (2015) {LFB00001256/13 §§2.31-2.32, 7.46-7.47, 7.51}: see further McGuirk {SMC00000046/79 §216}
[156] Roe {T212/88/8-89/1} {T213/36/9-39/10} {T213/164/2-166/8} {LFB00083834/8 §28}
[157] Upton (1 July 2013) {HOM00045997/1} (29 July 2013) {CLG10005807/1}, Cowup (3 August 2013) {LFB00084467} (12 September 2013) {LFB00102488}
[158] See only North Wales FRS {LFB00085675/7}, Cowup {T195/126/17-128/18}), FBU {LFB00098600/9}
[159] Groves {T177/150/18-25}, Cowup {T196/154/9-159/25} {T196/177/3-179/5}, Utting {T198/47/1-50/23} {T198/54/16-24}, Dobson {T211/116/11-121/18}
[160] Reason {T181/117/13 -118/6} {T181/122/21-123/15}
[161] Cowup {T196/76/19-78/8} {T197/26/21-31/20}, Utting {T198/85/12-94/5} {T198/95/21-98/23}: see further, the TCAP was drafted in July 2013 {LFB00051281}, delayed because of an intention to consolidate with other Lakanal House workstreams {LFB00086849/1}, only for it to be re-drafted in the same terms in February 2015 {LFB00051646}, but without considering the later amendments to GRA 3.2 and never delivered
[162] Cowup {T195/63/20-64/8} {T197/5/10-20}, Utting {T198/177/25-178/11}, Roe {T213/151/21-152/21}
[163] Cowup {T195/65/23-67/21}{T195/104/4-9}{T197/12/15-22}, Dobson {T211/136/20-138/8}

to assume compartmentation, rather than question its viability, and thereafter to focus on individual firefighting rescues, as opposed to proactively enabling whole residential population escape. It was in that mindset that Commissioner Dobson told the Lakanal House inquest that he could not even imagine an alternative more dynamic response to building failure.[164] He emphasised that senior management saw departure from Stay Put as operationally problematic, but there was never a coordinated consultation with stations and other sources, including other services, to develop a formal evacuation doctrine.[165]

2.38. COMMON OCCURRENCE: Evacuations nevertheless remained part of the natural behaviour of people in fire, with events like Lakanal House only encouraging high rise residents to evacuate regardless of instructions.[166] The reaction to these developments within the LFB was primarily to emphasise their risk management quality, rather than developing strategic responses to facilitate their inevitable occurrence.[167] The blind spot went so far as to suggest that evacuation from high rise buildings was comparatively rare, when that was not the case.[168] In the aftermath of Grenfell Tower, it was also commonly narrated that Stay Put had never been revoked in national FRS history, which of itself is myopic about how common mass evacuation actually was; but also overlooks the partial revocation of Stay Put that was ordered by LFB incident commanders both at the Shepherd's Court fire in August 2016 and the Adair Tower fire in November 2015.[169]

2.39. ALTERNATIVE APPROACHES: Kent FRS developed a method of high rise firefighting by 2010 which had its roots in the previous decade. It neither assumes compartmentation, nor the maintenance of a Stay Put strategy until it is established by rapid reconnaissance that it is safe to do so.[170] It prioritises stairwell smoke protection throughout an incident on the assumption that people will evacuate naturally, or because they need to, which either way will carry implications for compartmentation as they move through the building.[171] It

---

[164] Dobson {T211/7/23-12/21}, Dexter {T180/69/15-70/25}, Reason {T181/124/16-126/17}
[165] Dobson {CWJ00000010/115/12-17}{T211/120/22-121/2} {T211/126/4-23} {T212/57/15-58/17}: see further Dexter {T180/75/5-18} (still thinking about "*stay put business*" as of the night of the Grenfell fire)
[166] Daly (27 July 2009) {LFB00102961}, Snazell-Cowup email (8 February 2011) {LFB00109470}, Cowup-Utting-A'Court-Morton email (15 July 2013 {LFB00084459/1 and 4}, Cotton-Cowup email (24 February 2014) {LFB00117227}, Firkins-Turek. email (23 July 2010) {LFB00028515/64}: see Grimwood {T188/22/6-15} (dating more common evacuation to the World Trade Centre)
[167] Cutbill [Draft] Memo (18 January 2010) {LFB00118813/1-2 §§10, 12-13}
[168] Reason {T181/119/24-120/21}, Dobson {T211/127/4-12}
[169] Roe {LFB00060655/9 §20} *Cf.* Hanks {LFB00032724/3-5 §§6-8}, Biles {MET00080605/7-9}, Roe {T213/154/3-164/1}
[170] Grimwood {T188/82/25-85/18}, McGuirk {T190/151/15-18}
[171] TB F15 (2006) {KFR00000050/5 §§20-22, p.7 §§38-39 p.15 §§83-95} and SOP F4.1 (2014) {KFR00000049/15 §§3.38-3.42}

opposes the GRA, and LFB policy, of using dry risers on the floors below, and not the fire floor, which leaves more doors open for smoke to spread.[172] In the event that evacuation and rescue become the primary goals of incident response then it uses a conveyor belt system of crews on the staircase to facilitate the downward movement of residents.[173] In contrast to the admitted gaps in LFB operational policy and training, this is a system informed by fire engineering, sceptical about regulatory compliance, and which assumes building failure.[174]

2.40. INCIDENT COMMAND: The 'RICE' mnemonic developed by Kent FRS is a decision making model that helps incident commanders to evaluate under the stress of emergency whether it is safer to prioritise **R**escue, **E**vacuation, and **C**ontainment of a high rise fire, as opposed to automatic **I**ntervention to try to fight the fire.[175] RICE trains for readiness to adapt to the flow of potential evacuation down a single staircase when it naturally occurs, rather than to overlook or fear its consequences. Rule of thumb estimates about evacuation times are now being supplemented by research of actual evacuations.[176] It identifies triggers that would prompt decision making on the reversal of Stay Put: fire development, smoke travel, self-evacuation and a compromised staircase.[177] These were features of the fire apparent to early crews that arrived at Grenfell Tower and those in Control taking calls before 01.30, but they had no training or policy to act upon them.[178] Similar reassessment prompts of this nature are now written into all of the relevant LFB polices.[179] AC Cowup accepted that this should have been done before Grenfell.[180]

2.41. NATIONAL DISCONNECT: If there was proper inter-service dialogue in the UK then the Kent methods should have encouraged a national debate. Instead, the LFB have claimed they knew nothing about them, although recollections differ.[181] Either way, the fact remains that the LFB paid little attention to a paradigm shifting policy and training method adopted

---

[172] Grimwood {T188/12/1-15/14} {T188/25/13-26/10}
[173] Operational Information Note 68/19 (August 2019) {KFR00000038/5}: see figures 1 and 2
[174] Grimwood {T188/15/8-14} ("*we expect the building to be failing*") {T188/66/6-13} ("*we teach firefighters to expect failure*")
[175] Grimwood {KFR00000040/5-6 §15} {T188/62/14-68/1}
[176] Grimwood {KFR00000040/6-7§§16-18} {SMC00000004/5§16} {KFR00000058/1 §4} {KFR00000056/1-2}
[177] S.E. Group SOP F4.1 {KFR00000049/15 §§3.38-3.42}, McGuirk {SMC00000046/84 §225}
[178] Phase 1 Report {Vol. II §§10.71-10.99}, G4 Written Closing Phase 1 {INQ00000569/51} (early warning information from callers) [not on Relativity]
[179] PN633 {LFB00105468/22 §5.10}, PN790 {LFB00121163/8 §9.4}, PN970 {LFB00121164/9 §7.5}
[180] Cowup {T195/64/9-65/1}
[181] Cowup {T197/39/22-40/1} {T197/41/12-43/3) {T197/43/4-11} *Cf.* Grimwood {T188/94/12-95/3} {T188/97/9-16} {T188/99/8-100/7} {T188/104/5-105/16}

amongst its neighbouring South-East FRSs in circumstances where they had no doctrine of their own. The oversight was indicative of a metropolitan-centric attitude, which Commissioner Dobson accepted in evidence and was trying to address in his period in office.[182] More broadly, it speaks to a national disconnect, which cannot be allowed to continue to exist when it comes to generic risks applicable to all urban FRS.

2.42. PANIC MYTH: Before Grenfell Tower, and notwithstanding Lakanal House, high rise firefighting may well have been seen as more of a risk to firefighters who had died in compartment fires, as opposed to residents who had rarely died in numbers.[183] In that respect, operational policy did not give much thought to residents or human behaviour in high rise fires. As the Inquiry has studied the night of the fire like no other previous investigation of its kind, it is well to remember what firefighters instinctively feared about triggering an evacuation in the building. WM Dowden thought "*distressed people...confused in that environment*" made it "*very, very difficult*".[184] WM O'Keeffe believed it would be "*impossible*" and would cause a "*huge catastrophe.*[185] DAC Fenton wanted "*to prevent a mass exodus and panic*".[186] Commissioner Cotton declared that it would have ended with a "*significant number of crush injuries"* with a number of people "*panicking*" and trying to get out a single staircase.[187] However, AC Cowup agreed that this was an overstated view[188] and referred to his personal experience of the 7/7 bombings which indicated the extent to which people were able to behave calmly, especially when not directly in the vicinity of the explosions.[189] Self-evacuation during high rise fire should be considered an inevitability for the foreseeable future. Thus, evacuation strategy must counter the 'panic myth' by seeking to harness the resilience of the crowd, rather than fearing it. It will be essential to design assistance into buildings, including alarms, intercoms and better staircase protection. However, the next stage is to better understand that residents equipped with their own familiarisation and local knowledge can support themselves and others from evacuating from their homes, as has long been the case for

---

[182] Dobson {T210/105/8-107/11}
[183] McGuirk {T190/154/17-155/16}
[184] Dowden {T11/31/24-32/3}
[185] O'Keeffe {T18/88/24-89/9}
[186] Fenton {MET000080569/3}
[187] Cotton {T50/25/7-11} {T50/127/23-128/2}, Dominic Ellis {MET00007693/19}
[188] *Cf.* On the panic myth, see M5 Team 1 Opening {BSR00000079/41-42 §8.7}
[189] Cowup {T197/8/9-9/23}: confirmed by the academic studies on the 7 July survivors, for which see John Drury and Clifford Scott, *Contextualising the Crowd*, (2011) 6 Contemporary Social Science, 275-288, 284

commercial buildings, and policy must construct itself around such understanding, rather than being in denial about its potential.

[E.] FIRE GROUND COMMUNICATIONS

2.43. OVERVIEW: The lack of situational awareness of incident command management at Grenfell Tower was made worse by the fire ground communication system being so poor. The most significant problem was the intrinsically safe ('IS'), but low wattage, radio sets that were incorporated in the breathing apparatus (BA) worn by the crews, and known as BARIE. The LFB was (1) institutionally aware of the problem over decades, (2) avoided its definitive solution after Lakanal House, (3) entrenched itself throughout in an unreasonable and hyper-precautionary procurement of the BARIE model that was unnecessary in most instances of actual fireground deployment, (4) failed in breach of national and local policy to plan, test or train for worse case scenarios of loss of communication, and (5) otherwise failed to pursue alternative and fall back arrangements to mitigate the known problems. The consequences were that crews would be deployed into high rise building fires and lose contact with their command and/or each other, and thereby risk their own lives and the lives of residents. That, of itself, was a serious flaw of the LFB's high rise firefighting model.

2.44. SITUATIONAL AWARENESS: Effective communication lies at the heart of an incident commander's ability to gather situational awareness, make effective decisions, and then translate their plan into action, orders and briefings for the crews.[190] The absence of situational awareness during the Grenfell Tower response was critical, especially in its first hour in order to enable mass egress through a staircase that was not, at that stage, filled with smoke. Individual firefighters[191] and crews[192] inside the building quickly discovered the unusual spread of smoke and fire as well as the spontaneous evacuation of residents across a number of floors, but their radio communication to convey that information was not picked up by incident command, or the bridgehead. Although countless problems would arise with communication during the night, including the dependency on hand delivered lists of FSG rather than electronic dispatch, the lost opportunity to appreciate

---

[190] Roe {T213/80/18-24}
[191] FF O'Beirne {Phase 1 Report Vol. II §§10.79(c), 10.101(b)}
[192] FF Stern and Hippel {Phase 1 Report Vol. II §§10.79(a), 10.101(c), 11.15} and FF Badillo, Secrett and Dorgu {§§10.101(a) 11.10}: see further {Vol. IV §§28.130-131, 33.21}

outright building failure in that first hour which could have compelled an earlier reassessment of Stay Put was ultimately one of the most significant.

2.45. INSTITUTIONAL KNOWLEDGE: Problems with radio communications were well known to the LFB,[193] as was the fact that BARIE sets, radio repeaters and leaky feeders were not to be regarded as a panacea in high rise buildings.[194] Institutional knowledge dated back several decades from fires arising from high rise incidents and other disasters, both nationally[195] and internationally.[196] Government risk assessment had drawn attention to the need for contingency planning.[197] Earlier versions of GRA 3.2 had focussed on the issue.[198] It is upon that basis that GRA 3.2 (2014) required radio transmission to be considered on s.7(2)(d) visits,[199] and the revised PN633 (2015) endorsed the need for contingency planning and expressly required "*potential communications problems*" to be given consideration during the course of s. 7(2)(d) visits.[200]

2.46. LAKANAL HOUSE: The experience of those on the Lakanal House incident ground was a significant precursor to the communication problems at Grenfell Tower. The effect of concrete and steel high rises on the low-powered IS BARIE sets caused loss of communications when crews ascended the floors, which suggested the main issue was structure and congestion.[201] The LFB's Communication Department internally proposed a wholesale review but this was not actioned.[202] David Kennett of the Fire Safety Enforcement Department raised concerns in April 2013 that the problems would be a common issue across similar London high rises, however it was suggested nothing could

---

[193] LFB Review of the Specification for Fireground and Breathing Apparatus Radios {LFB00105466/2 §5} Johnson {T189/96/4-25} {CWJ00000119/69-75}, Roe {T213/80/9-24} {T213/83/3-14}{T213/86/5-25}, Cotton {T50/226/15-227/11}

[194] Johnson {CWJ00000010/72-75 and 99-100}{T189/51/20-52/8} {T189/54/19-55/8} {T189/125/15-126/2}{T189/130-132} Dobson {T212/44/22-46/4}

[195] Kings Cross (1987) {CWJ00000053/103-104 §§29-31}; Harrow Court, Hertfordshire (2005) recommending review of technology used and re-training concerning correct use of channels, effective communication and procedures {CWJ00000089/39-40 §§22-24}; 7 July bombings (2005) {CWJ00000049/35 §156} and {CWJ00000007/20-22 §§2.19-2.30}; and with "*BARIE roving*" recognised in the Peer Review Self-Assessment (2015) {LFB00032341/84}

[196] First World Trade Centre Bombing, New York (1993) {CWJ00000010/60 §4.5} {CWJ00000048/6}; 9/11 Terrorist Attacks on the World Trade Centre, New York (2001) {CWJ00000010/60 §4.6}, {CWJ00000023/49-50, 146-151}

[197] DCLG FRS circular 32/2006 {LFB00089209/3 §3.8, 4.1}; Home Office risk assessment for fighting fires in tall buildings 2007 {HOM00043622/1 §1.1}

[198] GRA 3.2 (2006) {HOM00003065/11}, GRA 3.2 (2008) {LFB00083632/7} and {11-12}

[199] {LFB00001255/18-19 and 38}

[200] {LFB00001256/3 §2.9, §4.8 (j) and §4.13} and Appendix 1{19}

[201] Operational Review Report ('ORR') for Lakanal House (completed 2012) {LFB00001843/61 §9.3.11}, Miller [evidence at inquest] {CWJ00000095/54/14-55/22} {LFB00041759/1} {CWJ00000119/80-2 §§4.14.2-4.14.3}

[202] {LFB00098636/2-3}{LFB00001843/61 §9.3.11} Johnson {CWJ00000119/78-79} {T212/14/2-3}

be done.[203] Others to an extent down played radio problems as wear and tear, notwithstanding the institutional knowledge that it was more than that.[204] Lakanal should have led to reconsideration of the utility of BARIE sets as part of BA operations and contingency planning for the known risks from radio promulgation in high rise buildings, both in terms of methodically testing the coverage of equipment in the built environment and pre-planning, and the creation of better training to mitigate its shortcomings during complicated incidents. It did not in part because Commissioner Dobson saw the issue as primarily one of the ill-disciplined use of radio channels. This explains the Coroner's focus on channel protocol and why more significant solutions were passed over in internal LFB debate at the time.[205]

2.47. PRECAUTIONARY PROCUREMENT: Professor Johnson's view is that use of a radio system with a standard 4 Watt transmitting power that was integrated with well-functioning headsets within BA would have helped firefighters "*tremendously*" at Grenfell Tower.[206] In the procurement of BARIE sets, which were never designed to support incidents within a high-rise building, the LFB adopted a "*one size fits all*" approach, and defaulted to a precautionary high level of intrinsic safety.[207] An IS standard justifies the otherwise adverse consequences it has for the quality of radio transmission, when crews go into an explosive atmosphere, or there is a risk of fire ignition when there is no fire. That is not the case in a high rise fire event. In those circumstances equipment constructed to a less rigorous standard may be used, thereby increasing coverage, which is what has occurred with other UK FRSs and abroad.[208]

2.48. RISK ASSESSMENT: Professor Johnson's criticism of that precautionary procurement approach is that it focussed exclusively on the value of *intrinsic* safety, without a more systemic analysis of the serious ramifications on insisting on IS equipment in fires that would not need such protections, as against potentially very adverse consequences for the quality of incident communication as a whole.[209] Commissioner Dobson accepted that the

---

[203] {LFB00049878/1 §8}
[204] Ellis {LFB00089131/8 §31}
[205] Dobson{T212/13/11-12}{T212/14/2-3}{T212/20/19 – 21/8}, Dobson-Kirkham (25 May 2013) {LFB00032150/8}
[206] Johnson {T189/44/16-45/20}
[207] Johnson {T189/98/21-99/10}
[208] {LFB00105466/2 §§5-7, 14-16}: see further McGuirk{T190/167/7-169/24}, Torero {T191/162/24-165/16}
[209] Johnson {T189/32/16-33/21}{T189/34/1-35/8} {T189/121/2-124/2}

"*slavish*" following of this overly precautionary approach could be problematic;[210] but in so far as he and others maintained the procurement of a generic single radio for all firefighters,[211] it was necessary to have a much more considered risk analysis of its consequences for high rise firefighting. For instance, if smoke was escalating in a building, it might be necessary to start to evacuate it early, precisely because good communications could not be relied on later. Insufficient discussion of these types of issue took place because the problems with the BA radio were allowed to exist as a fact of operational life, rather than stimulating discussion in the ODCB and across the different directorates.[212]

2.49. REPLACEMENT: Instead there should have been new procurement. The replacement of BARIE equipment was initiated in 2015 but a decision was taken to delay replacement as it was felt they were still effective.[213,] The LFB are now in the process of procuring entirely new BA with integrated communication equipment but this is long overdue.[214]

2.50. PRE-PLANNING: Seized with the knowledge that the BA sets could have consequences for high rise incident response, it was unacceptable for the LFB not to have any comprehensive procedures for testing equipment as part of its s.7(2)(d) obligations, and thus fail to plan for communications failure at Grenfell, contrary to well-established national and local standards.[215] BARIE sets were not tested at Grenfell Tower, only the handheld radios, and then only to communicate during the visit rather than carry out systematic tests. No tests were carried out for signal propagation between higher floors and lower floors.[216]

2.51. FALL-BACKS: Another feature lacking a sufficiently systemic approach is the LFB's failure to develop alternatives in the event of communication difficulties. From at least Lakanal House there had been an imperative to anticipate and plan for congestion. Professor Johnson maintained that contrary to the LFB reluctance, communication could be better coordinated using channel allocation to increase capacity and resilience of fireground communications.[217] Use of Airwave radio would also have been a better means of

---

[210] Dobson {T212/34/2-14} "*it's unlikely that firefighters are going to go into an explosive atmosphere, because the fire has already ignited the atmosphere...*") *Cf.* Reason {T181/204/12-206/13}
[211] Dobson {T212/34/15-23}{T212/36/16-17}
[212] Dobson {T212/42/10-44.10}: *Cf.* Dobson [inquest evidence] {CWJ00000010/70/22} and Johnson (CWJ00000119/57 §4.3.7} (on LFB's *"culture of "making do" over an expectation of technical excellence"*)
[213] Johnson {CWJ00000010/52 §3.6.6}
[214] Roe {T213/81/11-82/24}
[215] FOOTNOTES 199- 200 ABOVE
[216] Johnson {CWJ00000119/108. §5.4.2-5.4.5}{T189/107} McGuirk {T190/104/14-106/12}, Torero {T191/165/17-166/25}
[217] Johnson {CWJ00000119/48} {T189/78/10-80/2}

communication between the Control Room, Command Units and bridgehead at Grenfell.[218] The virtue of digital Airwave radios over Analogue radio across all the emergency services is now acknowledged.[219] The standard procurement of digital Airwave for all emergency service personnel was recommended by the London Assembly after the 7/7 Bombings who thereafter complained about the delay in achieving that end.[220] At the LFB, handheld Airwave radios were restricted to senior officers, namely those of rank of station manager and above, and therefore in short supply at Grenfell despite providing better coverage. Professor Johnson recommends more firefighters have access to Airwave radios.[221]

2.52. TRAINING: Despite the LFB knowing of both the inadequacies and the need to test effectiveness, their training did nothing to prepare station crews on either matter. In response to the Lakanal Coroner's Rule 43 recommendations, the LFB commissioned course TCAP 0039 on the use of handheld radios and Airwave in 2012 but there were various delays, and it was not delivered until well after Grenfell due to the same IT delivery issues that led to the non-delivery of TCAP 0212.[222] In any event, AC Reason accepted that the training did not sufficiently prepare crews for communication failure during a high rise fire; and as Groves conceded, it simply described the equipment.[223] The handling of TCAP 0039 represents a deeper systemic problem at the LFB that goes beyond the technical adequacy of equipment, but highlights deficiencies in training content and delivery.[224] Professor Torero's conclusion is that as a result of the poor training the competency of LFB crews on communications equipment was so low "*that it leads to practices that endanger the public and LFB staff and prevents the organisation from learning*".[225] Commissioner Roe accepted that it would be would be *"incoherent"* to suggest that the LFB was where it needed to be on communication training and use at an incident.[226]

---

[218] Johnson {CWJ00000119/222-224 §8.12}.{T189/159/11-161/10}{T189/93/20-96/2}
[219] Reason {T182/81/15-25}
[220] London Assembly's Report of the 7 July Review Committee.{CWJ00000007/20-22 §§2.19-2.29 and Rec 5} {CWJ00000097/13-17} Lakanal Rule 43 Report {CWJ00000049/36 §§159- 160 and 42 §§188-189}
[221] Johnson {T189/158/23-162/15}
[222] Groves {T177/197/17-198/1}: see PART II [A] §2.8
[223] Reason {T182/60/9-68/3} Groves {T176/2/20-5/4}: see further McGuirk {T190/103/13-23}
[224] Johnson { CWJ00000119/84 §4.16.5}{T189/147/2-148/18}
[225] Torero {JTO00000005/32/1030}
[226] Roe{T213/98/1-5}

[F.] CONTROL ROOM

2.53. OVERVIEW: The extent to which the Control room compounded the failures at Grenfell Tower by its false reassurance and blind insistence on Stay Put lays bare its own systemic deficiencies. It could not act as an early warning system that smoke had spread across the building and it was quickly overwhelmed by the number of calls. The danger of multiple callers in need of advice and how to effectively integrate that knowledge into incident command management had been recognised after Lakanal House and identified as a shortcoming in policy and training. Due to failure of management and oversight, these flaws were not corrected before the Grenfell Tower fire, not least because the Control room remained a disconnected and depressed function within the LFB service. It should have been fully integrated and genuinely valued as a first line of emergency response, but years of neglectful and incompetent management, at all levels, prevented that from happening.

2.54. LAKANAL HOUSE: It can be of no surprise that if the LFB as a whole failed to prepare for catastrophic construction risk and a consequential need to revoke Stay Put, then the Control room also remained in a state of incompetency to meet those challenges. During the Lakanal House fire Control had (a) assumed compartmentation, (b) offered false reassurance, (c) not coped with the volume of calls, (d) treated all Fire Survival Guidance ('FSG') callers as requiring rescue without exploring their capacity for escape, (e) had no notion of *if, when, or how* to revise the Stay Put advice, and (f) did not effectively communicate with the incident ground.[227] In its initial reporting, the LFB identified that Control room experience of FSG call handling had historically been minimal, hence its particular vulnerability when receiving multiple calls,[228] and that training and policy were not in accordance with national guidelines.[229] Contrary to indications given to the Lakanal House Inquest, these matters remained unremedied prior to Grenfell Tower.[230]

2.55. NATIONAL POLICY: One of the early Lakanal House actions was to review national policy, which as far back as Fire Service Circular ('FSC') 10/1993 had required care not to provide false reassurance and identified the need for operators to have an understanding of effects of fire in relation to people's ability to escape. Annual training was to include role play and

---

[227] LFB *Fire at Lakanal – Main report – Role and actions of LFB Control* ('Control Room Report') {LFB00004724/49-50 §286-297} {pp.53-54 §§310-320}: see further {pp.36-37 §§179-182}, {pp.37-149 §§37-285}

[228] {LFB00004724/28-29 §§149-152} (10 out of 225,000 calls in 2009 and 77 calls over 5 years) {p.49 §287}

[229] {LFB00004724/22 §102} {pp 24-25 §§119-120} {p. 25 §124} {p, 49 §286}, {LFB00004750/7-24}

[230] Kirkham-Dobson (28 March 2013) {LFB00032158/2-3}, Dobson-Kirkham (23 May 2013) {LFB00042089/1 and 7}

input from fire safety experts. Training was to be subject to planning and record keeping.[231] FSC 10/1993 was updated by FSC 54-2004 to reflect the duties arising from the FRSA 2004 and further national insight, including the three stage Emergency Call Management Protocol. Most significantly, it introduced a requirement to assess not only the situation, but the vulnerability of the caller, by asking about age, gender, ethnicity and mental or physical ability.[232] GRA 3.2 (2014) added specifically to national policy in relation to high rise firefighting by requiring arrangements in relation to FSG calls to re-evaluate Stay Put advice and to have effective arrangements in place to handle FSG from callers unable to leave the building "*due to disability, poor mobility, illness or the affects (sic) of fire*".[233]

2.56. NON-COMPLIANCE: Of the three national policies relevant to FSG calls, the LFB undertook to comply with FSC 10/93, but failed to do so adequately (see below). It deliberately elected not to consider FSC 54-2004, because it mistakenly believed it added nothing to FSC 10/93.[234] Control room managers did not know about GRA 3.2 and therefore did nothing to comply with it.[235] Looking then only at FSC 10/93, the refresher training courses were reduced to half days after 2011.[236] The number who were trained drastically decreased after 2013.[237] Active role play was not developed after 2010, at least in part because staff were embarrassed to participate.[238] After 2010, Fire Safety experts only sporadically delivered any training because of other competing needs. The content of training did not at any time deal with rapid external fire spread.[239] There was never a structured training plan.[240]

2.57. TRAINING: Aside from the content and duration of training there were formidable problems in the way in which training was provided and overseen. The fundamental difference between Control and other LFB training is that it was never outsourced to Babcock. As with the entire LFB organisation, the Operational Support Team ('OST') in Control

---

[231] FSC 10/1993 *Training of Fire Control Staff* {LFB00003617/1-3} {LFB00003617/6}: see further, Policy Gap Analysis {LFB00004750/11, 13-14}
[232] FSC 54-2004 *Emergency Call Management* {LFB00118945/17}, Control Room Report {LFB00004724/19}
[233] GRA 3.2 {LFB00001255/20 and 29-30}
[234] Hayward {T199/158/9-159/23}, Smith {T202/102/14-103/7} {T203/15/8-16/16} {T203/18/2-19/8} {T203/45/3-8} {T204/48/13-49/11}, Brown {T206/82/14-86/25}, Dobson {T211/140/12-141/18}
[235] Hayward {T200/53/13-54/22}, Smith {T203/19/15-21/6}}, George {T205/149/12-150/3}, Brown {T206/151/15-154/19}
[236] Hayward {LFB00055191/24 §70} {T200/193/4-198/3} {T200/208/9-209/19}
[237] Hayward {LFB00055191/26 §74} {T201/16/11-17/18} {T201/35/3-40/11} {T201/51/24-55/5} {T201/56/11-25}
[238] Hayward {LFB00055191/24 §69} {T200/171/3-18} {T200/192/5-15} {T200/210/22-215/21}
[239] Hayward {T200/89/2-91/22} {T200/111/2-113/11} {T201/3/14-7/11}, {T201/15/5-19}, Brown {LFB00084020/10 §20}
[240] Hayward {T199/71/14-16} {T199/74/5-75/19}

received no formal training on how to train,[241] and those leading them had no qualification to quality assure.[242] The reason why there was never a training plan appears to be that no one understood what it entailed.[243] Monitoring of the training was compromised by POM Hayward essentially delegating the task to the OST, with oversight so-styled as reporting "*by exception*".[244] Control's AC line managers did not consider the training in any detail, and unlike (at least) with Babcock, the training and development department had no assurance role.[245] There was a chronic failure to record training dating back decades, which was never corrected partly because the Control room software was not properly integrated with the recording software used by the rest of the brigade, but also because there was no discipline in actually recording what was going on.[246] The opportunity to train at all was complicated by the watch system, which after 2011 could not accommodate a full day training, and was always at risk of interruption by calls or compromised by staff sickness and holidays.[247] In the three to four years before Grenfell Tower, the available time and staff for refresher FSG training, or any other training, was diverted to learning to use the new mobilising software, Vision.[248]

2.58. INTERNAL AUDITS: From Lakanal House to the aftermath of Grenfell Tower, a series of LFB internal audits repeatedly showed the provision of Control training to amount to a serious corporate risk. SM Kelly's audit in August 2010 identified gaps in adequate planning and recording systems for training[249] but by July 2012, no training plan was in place,[250] and by September 2012 AC Chandler was warning there could be "*no robust defence*" for its absence.[251] Training on FSG call handling formed a central focus of the Lakanal House pre-Inquest recommendations and actions,[252] such that the Coroner avoided

---

[241] Hayward {T199/28/25-30/5}
[242] Hayward {T199/31/21--33/1} {T199/37/4-38/3}, Smith {202/73/2-18} {T202/80/6-81/22} {T202/82/25-83/1} {T202/87/11-90/5} {T202/98/15-22}
[243] Hayward {T199/68/22-71/16}
[244] Hayward {T199/37/4-38/15} {T199/50/8-52/13}, Smith {T202/17/20 -18/21}. There was no formal 'sign off' on training modules: Smith {T202/87/19-88/5}
[245] Hayward {T199/37/4-39/20}
[246] Hayward {T199/125/5-128/3} {T199/131/9-137/14} {T201/134/14-23}, Smith {T202/90/6-94/17}
[247] Hayward {T199/42/13--47/1} {T199/49/9-50/6}: see further Bagnelle-Hayward-Chandler email (15 August 2012) {LFB00049927/2}, George *Review of Brigade Control* (July 2016) {LFB00032169/9 §39}, AC Smith *Control – Overview and Control Improvement Plan* (22 July 2019) {LFB00084097/2}
[248] FOOTNOTE 237 ABOVE
[249] Kelly Audit (3 August 2010) {LFB00109092/7 §§47-50}, Hayward {T199/76/5-79/11}: of those who did not see the Audit, see George {T205/7/16-21} {T205/99/6-20}, Dobson {T211/158/12-159/3}
[250] Brigade Control Management Meeting ('BCMM') (18 July 2012) {LFB00113237/8 Item 5}
[251] BCMM (12 September 2012) {LFB00113402/6 Item 5}, Hayward {T199/97/21-98/21} {T199/100/21-25}
[252] Control Room Report {LFB00004724/26 §§131-134} (records between 1994-2009 had previously been deemed incomplete and unreliable) {pp 31-32 §§166-170} {p. 49 §286} {pp 51-55 §§298-321}

making recommendations on the subject, but the review by GM Lindridge in January 2013 summarised all of the Lakanal Actions on Control training to be outstanding.[253] Brown's response to Lindridge was either one of denial, or to instigate further additional queries, assuming that Lindridge had got things wrong, rather than accepting that management of Control was not working.[254] When further queries were made, they were not followed up. A review by LFEPA in February 2014 singled out failure to maintain training records as a matter that could give rise to "*reputational damage in the event of a serious incident*".[255] By the time of AC George's review in July 2016, robust annual watch training and planning was still being recommended.[256] AC Jonathan Smith's 2019 Control Briefing Note criticised the training as ad hoc, lacking in structure, without quality assurance, and in need of "*complete and systematic overhaul*".[257]

2.59. POLICY 539: The original 2007 version of PN539 contained no warning of the dangers of promoting a false sense of reassurance to callers and was therefore in breach of FSC 10/93, which advised that this "*may not be appropriate, and may even be dangerous in some circumstances*".[258] During the Lakanal House fire, callers had been given such assurances in circumstances where their lives were at risk. The Gap Analysis had advocated correcting the training on the issue, but did not explicitly require amendment to policy.[259] All later versions of the policy from 2014 onwards would lack the requisite warning.[260] Appendix 3 of PN539 also suffered from potential confusion as to what it meant to be "*affected*" by fire, heat or smoke such as to require evacuation, and if so "*affected*", how to assess fire behaviour to determine whether the caller was actually "*unable*" to leave.[261] Although Appendix 3 to PN539 dealt with FSG calls, the Appendix cross-referred to (only) FSC 10/1993 and the template for handling FSG calls was dealt with in the Reference

---

[253] Lindridge Review (4 January 2013) {LFB00033943/5-6}: see further Dobson {T211/168/15-18}, Brown {T206/81/11-14}, Cotton {T208/116/13-20} *Cf.* George {T205/28/24-29/4} (never saw the document)
[254] [Draft] Lindridge Review with comments of Brown and Dexter {LFB00085854/12-14} and Brown {T206/81-86} {T206/94-96} {206/103-108} {T206/138/16-141/6} {T206/168/12-23} {T207/68/23-72/25}
[255] {LFB00044640/25-26}, Hayward {T201/48/25-49/23}, George {T205/98/17-100/9}
[256] George Review (July 2016) {LFB00032169/12 §49} {T205/88/20-91/9}, Hayward {T199/109/21-112/24}
[257] AC Smith *Control – Overview and Control Improvement Plan* (22 July 2019) {LFB00084097/3}
[258] FSC 10/1993{LFB00003617/1 §2}
[259] {LFB00004750/11}, Hayward {T199/174/14-178/8}
[260] PN539 (2014) {LFB00000737/5-7 §§4.20.4.34} {App. 3 pp 16-17}, FSG RIF {LFB00003542/3}: see Hayward {T199/174/14-178/8} {T199/179/6-10}, Smith {T202/117/15-119/20} {T202/125/8-24} {T202/139/6-140/9} {T203/79/14-80/11} {T203/89/5-19}, Brown {T206/107/21-108/24}: on incorrect training, see also Smith {T203/199/11-201/7}
[261] Phase 1 Report, {Vol. IV, §29.45a-i}: see further Smith {T203/71/15-75/1}

Information Files ('RIFs'). Cumulatively, this meant that PN539 *in its own terms* did not comply with national guidelines.[262]

2.60. POLICY 790: The aim of this new FSG policy was to promote "*two-way communication*" between call operators and the fireground.[263] However, Control received no direction of what was expected of the policy and the outcome in PN790 was never the product of a joint vision between Control and Operations.[264] Despite the obvious application to call operators and the handling of FSG, Control saw the policy as operational, and although something that they assisted in drafting, they did not train on or consider it in practice.[265] Operations, through SM Utting, found Control to be difficult to work with: in fact "*very, very controlling*".[266] He too lacked direction of what was required of the policy.[267] At root, POM Hayward always saw Control as taking its direction from the fireground. Control "*was not a command and control function, it was a service delivery function*" and therefore he could not conceive of it initiating a discussion about revision of Stay Put based on information received from callers.[268] SOM Smith understood that Control might at least "*contribute*" to the decision to change Stay Put advice,[269] but accepted that she personally had insufficient training on the detail of high rise fires to know how to take a more proactive role.[270] That left Control ill equipped in practice and in theory to participate in the revision of Stay Put advice.

2.61. STAY PUT: PN790 explicitly envisaged that in "*exceptional circumstances*" an Incident Commander may consider informing Control that their Stay Put advice should be altered.[271] Utting said he wrote the text and Control were not universally accepting of it. Smith said she suggested the matter based on events at Lakanal House.[272] Either way, the policy provided no explanation as to when, or how this would be done and there was no consequential training or amendment to the RIFs by Control to enable the change to be made.[273] Hayward's explanation was that Control did not ever expect revoking Stay Put

---

[262] Hayward {T199/182/14-186/20}
[263] Control Room Report {LFB00004724/55 Rec. 7}
[264] Smith {LFB00121219/26 §69}, Hayward {T199/202/10-203/3}
[265] Hayward {T199/204/5-205/15}, Smith {LFB00121219/26 §69} {T203/98/20-100/4}
[266] Utting {T198/104/25-105/17}
[267] Utting {T198/106/15-107/21}
[268] Hayward {T199/219/9-221/9}
[269] Smith {T203/93/12}
[270] Smith {T203/98/2-19}
[271] PN790 (2012) {LFB00001257/5 §8.7}: see also the original draft {LFB00083447/4 §6.6}
[272] Utting {T198/103/23-104/23}, Smith {T203/91/4-92/21}
[273] Smith {T203/94/12-98/1}

advice to happen; Smith agreed; and therefore no more was done to prepare for the possibility that it might.[274] The matter was also not revisited, as it absolutely should have been, when GRA 3.2 was finalised in 2014.

2.62. MULTIPLE FSG CALLS: There was never a system to register how multiple FSG calls, taken in their own right, could act as an early warning to consider revoking Stay Put. SOM Smith's explanation was that even after Lakanal House, 'multiple FSGs' "*was not a known phrase or concept*", and despite Lakanal, no one at Control anticipated "*a mass FSG incident*".[275] AC Brown suggested that multiple FSG was a "*scale issue of normal business*"[276] and so-called spate conditions (i.e. overload of calls) could be handled by the 'buddy' system with other brigade control rooms.[277] That overlooked the extent to which a 'buddy system' would lack even more situational awareness and integration with the fire ground than LFB's Control room. POM Hayward did not know why the findings (and indeed experience) from Lakanal House did not prompt a change of policy or training. He accepted that it should have done.[278] However, during his time none of the various joint training exercises matched the level of multiple FSG calls in Lakanal House, or anything more exacting.[279]

2.63. VULNERABLE CALLERS: Neither the policies nor the training emphasised the importance of collecting information on the vulnerability of callers, and including those who were with them.[280] This was contrary to national policy.[281] There was also a failure to study the profile and characteristics of the deceased at Lakanal House. Of the six who died, five were from Black or other migrant backgrounds, and three were children.[282] Two of the adult deceased were in contact with Control, as were the relatives and intermediaries of all three adults trying to seek information on their behalf.[283] POM Hayward and SOM Smith thought it

---

[274] Hayward {T199/221/10-222/20}, Smith {T203/94/17-18}
[275] Smith {LFB00121219/12-13 §29} {T202/158/18-159/24} {T202/162/5-163/9} {T203/106/21-22}
[276] Brown {T206/124/3-19}
[277] Brown {T206/131/2-133/2}
[278] Hayward {T201/141/9-144/23}
[279] See *Florian* (x 3 calls) {LFB00028803/6}, *Heygate* (x 4 calls) {LFB00033384/11 §7}, *Penfold* (x 4 calls) {LFB00003706}, Hayward {T200/25/12-23} {T200/42/9-25}, Smith {T202/171/13-177/10}: for expectation of no more than 5+ FSGs, see Hayward {LFB00121176/13 §49} {T200/59/23-68/6}, Smith {T203/134/7-135/16}, Utting {T198/124/6-125/19}
[280] As to PN539, see Smith {T203/11/23-12/22} {T203/13/20-16/18}. As to PN790, see Smith {T202/143/1-144/3} {T203/143/12-145/18}
[281] *Cf.* GRA 3.2 (2014) {LFB00001255/20}, FSC 54-2004 {LFB00118945/17}, Smith {T203/17/14-21/6}
[282] Catherine Hickman, Flat 79, 15.07.77, Southampton {TMO10038818}; Helen Udoaka, Flat 82, died in Flat 81, 31.05.75, Nigeria {TMO10038820} and her baby, Michelle Udoaka, 13.06.09 {TMO10038821}; Dayana Francisquini Flat 81, 14.12.82, Brazil) {TMO10038819} and her children Felipe Francisquini Cervi, 19.09.05 {TMO10038817} and Thais Francisquini, 25.09.02 {TMO10038822}
[283] {LFB00004724/37-38 §§185-186} {pp 41-49 §§ 220-285}: other FSG calls summarised {pp 38-49}

was intrinsic to the skill of call handling to encourage the caller to volunteer relevant personal information,[284] albeit that calls from Lakanal House and Grenfell Tower did not show that to be the case. Smith also believed that the prompts were contained in the RIFs and the training, only to be shown that they were not.[285] There was no instruction on how to speak to a person whose first language was not English, or otherwise to be culturally sensitive to people from different backgrounds.[286] Neither PN539[287] nor PN790[288] were the subject of Equality Impact Assessments.[289]

2.64. MANAGEMENT: Basic managerial standards in Brigade Control were fundamentally absent. Due to his multiple roles, AC Brown was never able to devote considerable time to the task and relied on AC Chandler, who was only in place for a short period, and then waited over a year for AC George's promotion to replace Chandler's vacant position.[290] At all times, the AC line managers did not habitually observe the Control room in action.[291] AC Brown took an unacceptably passive role to management leaving vital improvements undone for 6 years with inadequate follow up,[292] and relying on assurances as to progress with inadequate monitoring and oversight.[293] POM Hayward who was in the senior oversight position for ten years was a weak link; and known to be. Brown knew that there were problems with day-to-day management and Hayward simply not being proactive enough.[294] Yet Hayward's Key Performance Indicators ('KPIs') were limited to ensuring speedy call response times,[295] and nothing to do with training, record keeping, or any of the actions identified post-Lakanal and by the other audits.[296] The assurance of management performance was left to private meetings without formal KPIs and minutes. This left Hayward attending Departmental Management Board meetings that were invariably dominated by operational matters and not feeling he could speak up.[297] However capable SOM Smith may have been, she was stretched too thin and left to do far too much. It also

---

[284] Hayward {T201/96/7-98/12}, Smith {LFB00121219/16 §§40-41} {T203/12/19-20} {T203/17/1-13}
[285] Smith {T203/16/18-25} {T203/51/4-53/18} {T203/57/20-60/1} {T204/48/13-49/11}
[286] Smith {T203/22/16-24/6}
[287] Smith {T203/21/7-22/15}
[288] Utting {T198/138/4-139/18} {T198/147/4-21}, Smith {T203/146/6-149/13}
[289] Brown {T206/109/2-110/25}, George {T205/45/15-48/8}
[290] Brown {T206/52/18-53/17} {T206/56/16-59/12}
[291] Hayward {T199/10/15} {T199/13/7}
[292] Brown {T206/173/6-175-14}
[293] Brown {T206/10/18-12/2} {T206/47/25-48/18}
[294] George {T206/50/19-52/5}
[295] Hayward {T199/14/24-16/7} (92% of calls to be answered in 7 seconds)
[296] Hayward {T199/17/20-18/10}, George {T205/69/1-72/4}, Brown {T206/44/16-47/13}
[297] Hayward {T199/20/9-17}

left the OST playing a more extensive leadership role than was justified.[298] In all the circumstances described above, the entire system degraded in the way discovered by AC Jonathan Smith upon arriving at the LFB in 2019.[299] First Brown and then George ultimately held responsibility for ensuring that there was adequate management within Control and that Control could perform its required functions. They failed to discharge that responsibility. Hayward's redundancy in 2020 came far too late, but the failures – and their causes – were systemic.[300]

2.65. DEPRESSED SERVICE: The broader reasons for Control failing lay in it being a profoundly depressed and insecure service. Waiting for the FiReControl Project to arrive, and then ultimately terminate, meant that Control development was treading water for several years before and after Lakanal House, which included a freeze on recruitment and FRSs deliberately holding back on new infrastructure.[301] In the LFB, the consequences included Control room training never transferring to Babcock in 2012, because it was unknown whether Control would remain a service function.[302] By that stage the LFB needed to change its now aged software, but the change caused a massive blockage on all other Control development, because it was deemed as all-consuming to train on and it monopolised management and staff focus at the expense of all else.[303] The low morale and arrested development is what AC George encountered in his review of Control in 2016. Without ringfenced days, the shift system was seen as clearly contrary to the myriad demands of training, but George did not feel that the union could be tackled because the challenge of adapting to Vision were so great.[304]

2.66. FURTHER DISCONNECT: Control remained in another of the LFB's silos. The disconnect was geographical, but it was also cultural in that Control had simply not kept up with even the slow pace of change in the rest of the organisation.[305] If in theory it was given a seat at the organisational table as an "*essential department*",[306] it did not enjoy parity of esteem and

---

[298] For the failure to recognise the full extent of the failings, see Brown {T206/19/22-20/10}, Smith {T202/139/19-21} {T202/126/17-23}{T203/51/8-25}
[299] Jonathan Smith {LFB00084097/3}, George {T205/108/1-18}
[300] George {T205/108/19-24} {T205/137/23-140/4}
[301] George {T205/53/15-24}
[302] Dobson {T212/61/7-62/3}, Hayward {T199/115/9-116/1}, Smith {T202/64/2-6}, George {LFB00032169/4 §§16-17}
[303] Hayward {T201/137/2-9}, George {T205/18/17-20/23} {T205/43/19-44/9}
[304] George {T205/129/16-130/19}: see also Hayward {T201/76/4 -77/16}, Smith {T204/171/19-173/2}
[305] George {T205/82/7-84/20}, Roe {T213/179/3-180/24}
[306] Brown {LFB00032166/11 §27}

was never properly integrated as a fundamental component of operational response.[307] Ultimately it lacked the voice, management and drive to transform. The result was a service that answered phones, deployed resources, and could be reassuring to callers, but it did not have the competency to become an intelligent first and foremost line of response to people in danger, or an information resource and partner to assist in incident ground decision making. The adverse consequences for Grenfell Tower were enormous.

PART III: UNDERLYING CAUSES

[A.] GOVERNANCE

3.1. OVERVIEW: In the generation before the Grenfell Tower fire, the LFB service degraded because it lacked proper governance, culture, and accountability.[308] Those underlying causes explain why the organisation failed to evolve generally, and particularly with regard to preparing for foreseeable risks of catastrophic disaster. Governance of the LFB was compromised by the absence of (1) management competency, (2) organisational integration, (3) the exchange of information and ideas, and (4) quality assurance. Change will not occur without greater mastery of these areas.

3.2. COMPETENCY: Almost every modern study of UK FRSs has questioned the capacity of operational firefighters to competently rise from station to senior management, without discrete education, fast-track promotion, and lateral hire from other industries.[309] The pre-Grenfell generation of LFB leaders that the Inquiry has heard from joined in the 1980s, nearly all stayed at one service for all of their working lives and spent long years in middle management before ascending to DAC level or above. They then became responsible for the significantly enhanced statutory duties and managerial burdens on the public sector enacted by the FRSA and the RRO; as well as various guidance documents produced by the HSE and government. However, on very basic levels, these managers did not understand fundamental features of their role. By way of example, they could not distinguish between formal KPIs and setting unwritten goals that they might have with

---

[307] Jonathan Smith {LFB00084097/3}, Smith {T202/174/25-175/1}, George {T205/16/16-18/12} {T205/85/10-15}, Brown {T206/62/10-65/8}, Dexter {LFB00040774/11}, Cotton {T210/36/4-13}, Roe {T213/176/2-17} {T213/182/17-183/6}

[308] Roe {T212/169/18-170/12}: and see The Guardian (1 September 2020) {INQ00015028}

[309] Team 1 Module 5 Opening {BSR00000079/4-8 §§2.1-2.9}: see further Audit Commission (1995) [not on Relativity] §§96, 99-100}, Bain Report (2002) [not on Relativity] {p. 64-65 §§7.36-7.38}, White Paper (2003) {HOM00000584/58-59 §§8.1-2, and §8.5}, Knight Report (2013) {HOM00000023/35 §§20-21}{37-38 §26}, Thomas Review (February 2015) {HOM00031999/14-18 esp. §§31-33, 39 and 41}

staff in meetings without minutes.[310] They needed to be prompted to comprehend that the Health and Safety at Work Act 1974 applied not only to the safety of employees in the workplace, but safety of the public arising from the work of their employees.[311] They rarely considered the requirements of EIAs; [312] and when they did, saw it as staff-related and not of potential relevance to the protected characteristics of the public.[313] Non-operational and lateral hires from other sectors did not fare well.[314] DC Dexter's efforts to rationalise information gathering did not last beyond her tenure.[315] She was repeatedly informed by Commissioner Dobson to "*go a bit slower*" and advised "*you need to carry people with you*" but that was never "*straightforward*" in what was a "*complicated*" organisation.[316]

3.3. CONSEQUENCES: The lack of management skills did real damage. Commissioner Dobson began his post knowing that Fire Safety was disconnected from the rest of the LFB and that the LFB was disconnected from the rest of the country. He retired almost a decade later having solved neither problem.[317] AC Brown presided over a flawed system of high rise premises risk assessments[318] and chronic mismanagement of the Control room.[319] AC Cowup spent near on four years working on high rise firefighting policy, but left the LFB without guiding local policy and training into being ready to plan and evacuate for whole building failure.[320] AC and then Commissioner Cotton spent all of her senior leadership years in operational assurance, including applicable health and safety, but she did not assure service incident command readiness for catastrophic high rise fire risks.[321] She was then overwhelmed by the responsibility of the Commissioner role, and but for the Grenfell Tower fire she might have inadvertently led the organisation in siloed incompetence for years to come.[322] These people had no doubt excelled as (operational) firefighters and acted as good faith public servants, but they managed by metaphorically putting out fires rather than with strategic insight and vision. They were as ill-prepared for their

---

[310] Brown {T206/42/16-47/13}, Cotton {T208/17/10-25}
[311] Cotton {T208/11/16-23}
[312] Brown {T206/109/2-110/25}, George {T205/45/15-48/8}: PART II [F] §2.63
[313] PART II [C] §2.31
[314] Dexter {T180/78/21-80/11}: see also Roe {T213/127/10-18} (*"resistance…to bring in non-uniformed members of staff at a senior level…"*)
[315] Dexter {T180/79/15-80/11}
[316] Dexter {T178/164/8-165/2}
[317] Dobson {T212/60/22-61/6} {T210/105/8-107/11}
[318] PART II [B] §§2.15, 2.18
[319] PART II [F] §2.64
[320] PART II [D] §2.36
[321] PART II [C] §2.32
[322] Cotton {T210/28/19-29/6}

management roles in the LFB as WM Dowden was ill-prepared for his incident command at Grenfell Tower.

3.4. STRUCTURE: The structure of LFB governance significantly contributed to the creation of departmental silos and barriers to change.[323] The catalogue of disconnection outlined in PART II above left operational firefighting disconnected sometimes from *all* of Fire Safety, policy making, training specification and the Control room. Governing structure encouraged this disconnect because it persisted with vertical responsibility rather than cross-cutting horizontal leadership.[324] It allowed Directors and their Heads of Service to become overly focussed on their own departments and tasks rather than integrated into a single service. Too many times initiatives then got lost; policy did not translate into training (e.g. reversing Stay Put[325]); training did not get delivered despite being commissioned (e.g. construction risk[326]); or agreed actions were not properly audited for completion (e.g. control room policy and planning[327]). Aside from creating gaps, the vertical structure offered several opportunities for competing departments to hold up change because of their domain interests or habitual way of doing things[328] (e.g. adopting the DCP based on the burden it was perceived to pose to both operational training and amendment to policies[329]). Regardless of roles, all Directors ought foremost to have had lateral vision across the golden thread and interlinked functions of training, policy, prevention, planning, enforcement, control and response; but that continuously did not happen.

3.5. INFORMATION EXCHANGE: Each of the failures at Grenfell Tower rested on key actors, or departments, not knowing what should have been reasonably obtainable information within the organisation. Examples included: (1) the outward facing letters to central and local government about the instability of the regulatory regime, including the risk posed by cladding systems;[330] (2) not cascading the same information down to station crews;[331] (3) the extent to which the quality of the ORD entries was questioned by Borough group

---

[323] HMICFRS {SMC00000011/23}
[324] Roe {T212/159/11-160/12} {T212/83/4-84/10} *Cf.* Reason {T180/98/17-24}
[325] PART II [D] §2.36
[326] PART II [A] §2.8
[327] PART II [F] §2.58
[328] Cohen-Hatton {T185/88/2-90/10}
[329] PART II [C] §2.31
[330] PART II [A] §2.10
[331] PART II [A] §2.6

managers at the very time that it was being assured as reliable;[332] (4) the various audits of Control that showed it to be in breach of its Lakanal House action plan;[333] and (5) Control not even knowing about the existence of GRA 3.2, despite core parts directly affecting its service to high rise residential callers.[334] The fundamental failure of knowledge transfer about cladding risks, rapid fire spread and widespread compartmentation failure within the organisation was therefore indicative of a much graver problem involving lack of information exchange and joined-up thinking.[335]

3.6. HANDOVER: A particular failure of information exchange was the lack of proper handover between successive generations of higher management. The damage was greater precisely because the Brigade did not require subject matter specialists to assume Head of Service Directorial roles, and thus they depended on sufficient briefing to enable them to lead.[336] AC Daly became Head of Fire Safety without knowing of the Commissioner's letters to the DCLG in December 2010 and 2013 about the regulatory system; or that the Lakanal House fire involved non-compliant external cladding.[337] Andy Roe became AC for Fire Stations in 2017 without knowing that GM Elwell's paper had questioned the overall quality of ORD entries.[338] When AC Cowup and SM Utting retired from the Operational Policy department, the draft training on PN633, and all of the consequences of the late amendment to GRA 3.2, were left unresolved with their departure.[339] When AC George became responsible for Control under AC Brown's command he never saw SM Kelly's Audit, the two versions of the Lindridge Review, or the LFEPA governance and performance review all of which indicated serious shortcomings in the Control function.[340] Cotton became Commissioner without "*as clear a handover as anyone would have liked*", sufficient optimism in the regulatory regime such that she did not think that cladding fires could happen here, with little knowledge of the HSE landmark guidance that applied to her subject matter expertise in fireground operations, and with no strategy, or even comprehension, of the grave risks that faced her organisation.[341] Whatever regrets that

[332] PART II [B] §2.19: Elwell Paper (11 December 2013) {LFB00032825}
[333] PART II [F] §2.58
[334] Hayward {T200/53/13-54/22}, Smith {T203/19/15-21/6}, George {T205/149/12-150/3}, Brown {T206/151/15-154/19}
[335] Roe {T212/80/15-81/11}
[336] Brown {T206/41/6-25}
[337] Daly{T183/71/9-10}{T184/49/5-52/7}
[338] Roe {T213/110/1-111/8}
[339] Cowup {T196/75/3-25} Utting {T198/92/9-94/5}
[340] George {T205/5/25-9/2}: PART II [F] §2.58
[341] Cotton {T208/19/5-20/3}: PART II [A] §2.12

Commissioner Dobson now has about his failure to integrate the organisation or not pushing government to bolster fire and building regulation,[342] he did not tutor his successor on those insights.

3.7. ASSURANCE: In organisations, words like 'assurance', 'accountability' or 'culture' are spoken of without necessarily agreed understanding of what is meant by them. 'Quality Assurance' was completely misunderstood in the LFB to such an extent that the current Commissioner has essentially started the true discipline from scratch by the enrolment of outside consultants.[343] In 2018, AC Mills (as Cowup's successor) formally brought the auditing of all training into the Operational Policy remit with the admission that quality assessment is a skill in its own right, and that no one, or few, within the LFB had training/knowledge or qualification in its provision.[344] Until then, that basic understanding had not been confronted by LFB management. The idea that AC Brown and AC George should have grappled with how best to measure the pursuit of aims for premises risk assessment without expert input indicates an organisation that despite being responsible for the safety of a major capital city, was still measuring its performance by the rule of thumb evaluation carried out by traditional station firefighters. The lack of internal quality assurance was then further aggravated by the fact that the LFB, like all other FRSs, was not subject to external assessment and audit in the ten years before Grenfell Tower. The Commissioner repeatedly recognised the damage that had been done by this absence of scrutiny (see, further, PART III [F] BELOW).[345]

[B.] CULTURE

3.8. OVERVIEW: The governance of the organisation was very much a product of its culture. Its various blind spots came from collective mindsets that obstructed awareness on core issues, be it the need for guidance on evacuation, the importance of teaching crews about cladding, or proactively contemplating how policy and planning should adjust to aid residents requiring different assistance on grounds of race, gender and disability. Although industrial disputes and the theme of management-station divide is a continuing one, it is more helpful to see Brigade membership at all levels as heralding from the same dominant culture, with some of its more problematic attributes being (1) disproportionate virtue and

[342] Dobson {T212/62/4-18}
[343] Roe {T212/82/7-83/3}: see also HMICFRS (February 2021) {INQ00014795/19}
[344] Mills {LFB00055160/3-4 §§6-11} {LFB00055164/3 §§11-14}
[345] Roe {T212/79/18-80/14} {T212/81/21-82/6}

status afforded to traditional operational firefighting, (2) ambivalence about fire safety and other forms of less heroic tasks, (3) rigid hierarchy, (4) fear of criticism and (5) misunderstanding of the relationship between discrimination and actual service outcomes.

3.9. STATUS OF FIREFIGHTING: The real island unto itself in the LFB and probably other FRSs was Operations. Other functions culturally languished for recognition, and critically, Control and Fire Safety struggled for parity of esteem. Commissioner Dobson accepted the characterisation of Operations as the "*big beast*" as "*crude"* but "*accurate*".[346] This situation, and indeed its solution, requires understanding that it was culturally determined. Those who excelled in the organisation held that 'big beast' status. They excelled in engaging with fire, muscle memorising the standard techniques, fitting into watch culture; and functioned as hands-on charismatic leaders. They were rarely women, higher education qualified, or inclined to intellectual horizon scanning. They represent an ideal of courage and community service associated with original fire stations of the 19th century. Baigent's study refers to the impression of the heroic rescuer contained in the art of the period, to make the suggestion that at some level firefighters only like to deal with the public if they can save them.[347] Indeed, the cartoon of the firefighter saving the scantily clad female under the heading 'Standard Night Shift' in the A39 Blue Watch FSG training of January 2017 is strikingly similar to Charles Vigour's *Saved* (1892) that hangs in the Fire Heritage Centre of the Fire Service College.[348] The continuity rather proves the point that there is, at play in FRSs, a long-term ethnographic group identity reason why the operational response in the modern built environment has disproportionately focused on rescue, at the expense of any consideration of facilitated escape.

3.10. AMBIVALENCE TOWARDS OTHER TASKS: The flip side of the heroic operational firefighter is the ambivalence towards less heroic tasks of protection and prevention, especially if it involves paperwork or learning beyond standard routine.[349] This is why Fire Safety struggled for parity of esteem, both because its subject matter was non-operational, but also because all ranks, going right to the top, themselves struggled with

---

[346] Dobson {T210/108/7-17}
[347] {JTO00000002/136} showing (the wrong way round) Charles Vigor, *Saved* (1892) and John Everett Millais, *The Rescue* (1855): see further {JTO00000002/22-23 §1.11.2} {pp 98-99 §§6.2.2} https://www.frimedia.org/uploads/1/2/2/7/122743954/heritage-vol-4-no3.pdf
[348] {LFB00060350/7} *Cf.* Roe {T212/129/1-10} {T212/132/2-4}
[349] Dexter {T179/133/23-134/14} ("*difficult to interest people in fire safety*" which was "*overshadowed*" by firefighting)

confidence and clarity over the subject.[350] A powerful case in point is the email exchange in January 2016 between AC Cotton, GM Tony Biles, and other members of Operational Assurance and Resilience, over the article on the Dubai Torch Tower fire and its flammable ACM cladding panels, which made reference to paragraph 12.7 of ADB.[351] Cotton explained that her response to GM Biles, who wrote "*Always knew Clause 12.7 would be used somewhere by someone*", that she was "*surprised it's taken them so long to reference such a key piece of information!*", was truly a "*private joke*" and being "*flippant*"[352] (bluntly, mocking those who made granular citations to sub-paragraphs on building regulations and acknowledging that they did not know what they were talking about). No one in Operational Assurance thought to ask themselves about the relevance of ADB paragraph 12.7 or to seek considered advice from Fire Safety, even though its breach could be life threatening to both responders and residents.

3.11. HIERARCHY: In circumstances similar to the path of non-commissioned officers in the army, seasoned firefighters wait long years for promotions, where available posts as Deputy and Assistant Commissioner are strictly limited.[353] The actual mechanics of who got promoted and why have not been dwelt upon in the Inquiry evidence, although they have been queried as regards general process in other reports and the renewed HM Inspections.[354] As the organisation retains deference to hierarchy, it must have been difficult for their junior commissioners and borough commanders to navigate around the deficits of those who were more senior. In this complex order, even higher ranks would bow to superiors.[355] The *Peer Review* (October 2015) and the Peoples' Service Review (December 2017) respectively alluded to the opportunity for "*reset*" and "*unfreezing*" occasioned by the generation of Dobson-Reason-Brown-Cowup, all about to retire or having already done so.[356] Although the practical challenges of FBU strikes were mentioned by the three Commissioner witnesses, it is of some significance that mention

---

[350] Dobson {T210/144/11-19}: see further McGuirk {T190/109/10-110/12} (Fire Safety needed a big seat at the management table) but {T190/110/13-111/1} (operational officers required more technical knowledge)
[351] Biles-Cotton-Ellis-Drawbridge (7 January 2016) {LFB00024217/1} {INQ00014890/4}
[352] Cotton {T209/224/23-232/11} {T210/7/20-12/8}
[353] E.g. Brown {T206/56/19-59/5} (explaining the delay in George's appointment due to the AC quota of six)
[354] FOOTNOTE 309 ABOVE: further HMCIFRS (December 2019) {SMC00000011/37, 41, 44-45}, and for internal LFB recognition, see Roe, *Peoples' Service Review* (December 2017) {LFB00083845/3-4, 6, 22-23}
[355] Cohen-Hatton {T185/52/5-25} (communicating her disappointment on DCP to Cotton "*gently, perhaps too gently*"), George {T206/23/9-19} (on rejecting the Elwell recommendations, "*Dave felt that the – that that recommendation by itself did not meet the action from the coroner, and I had to go with Dave Brown's view on that.*"), Cotton {T209/80/15-16} ("*wouldn't presume to tell my line manager what he was going to tell the commissioner*")
[356] Peer Review (October 2015) {LFB00048265/27 §20}, Peoples' Services Review (December 2017) {LFB00083845/3}

has equally been made of the need to develop a greater degree of courtesy and joint responsibility as part of the makeup of the organisation.[357]

3.12. FEAR OF CRITICISM: There also appears to have been considerable negativity within the ranks about being performance reviewed, or otherwise focussing on lesson learning. Despite DC Dexter's efforts in the ODCB there was a general reticence to telegraph negative learning information upwards, and generally performance review and IMP data gathering was perceived to be a "*punitive experience*".[358] The consistent low level of any information reporting (on average never more than 4% of incidents) was accepted to reflect a default aversion to criticism.[359] The stance likely travelled into the reluctance to embrace the introduction of operational discretion.[360] Although Control had access to 'Call Coach' software to monitor calls, there was considerable staff opposition to the exercise to such an extent that FSG calls were not listened to through that medium.[361] But it would be wrong to see this sensitivity as limited to the lower ranks. Commissioner Cotton's defensiveness in the Phase 1 hearings was problematic, not least because it indicated an organisational closed mindedness to lesson learning or critical reflection from even the most senior rank. The witness statements to the Inquiry of both Commissioner Dobson and AC Brown expressed their belief that the LFB was governed by strong and open lesson learning values;[362] however, both of them were senior figures in the critical years between Lakanal House and Grenfell Tower, when the Brigade was unable to learn. Ultimately, fear and deflection of criticism at some of the higher levels combined with innate conservatism and resistance to change,[363] to obstruct the essential learning that was required throughout the organisation.

3.13. DISCRIMINATION: Commissioner Roe has accepted that there are continuing unresolved problems with racism and sexism within the service which are damaging to workplace culture, and have necessitated a wide ranging review that is now ongoing.[364] In advance of that review concluding, the Commissioner has denied that these matters affect service

---

[357] Roe {T213/214/25-216/21}: see further Peer Review {LFB00048265/34 §46}(concerning "*trust, openness and respect*" on all sides)
[358] Cohen-Hatton {T185/131/19-133/18}
[359] FOOTNOTE 152 ABOVE
[360] PART II [C] §2.34
[361] Smith {T202/38/11-39/13}
[362] Dobson {LFB00032157/8 §31}, Brown {LFB00032166/10-11 §§25-26}
[363] Cohen-Hatton {T185/89/7-16}("*a culture in London that is very conservative*"), Roe {T213/69/12-70/18}(accepting "*there has been a degree of conservatism and resistance to change in the Brigade*")
[364] The Guardian *Head of London Fire Brigade says it must face up to Racism and Misogyny* (19 March 2021) {INQ00015080}, Roe {T212/119/25-122/15}

outcome, emphasising that firefighters have always "*reached in to rescue people regardless of background*".[365] The story was told of a fire in King's Cross when the Commissioner still worked in stations, where his colleague was brave and adept at an incident involving Somali women and children, but then racist about "those *Pakistanis*" (using the offensive and abusive term), saying "*God, they breed like rabbits*", and to which Roe replied, ""*I hope so, mate, because I just married one", and there was a sort of tumbleweed moment*".[366]

3.14. DIVERSITY: This story tells something broader about culture and the continuing lack of diversity in FRSs. First, the younger firefighter Andy Roe, whose background was ex-army and boxing,[367] was quick witted and strong enough within the watch culture to fire right back at his colleague and create the "*tumbleweed moment*", but he did not report the racism, and presumably it would have been inconceivable to do so under the unwritten rules of watch culture. Second, and perhaps most importantly to the fatalities at Grenfell Tower, even accepting the Commissioner's evidence that the LFB's continuing problems with racism and sexism do not affect their approach to rescues, service outcome is not just about the bravery of rescue. Discrimination did damage the actual service provided to the BSR in terms of its contribution to the failures to plan.[368] Core policies that affected gender, race and nationality, and disability of residents were not quality impact assessed. National policy that in terms required consideration to be given to those matters as part of premises risk assessment and operator assessment of callers was overlooked. It is an elementary feature of discrimination that no one within the LFB even noticed that these matters were not in focus until the evidence of this Inquiry brought them to the fore. Third, consideration should be given to the extent to which disability was extraordinarily unconsidered across planning, control and evacuation, and the fact that people with disability are hugely underrepresented in FRSs, and potentially are not adequately related to as against the model of the ideal able bodied firefighter. Finally, lack of diversity in an organisation always constitutes a general danger to its service outcomes, because over-uniformity of background and experience impacts on diversity of thought, tolerance of difference, and broader capacity for service outcome evolution. Defensiveness and lack of curiosity on this subject is unnecessary;

---

[365] Roe {INQ00015080/2}
[366] Roe {T212/123/13-124/10}
[367] Roe {T212/72/11-73/5} {T212/132/19-133/4}
[368] *Cf* Roe {T212/124/15-126/15}: focus only on the point of rescue

for as Commissioner Roe accepted, it should not be lost on anyone that the vast majority of the victims at Grenfell Tower were Black or Asian or from other migrant backgrounds. Of course the same can be said of Lakanal House, although that factor was apparently never acknowledged internally by the LFB.[369]

[C.] EDUCATION

3.15. OVERVIEW: The shortcomings in training content and delivery, which there undoubtedly were, need to be seen through a default education culture in the LFB that: (a) learned primarily by reference to statistically expected and predominant experienced norms and assumptions, (b) avoided technical competency beyond practical steps required to discharge standard pre-planned responses, and (c) acquired from its outsourced training provider no more, and likely less, than the very limitations that would have existed if it was training itself. Cumulatively this amounts to learned deficiency where firefighters could discharge pre-existing plans but found it difficult to create new ones. Change would require a transformation of both this default education culture, but also the broader focus of the organisation.

3.16. NORMALCY: The failures uncovered by this Inquiry were of limited consequence to the normal course of fire ground operations. Most of the time, FRS responses do not require detailed knowledge of construction. BA teams essentially incident command themselves. Extensive radio communication is unnecessary. Emergency evacuation is uncalled for. Control provides logistical support to the fire ground and reassurance to the residents unaffected by fire. Most people who die in fires have not had time to make an emergency call. The neglectful failure to prepare for outright building failure might also be understood as the *risk of normalcy*: i.e. the potential for the statistical and experienced norm to overly condition both expectation and aspiration for what the organisation should be prepared for. That is the normalcy that impacted on the education of the LFB, and it provides the essential backdrop for the critique of competency provided by Professor Torero in his Module 5 report.

3.17. COMPETENCY: Torero's root cause for the failure of incident response at Grenfell Tower is that the LFB planned and trained on the basis of high rise building 'design' assumptions, without technical knowledge and understanding that those assumptions could fail and what to do if they did. The evidence in relation to all of the six failures in Part II are predicated

[369] Roe {T212/124/15-20}: for Lakanal House, see PART II [F] §2.63

upon a system that could not substantially conceive of a response beyond fire compartment intervention and rescue.[370] Commissioner Dobson's answer to the Lakanal House Coroner was that he could not "*imagine*" alternative planning.[371] The managers of the Control room did not believe that reversal of Stay Put and mass FSGs were ever going to happen.[372] Commissioner Roe accepted responsibility for the failure to provide guidance on when and how a Stay Put policy should be disapplied, but the organisation remained "*conscious of the challenges in setting such parameters, particularly in the light of the effectiveness of the stay-put strategy in appropriately built and maintained premises and the likely inability of such buildings to support alternative strategies*".[373] All these responses reflect a learned normalcy;[374] especially so as those who rise to the top of FRS management have tended to master practical approaches to standard firefighting.[375] Hence, Professor Torero's particular criticism of the LFB's failure of foresight in relation to cladding fires, which were known of domestically and internationally for more than a decade, such that the leadership who say that they could not envisage such disasters are admitting to "*an absolute lack of knowledge of past fires, but also complete misunderstanding of the behaviour of modern high-rise buildings*".[376]

3.18. FRAGILITY: An organisation, especially an emergency service in a major capital city, will be fragile if it evolves too heavily by reference to statistical likelihoods based on past events, without also considering the danger of statistically low probability but foreseeably severe impact future events. High rise residential firefighting is particularly exposed on this front. Past statistics, for instance those claimed in the LGA Guide and cited by Colin Todd that refer to 22 evacuations of more than 5 persons during 8,000 fires in blocks of flats in 2009-2010, tell something about frequency, but (as Torero emphasised) they tell you nothing about severity.[377] Moreover, they do not reflect that risk associated with the built environment is not static over long periods, such that even if the nature of construction over a given period has produced a set of statistics, new developments like the introduction of unsafe materials onto the construction market, can quickly transform the probability stakes.

---

[370] Team 1 M5 Written Opening Statement (6 August 2021) {BSR00000079/16-18 §§4.1-4.5}
[371] Dobson {CWJ00000010/115/12-17}: see further Dobson {T212/57/15-58/11}
[372] Hayward {T199/221/10-222/20}, Smith {T203/94/17-18} {T203/106/21-22}: further PART II [F] §§2.61-2.62
[373] Roe {LFB00060655/9 §21}
[374] Torero {JTOR00000002/25/875-879}
[375] Torero {JTOR00000002/25/884-885}
[376] Torero {JTOR00000002/23-24/828-831} {T191/153/23-155/1}
[377] LGA Guide {LFB00118893/20 §12.1}, Todd {CTAR00000001/109 §9.2.35(v)}, Torero {T191/39/12-14/19}

For those reasons, Torero emphasises that foreseeable risk must always be multiplied by consequences; and particularly so when the rarity of an event happening was changing as it was with cladding fires, and the adverse consequences if it happened were potentially catastrophic.[378] The LFB's approach to high rise firefighting before Grenfell Tower foresaw the hazards of rapid external fire spread, breach of compartmentation, emergency evacuation, and instability of the regulatory regime giving rise to a real risks, but then did not prepare itself for what remained a comparative statistical rarity of total building failure.[379]

3.19. TEACHING: Torero describes a fundamental flaw in training to confuse and thereby underemphasise real 'technical' competency with the teaching of prescribed 'practical' steps. The latter are part of the drilled behaviour required to discharge standard pre-planned responses in a confident and safe manner. What the LFB did not do (despite one training package that was drafted but never delivered) was to teach theoretically how fire behaves, and in particular how it interacts with the environment in which firefighters operate; in this case, a built environment determined by modern methods of construction and materials.[380] Research on FRS training suggest a strong bias of practical training over technical training.[381] The causes of this bias are explained in part by the trainers (and those who commission them) being serving or previous firefighters who were taught that way.[382] Its deeper roots lie in the continuing cultural ideal of operational firefighting, which values heroic masculine fitness and muscle memory, as opposed to theoretic and analytical endeavour; all of which studies have shown to be perceived as lesser, unheroic and stereotypical 'feminine' attributes.[383] Torero's view is that the research is strongly borne out in the training provided to the LFB and further translates upwards to compromise the decision-making of the incident commander and brigade leaders who can be lacking in more developed attributes.[384] It also explains the cultural disconnect between Fire Safety and the rest of the organisation, with Torero joking in his testimony, but with serious

[378] Torero {T191/38/14-40/22}, LGA Guide {LFB00118893/20 §12.1}
[379] Torero {T191/42/16-44/1} {T191/47/14-49/6}
[380] Torero {JTOR00000002/17/645-649} {T191/111/4-113/2}
[381] Torero {T191/115/15-118/9}, Holmgren *Reformed Firefighter Training Program in Sweden: conflicting instructor conceptions of professional learning* (2014) 4 Nordic Journal of Vocational Education and Training, 1-14 {JTO00000003/4}
[382] Torero {T191/121/18-122/6}: see further on Babcock's teaching faculty, Groves {MET00071103/16}, Ribband Star *Independent Review of Training* (11 September 2019) ('Ribband Star') {LFB00067786/12-16 §4.5}, Dobson {LFB00032157/12 §§51-52}
[383] Torero {JTOR00000002/17/650-652} {p.25/875-879} {T191/122/17-124/9}
[384] Torero {T191/113/22-124/16}

implication, that he warns his students that the primary experience of a fire engineer within UK services is one of "*humiliation*" based on the extent to which the intellectual orientation is so undervalued.[385]

3.20. OUTSOURCING: Against that background, the major problem with Babcock was not the outsourcing of training in its own right, but Babcock's co-dependency on the limited educational horizons of the client who by virtue of the contract terms and in practice remained the dominant party over curriculum content.[386] Although in theory Babcock was contracted to identify training needs and improvement,[387] it essentially did what LFB told it to do.[388] For their part, the Heads of Service tended to order the training modules based on previous years without too much analysis or broader planning.[389] A "*training burden*" operated within the organisation, in the sense that with its 400 workplaces and 1,700 station firefighters, priorities needed to be established.[390] Officers who pushed from below for new types of training, for example Cohen-Hatton and Elwell, were met with refusals that in substance concluded that the burden did not justify the perceived benefit.[391] The burden itself likely privileged practical learning over theory and innovation; and embodied the false statistical confidence that favoured training for frequency, as opposed to exposure to risk. The narrative that cladding fires *could not happen here* and that reversal of Stay Put was not ever expected, was another way of saying their perceived lack of likelihood did not justify the logistics of training on their possibility. Overall, the "*sheep dip*" quality of some of the training – so described by the Peer Review of 2015 – could therefore best be understood as the product of the LFB's true, if not wholly acknowledged – intentions.[392]

3.21. CONTINUITY: The TCAP process was "*lengthy, slow and cumbersome*".[393] In certain respects, most notably in incident command, Babcock lacked subject matter expertise, albeit like did the Brigade itself.[394] However, even with more trainers and less bureaucracy, it is not apparent that markedly different training would have been ordered or suggested.

---

[385] Torero (T191/125/13-17}: see further {JTOR00000002/17/630-637}
[386] Groves {T177/12/14-20}: see further Roe {T213/38/21-39/10} {T213/41/2-16} (emphasising that responsibility had to lie with the "*intelligent client*" in this sort of outsourcing arrangement)
[387] Reynolds {BAB00000074/3 §§12, 14, 18 and 27}, Kelly {MET00072166/10}
[388] Groves {MET00071103/11} {T177/35/11-23} {T177/36/3-37/25} {T178/9/2-24}
[389] Ribband Star {LFB00067786/31}, Groves {T177/17/16-18/4}
[390] Groves {T177/23/13-22}, Dexter {T178/159/18-160/11}
[391] Brown {T186/203/12-204/8} (process required existing training on PN800/s.7(2)(d) to be tested before adding to it), Cotton {T209/115/3-116/7} (reasons for not adopting DCP)
[392] {LFB00048265/31 §37}
[393] Kelly {MET00072166/11} {MET00040010/18}
[394] Groves {T177/48/20-55/19}, Ribband Star Report {LFB00067786/33}

AC Reason, whose responsibility for training predated the outsourcing, emphasised the considerable continuity of the training personnel.[395] Commissioner Dobson felt compelled to disagree with his successor Commissioner Cotton that there was a halcyon days gone by when new training could be easily and efficiently acquired from within the LFB.[396] Evidence relating to continuing LFB training of Control would tend to support this rebuttal. Moreover, irrespective of outsourcing, the vast majority of training was reliant on watch managers guiding CBT packages during shift hours, with no training on how to train,[397] and with other features of watch culture potentially operating to limit the quality of the learning experience. Finally, until recently the LFB did not understand quality assurance in any real sense; so, if it particularly failed to quality assure its training, that was a long term default, not something it could delegate to Babcock, and mirrored across other features of the service, most notably premises risk assessments.

3.22. POTENTIAL: Professor Torero's criticism of the institutionalised incompetency of LFB education can be summarised as (a) compliance was assumed, (b) knowledge of how to operate in complex construction or substantial non-compliance was never taught, and (c) technical understanding of the construction methods and materials of a building, and how this could impact on effective firefighting, was not a mandatory learning requirement for *all* levels of the organisation.[398] Commissioner Roe has essentially accepted these criticisms and sought a solution in the training of all employees to a certain level of fire safety.[399] Some vision of what is possible is demonstrated by SM Charlie Hanks in his brief role of incident commander during the Shepherd's Court fire in August 2016. He identified the external escalation of the fire via the uPVC window panels, concluded that there was an unacceptable risk of external vertical spread with an unknown risk of internal spread, and ordered a partial evacuation of the higher flats on the relevant side of the building, whilst keeping the need for total evacuation under review.[400] The education of this particular incident commander was that he was a qualified fire safety officer, similar to SM Egan who attended on the night of Grenfell Tower and who also believed that the behaviour of the fire in the context of the building made evacuation necessary.[401] SM Hanks

---

[395] Reason {T182/122/11-123/16}
[396] Dobson {T212/67/11-68/6} *Cf.* Cotton {T209/119/24-120/3}
[397] Reason {T181/5/19-6/11} {T181/7/10-8/16}, Cotton {T208/77/10-79/6}, Groves{T177/100/18-22}, Ribband Star Report {LFB00067786/19 §4.7}, Roe {T213/37/17-38/3}
[398] Torero {T191/11/12-12/16}
[399] Roe {T212/115/12-116/23}
[400] Hanks {LFB00032724/2-5 §5-8}
[401] Egan {MET00007515/2}

had also been a junior officer in the LFB unit responsible for the Lakanal House inquest.[402] Looking to the future, not every firefighter can be Jose Torero, but all of them could be like Charlie Hanks.[403]

[D.] HEALTH & SAFETY

3.23. OVERVIEW: The dictates of health and safety law prohibited the LFB from remaining uninformed and unprepared in relation to the key failures identified in PART II above, but legal regulations and core guidance issued by the HSE and Government were (1) not properly, if at all, reflected in the decision making of the senior leadership; and (2) compliance breaches were apparently unrevealed to them by internal assurance processes.

3.24. LEGAL FRAMEWORK: The relevant framework that should have acted as an internal safeguard against failure is contained in the Management of Health and Safety at Work Regulations 1999 (the 'Regulations'), which in this context, require systems to be in place to risk assess (Reg. 3), plan, organise, control, and monitor chosen risk preventive and protective measures (Reg. 5), inform (Reg. 10) and train (Reg. 13). The FRS sector related guidance issued by the HSE and DCLG in the aftermath of resident and firefighter fatalities between 2007 and 2010 particularly focused on supplementing the weaknesses in Incident Command and developing both the quality and processes for information exchange, both of which were to be properly supplemented by adequate FRS training, policy and assurance monitoring.[404]

3.25. BREACHES: It is manifestly the case that the LFB breached its duties under the Regulations and discrete guidance in that it unreasonably failed to sufficiently plan, inform and train operational firefighters in relation to (1) cladding system fires and other material sources of rapid and unusual fire spread, (2) the potential for multiple breaches of compartmentation, (3) revocation of Stay Put, and (4) methodology of emergency evacuation. It otherwise failed to comply with the PORIS and GRA 3.2 guidelines both with regard to preparing fireground response to identify a cladding system fire, and with

---

[402] Hanks {LFB00032724/1-2 §3}

[403] For Torero's "*required new approach*" for the organisation as whole, see {JTOR00000002/25-26} and Team 1 M5 Written Opening {BSR00000079/40 §§10.2-10.3}

[404] For the suite of relevant guidance, see PART II [B] §§2.14 and 2.26 concerning: HSE *Striking the Balance* {LFB00118237/2 and 4} (March 2010) HSE *The Management of Health and Safety in the GB Fire and Rescue Service* (October 2010){CWJ00000022/23-24}, DCLG *Fire and Rescue Authorities: Health, safety and welfare framework for the operational environment* (June 2013) {SMC00000012} esp. {8-9 §4}{19-23 §7}{23 §7.3}{32 §9}(DCLG and CFRA PORIS Guidance (March 2012) {LFB00091784}{20 §5.7}{21 §5.9}{37 §9.5}{38 §9.9}38 §9.10} {App. pp80-81, 84-85}and further GRA 3.2 (2014) {LFB00001255}

regard to establishing occupancy profile of vulnerable residents who were not otherwise able to self-evacuate. It equally failed to prepare Control to play its integral part in the revocation of Stay Put and provide its own protection of vulnerable and disabled resident callers.

3.26. FAILURE OF OVERSIGHT: Although the Inquiry has not heard from the relevant heads of the HSE department it is remarkable how little either the guidance or the manifest breaches reflected in the leadership decision making around the six core failures set out in PART II, so much so that it can only be understood as a further horizontal disconnection in LFB governance, in which health and safety law was also unable to impact on the mindset of the leadership with sufficient rigour.

[E.] ACCOUNTABILITY

3.27. OVERVIEW: The LFB was not sufficiently accountable at any point in time before the Grenfell Tower fire, when each of the above systemic flaws might have been identified and corrected by external oversight. Despite formal democratic oversight from the London Assembly and Mayor's Office, the LFB and all other FRSs in England and Wales operated for more than a decade without external inspection from HM Inspectorate or any other independent rigorous auditing as a direct consequence of Conservative party policy. This did damage to (1) the LFB's own capacity for self-accounting, and (2) the effectiveness of Government in discharging its duty to protect the public.

3.28. SELF-ACCOUNTING: Although accountability is generally favoured as a good thing, it is not necessarily defined why that is so, and often the virtues of transparency and accountability are treated as interchangeable when that is not the case. While the LFB went some way in seeking to be self-accountable to inquest proceedings and the London Assembly, it did not always succeed. A significant case in point is the first version of the Lindridge Review in January 2013 that set out in detail what pre-inquest actions were incomplete, as opposed to the final version in November 2013, which was much less explicit on the subject.[405] The episode reflects the systemic difficulty that public authorities (as indeed private companies) often manifest when they seek to self-account in that their candour tends to accentuate "*the good*", and under play "*the bad and the ugly*" unless legally required to do so.[406] The current

[405] Reason {T180/128/16-24} {T180/129/11-16} {T180/131/6-13} {T180/133/7-16} and Dobson {T211/169/22-170/10} {T211/172/8-25}
[406] *R (Citizens UK) v SSHD* [2018] EWCA Civ 1812 [2018] 4 WLR 123 §106

proposal for a public sector duty of candour would place the public interest above the reputation of any given authority.[407]

3.29. POLICY: As indicated in the Opening to Module 6, the removal of formal inspections of FRSs was the product of deliberate government policy.[408] This left the LFB accountable to the London Assembly but that singular principal/agent formal democratic accountability did not involve outside professional expert analysis; and could yield to the pressures of local politics that might prioritise one aspect of accountability (e.g. station closures) over others. Democracy as an accountability tool is necessary, but not sufficient. It also left Fire Services considerably less accountable than other public sectors, including emergency services. To take policing as a comparative example, in the ten years before Grenfell Tower, local police forces were subject to HMIC inspections, a complaints procedure overseen by the (now) Independent Office for Police Conduct, and the oversight of elected Police and Crime Commissioners. By contrast, aside from having none of those things, the FRS was no longer the subject of Audit Commission reporting as a result of its abolition in 2014. The National Audit Office report in November 2015 queried the effectiveness of delegated local accountability because the Peer Review processes were "*not always rigorous and independent*" and "*councillors generally lack independent technical support*" and could not easily compare standards with other authorities.[409] Localism, in this context, also detrimentally confused transparency with accountability, because even if it could be assumed that the LFB was acting in good faith in periodically publishing its headline aims, actions and spending, the same assumption could absolutely not be made that it was internally assessing and then publicly identifying its deeper systemic shortcomings. The evidence concerning LFB governance and management capability that has been given to the Inquiry indicates that the organisation was not capable to do so, even if it wanted to.

3.30. DAMAGE: The consequence was to leave the LFB without constructive expert criticism of its local weaknesses of governance, culture, education and compliance as identified above. The impact of the renewed HM Inspectorate reports after 2019 in identifying long term systemic deficiencies in UK FRSs across the country, and especially in the LFB, is a powerful indication of what was missed in the previous period. The various structural and

---

[407] Rev. James Jones, *The Patronising Disposition of Unaccountable Power – A report to ensure the pain and suffering of the Hillsborough families is not repeated* (Nov 2017 HC 511) The issue arises here, but applies strongly to RBKC and the TMO as examined in Module 3

[408] Team 1 M6 (Firefighting) Written Opening Statement (15 October 2021) {BSR00000087/3 §1.3} {p. 6 §1.8}

[409] National Audit Office *Financial sustainability of Fire and Rescue Services* (23 November 2015) {HOM00045998/12 §21}.

cultural disconnections within the LFB were incapable of seeing those problems in their full light, or otherwise achieving solutions to them. Commissioner Roe singles out this lack of scrutiny as a discrete explanation for the LFB's own failures in self-correction.[410] At least by 2016, before the Grenfell Tower fire, the danger of lack of FRS accountability was known to government, not least because upon the return of the responsibility of Fire Services to the Home Office, Theresa May (as Secretary of State) took immediate steps to introduce the inspectorate function. In the seminal speech announcing the change delivered in May 2016, she referred to a "*landscape still beset by poor governance and structures*" and a "*service that requires further reform to improve accountability, bring independent scrutiny and drive transparency*".[411]

PART IV: CONCLUSION

4.1. The depth of the failures of the LFB that contributed to this disaster is shocking. They impact not only on the BSR who directly experienced their consequences, but all other observers of the evidence who would otherwise instinctively depend upon and admire the firefighting vocation. The Brigade was incompetent and incapable at every level to respond to a fire that was extreme but foreseeable, and acted in breach of its duties under statute and policy. Those failings and their underlying causes ought to be recorded by this Inquiry in a fashion that ensures that no FRS could ever forget them and society from hereon will steer its path by them. The sooner the LFB publicly declares and acknowledges its own responsibility for the disaster, in acceptance of all the legal and reputational consequences this entails, the sooner it will begin to reclaim the trust that Commissioner Roe accepted that after Grenfell it lost the right to ask for.[412]

4.2. However, these failures did not take place in a vacuum. They were forged in the crucible of decades of government policy and practice. The idea advanced by the Commissioner that local fire services should, as they once did, operate within a national structure and be supported by consistent national guidance, assurance and inspection,[413] dates back to the review of the Fire Service chaired by Sir Ronald Holroyd in 1970. The report recommended enlarging and strengthening the Fire Department in the Home Office with "*specialist staff of high calibre with the appropriate professional training, qualifications*

[410] Roe {T212/79/23-80/10} {T212/81/21-82/6}
[411] May, Reform Event Speech {HOM00033231/8}
[412] Roe {T213/60/17-18}
[413] Roe {T212/79/18-80/9}

and experience". That body was to take greater responsibility for the collection of information, study of fire problems, and the provision of managerial services and guidance to the Fire Services on matters relevant beyond their local perspective. This would include administrative and functional responsibility for training colleges for operational research on firefighting, and fire prevention matters and for other forms of fire research. An Inspectorate was also to be under a mandatory duty with investigatory powers to inspect all Fire Brigades and report on the efficiency with which fire authorities discharged the whole range of their statutory functions.[414]

4.3. More than fifty years later, this Inquiry is about to hear that the FRS cover in the DCLG after 2006 was limited to a small department, which was cut considerably after 2010, and as a matter of political philosophy was increasingly encouraged to oppose central government involvement in the direction of local FRSs. The dangers of excessive localism and the costs of running down the centre have been dramatically seen in the erosion of the LFB. It would be naïve to conclude that the problem was not more widespread in other FRSs. Thus far the Government has taken no responsibility for allowing FRSs to degrade in the manner that the present Commissioner describes. The evidence of the systemic failings of the LFB begs the questions: what did central government know, or what should it have known, and what choices did it make? These questions (and more) fall to be put to some of the witnesses who will attend in the latter stage of Module 6, but as regards the LFB it appears that DCLG policy and practice allowed oversight and assurance of the service to fall into such a parlous state, that once the Home Office confronted its re-inherited brief in 2016 it had to act. By that stage, not only was it too late to intervene to rectify the provision of inadequate fire services, but successive governments had also presided over the degradation of the building regulatory system, such that residents and attending crews in high rise urban environments were exposed to a risk of disaster that the State foresaw, and contributed to, but did not take steps to prevent.

4.4. The bereaved and survivors will forever be connected with the LFB. Even though some were saved, many more deaths were avoidable, and those who were rescued were fortunate to survive. In their critical study of the evidence, the BSR have therefore done all they can to help the LFB improve, in memorial to those whose deaths were contributed to by its failures, and in support of the recovery of those who survived notwithstanding them. The

[414] Report of the Departmental Committee on the Fire Service, Chair Sir Ronald Holroyd (May 1970) ('Holroyd Report') {CTAR00000002/16 §§29-31} {CTAR00000002/81-83 §§105-109}

fact that previous inquiries, inquests and reforms have been frustrated makes it all the more essential to achieve the deepest possible understanding of why things went wrong at Grenfell Tower in order for that understanding to act as lodestar for what must now be put right.

DANNY FRIEDMAN QC & IFEANYI ODOGWU

BHATT MURPHY, BINDMANS, HICKMAN & ROSE, HODGE JONES & ALLEN

14 January 2022