LONDON FIRE
AND EMERGENCY
PLANNING AUTHORITY

Report title

Coroner's Inquests following the fire at Lakanal House on 3 July 2009

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Summary

This report presents the outcomes from the recent Inquests relating to the fire at Lakanal House on 3 July 2009 at which six members of the public tragically lost their lives and details the actions that the London Fire Brigade (LFB) will be taking in response to the Coroner's recommendations. The report also details the financial implications for implementing these actions and describes the governance and reporting arrangements that will be used as a means of monitoring the implementation of the actions.

Recommendation

To note this report including the cost implications and monitoring proposals, which are detailed in paragraphs 19 and 20.

Introduction/Background

1. On 3 July 2009 the LFB was called to a fire in a high rise residential block, Lakanal House, Camberwell, London. The fire started in a maisonette on the 9th floor and very quickly spread up the building to the 10th, 11th and 12th floors. Uniquely, the fire also spread down the building to the 5th and 7th floors. 6 people, including three children, lost their lives as a result of the incident. Additionally, 15 people were taken to hospital suffering from smoke inhalation and one firefighter was admitted to hospital for two nights to receive treatment for heat exhaustion. 38 people were assisted out of the building or rescued by the Brigade.

2. At the height of the incident more than 100 firefighters were at the scene as part of an attendance that included 18 pumping appliances, 9 Fire Rescue Units (FRUs) and a range of other specialist appliances and officers.

3. Following the fire the Metropolitan Police Service (MPS) initiated an investigation, which involved the Health and Safety Executive (HSE) and LFB, looking at possible manslaughter charges. However, in May 2012 the Crown Prosecution Service (CPS) announced that they would not prosecute as they were satisfied there was no realistic prospect of conviction for an offence of manslaughter by gross negligence or corporate manslaughter against any body or persons.

The Inquest

4. Following the CPS's decision not to prosecute, the Coroner, Her Honour Judge Frances Kirkham, set a date for the inquests. The inquests commenced at Lambeth Town Hall on 14 January 2013 and continued until 28 March 2013.

5. 45 LFB witnesses were called to give oral evidence and 20 statements were read out in court. This covered a range of operational staff who attended the incident and a number of senior/principal and specialist officers including myself who gave evidence in relation to a range of issues such as policy, familiarisation visits, communications, training and incident command.

6. As part of the preparations for the inquests a team of legal, operational, communications and Advisory & Counselling officers was formed to provide the appropriate support to all of the Brigade witnesses. This included face-to-face briefings on the procedures to expect at the inquests and welfare assistance in attending to give evidence. Throughout the inquests Brixton Fire Station was used as a base for the Brigade witnesses and guidance on Brigade policies relating to contact with the media was provided to all staff. The Brigade's Advisory and Counselling Service was also made available to provide private personal support to witnesses both before and after they gave evidence.

7. The Coroner summed up the evidence to the jury on 20 and 21 March 2013 and the jury provided their narrative verdicts on 28 March 2013. A copy of the 6 narrative verdicts are attached (Appendix 1). A full transcript of the Coroner's summing up to the jury, together with transcripts of the proceedings can be found on Lambeth Council's website[1]: http://www.lambeth.gov.uk/Services/CouncilDemcracy/LakanalHouseCoronerInquest.htm

8. During her summing up the Coroner also thanked all of the Brigade witnesses who gave evidence, especially those who found it difficult to relive the events of 3 July 2009.

Verdicts and Rule 43 Recommendations

9. In relation to the Brigade's response to the incident the jury's comments focused mainly on three matters. Firstly the perceived lack of knowledge amongst Brigade personnel about the layout of the building and flat numbering system. Secondly, the fact that smoke logging within the communal areas of the building, together with firefighters becoming involved in rescuing other residents, hampered rescue attempts from flats 79 and 81 (where the 6 deceased people were found). Additionally, the jury commented that insufficient efforts were made to prioritise these flats. Brigade Control training, communications between Brigade Control and the fireground and

[1] Lambeth Council hosted the Inquests. Lambeth Council further agreed to host publication of daily transcripts on their website so that proceedings could be closely followed without the need for attendance.

Brigade Control operator's reliance on callers being rescued were issues also highlighted by the jury.

10. The jury's verdicts should be considered against the background of the evidence of the fire officers and experts that this was a unique fire in the history of the fire and rescue services in the United Kingdom. In particular, the Coroner's firefighting expert Brian Davey explained that he had not found any other examples of fire having spread downwards in a similar manner. The jury also expressed their views in each verdict on the lack of fire compartmentation within the building.

11. The Coroner has consequently made 5 recommendations using her powers under Rule 43 of the Coroners Rules 1984. A Rule 43 report identifies actions that should be taken to prevent future deaths; one of these was addressed to the Brigade. However, the Coroner also acknowledged the extensive work that the Brigade has specifically undertaken in the period since the Lakanal House fire, which includes the following:

    - guidance to crews making risk assessments for sites in their area
    - guidance as to matters which should be noted by crews making familiarisation visits and visits pursuant to section 7(2)(d) Fire and Rescue Services Act 2004, including the gathering of information regarding flats or maisonettes with unusual layouts and
    - arrangements for access and use of aerial ladder platforms and other specialist vehicles
    - cooperation with London Boroughs to develop a pilot scheme for the provision of "premises information plates" at buildings
    - awareness that fire can spread downwards and laterally in a building and that burning debris might fall through open windows or on to balconies
    - awareness of the risk of spread of fire above and adjacent to a fire flat
    - procedures for moving a bridgehead
    - communication between Brigade Control and those at an incident
    - new guidance as to the handling of fire survival guidance calls and training for officers dealing with such calls
    - introduction of Mobile Data Terminals in all front line pumping appliances, and
    - introduction of forward information boards.

12. A summary of the specific Rule 43 recommendations sent to the Brigade is as follows:

    - It is recommended that the Brigade considers how to improve the dissemination of fire safety information to achieve effective communication with residents of high rise buildings
    - It is recommended that the Brigade review procedures for sharing information as a result of section 7(2)(d), familiarisation and home fire safety visits with crews both within the station in question and at other local stations
    - It is recommended that the Brigade review its policy and procedures concerning incident command, having regard to whether it is effective for the choice of IC to be tied closely to the number or type of appliances attending an incident and the effectiveness of a policy which may result in rapid and frequent changes of IC. It is also recommended that consideration be given to training of Incident Commanders to enhance their performance in relation to a number of specific areas
    - It is recommended that the Brigade consider whether training be given to operational crews about Brigade Control practices and procedures.

- It is recommended that the Brigade consider whether it would be beneficial to use additional breathing apparatus radio communications channels and personal radio channels at major incidents to reduce the amount of traffic on each channel.

13. Rule 43 reports have also been sent to the Department of Communities and Local Government ("DCLG") and the London Borough of Southwark ("LBS"). The Coroner has sent copies of the Rule 43 reports for DCLG and LBS to the Fire Sector Federation. Copies of all four letters are attached (Appendix 2).

14. The recommendations sent to DCLG covered consolidating national guidance in relation to advice to be given to high rise residents and reviewing guidance for tackling high rise fires in light of the unusual fire and smoke spread. The Coroner has also suggested that DCLG give consideration to requiring responsible persons for premises to provide information on or near to the premises which is tailored to the requirements of the fire and rescue service. This is something that the Brigade supports and has been proactively started to progress with London councils. The Coroner has also suggested that further guidance is needed in relation both to the scope of risk assessments of common parts of residential buildings that should be carried out under the Regulatory Reform (Fire Safety) Order 2005 and also the "definition of common parts of buildings containing multiple domestic dwellings."

15. Perhaps most importantly the Coroner recommended to DCLG that they encourage providers of housing in high rise residential premises containing multiple domestic premises to consider retro fitting of sprinkler systems. A specific recommendation has also been made to LBS that they consider retro fitting sprinklers in their high rise residential buildings. The Coroner in the Inquests into the deaths of two firefighters in Shirley Towers, a high rise residential block in Southampton, made a similar Rule 43 recommendation to DCLG in February of this year.

16. A further common theme to the Shirley Towers Rule 43 report was in relation to signage. The Coroner has recommended that LBS reviews signage within their premises to "provide information to those in emergency services which would assist them to understand a building's layout and enable them quickly to find a particular flat or maisonette once inside the building."

Response to Rule 43 Recommendations

17. Following receipt of the Rule 43 Report on 28 March 2013 the Brigade had 56 days in which to respond to the Coroner. The response was required to include details of any action taken or which the Brigade proposes to take, or an explanation as to why no action is to be taken.

18. The Rule 43 Report and narrative verdicts have now been carefully reviewed by the Brigade, with officers looking at a range of responses to address the underlying issues that prompted the Coroner's recommendations. In developing these responses officers have focused upon the key activities that will provide the most effective and sustainable improvements . Attached is a copy of the Brigade's response and the associated actions (Appendix 3) that was sent to the Coroner on 22 May 2013. Also attached as Appendix 4 is a letter dated 4 June 2013 from the Assistant Deputy Coroner to the Commissioner, acknowledging the careful thought that the Brigade has given to the recommendations proposed.

19. It should be noted that the Brigade's commitments detailed in the response to the Coroner's Rule 43 recommendations have a number of resource dependencies. These are:

- The communications department will require some additional resourcing to produce and deliver a campaign, including the production and distribution of campaign materials aimed at target audiences. This is expected to require additional staffing equivalent to an FRS E post and external costs for campaign materials of £60k.
- Two TCAPs (Training Commissioning and Alteration Process) have been completed with Babcock for the proposed training. The first covers the request for a high rise case study incorporating the learning points from Lakanal House and other high rise incidents. Babcock are responsible for the design of appropriate training and it is anticipated this will be computer based training. The second TCAP enhances existing training for incident commanders and for command and control to address the specific issues raised by the Coroner. The High Rise case study would probably involve contemporary media techniques, such as 3D modelling, to create a real time case study and some officer time to support the development. From previous similar exercises the total cost is estimated at £11,500 to £13,500. The additional costs of the enhanced incident commander and command and control training are anticipated to be minimal and deliverable within existing budgets.

20. Implementation of the proposed actions will be monitored at officer level by the Operational Directorates Coordination Board. It is proposed that regular monitoring reports will also be presented to meetings of the Resources Committee.

Head of Legal and Democratic Services comments

21. Rule 43 of the Coroners Rules 1984 allow a Coroner, who believes action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held, to report the matter to the person or authority who may have power to take such action. A response detailing any action taken or which it is proposed will be taken, whether in response to the report or otherwise, or an explanation as to why no action is proposed has to be given to the Coroner within 56 days. The Brigade has complied with these requirements.

22. Following the conclusion of the inquests the Authority, along with the London Borough of Southwark and one of its contractors who undertook refurbishment work at Lakanal in 2006/07, have been served jointly with civil proceedings. These proceedings fall under the Fatal Accidents Act, the Law Reform (Miscellaneous Provisions) Act and the Human Rights Act and have been served by the administrators of the estates of the people who died in the Lakanal House fire. Particulars of all of the claims against the three defendants have yet to be received, but the two so far received by the Brigade are each for significant sums. The Authority has insurance in place to cover its liabilities of this nature with an excess of £500k for all claims from any one occurrence. At present the insurer has not indicated that they intend to take over the management of the Brigade's part of the defence to the claims, but they are entitled to do so. As a result of this development the Authority has instructed Counsel to advise on the two claims that have been particularised, including the share of any liability between the defendants. A decision on how to respond will be taken once that advice has been received.

23. The Head of Legal and Democratic Services' further comments are included in the body of this report.

The Director of Finance and Contractual Services comments

24. As the report notes additional resourcing to produce and deliver a campaign, including the production and distribution of campaign materials aimed at target audiences, is expected to require additional staffing equivalent to an FRS E post and external costs for campaign materials

of £60k. This cost can be managed within officers delegated spending limits and it is proposed that the pressure this causes is monitored within the overall financial position as reported on a quarterly basis to the Resources Committee. The additional training commissioned from Babcock is deliverable within existing budgets.

Environmental Implications
None.

Staff Side Consultations Undertaken
None.

Equalities Implications
There are no equality implications.

List of Appendices to this report:
1. Appendix 1 - Verdicts
2. Appendix 2 - Rule 43 Reports
3. Appendix 3 - LFB Response to Rule 43 Report
4. Appendix 4 – Letter from Assistant Deputy Coroner

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985	
List of background documents: There are none.	
Proper officer	**Commissioner**
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