LONDON RESILIENCE PARTNERSHIP
Mass Fatalities Framework
STRUCTURED DEBRIEF REPORT

Incident:	Grenfell Tower Fire
Date of Incident:	14 June 2017
Date of Debrief:	18 July 2018
Debrief Location:	Prospero House, 241 Borough High Street, London, SE1 1GA
Debrief Team:	**Facilitator:** Steve North **Digital Scribe**: Charliy Merrick

Debrief Participants:

No	Name	Incident Role	Organisation
1	Barry Emmerson		NHS England London
2	Ashley Fegan-Earl		Home Office – Pathology
3	Neil Thomson		London Ambulance Service
4	Terry Leach		HM Coastguard
5	Manuela Roedler		London Resilience Group
6	Alex Townsend		London Resilience Group

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	Drake		
7	Gary Sheppard		Westminster Council Monetary
8	Sue Jones		Westminster
9	Howard Way		Met Police/ UK DVI
10	Hiternra Godhava		Royal Borough of Kennington and Chelsea
11	Dr Fiona Wilcox		Coroner
12			
13			
Jeremy Reynolds		None	LRG Observer
Fiona Mair		None	LRG Observer

Debrief Notes:

- Participants were informed of the ethics of the debrief process
- For purposes of cross-referencing comments, participants have been allocated a number
- The structured debrief will allow each participant the opportunity to reflect on their respective organisation's involvement at strategic level in the incident. The key issues around what went well, aspects for improvement, and recommendations will be discussed based on the protocol section headings.

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Item 1: Activation

Aspects that went well	Comment from	Supported by
Mass Fatalities Coordination Group followed the plan as soon as the group convened. This has been trained and exercised previously.	6	2, 3, 5, 7, 8, 9, 11
The local disaster plan helped to inform decision making (Westminster plan).	7	8, 9
The mortuary was extended as part of the plan (Local Mortuary Plan – Westminster)	9	

Aspects for improvement	Comment from	Supported by
Do organisations know the arrangements cover a Mass Fatalities incident occurs on the River Thames?	4	3
What triggers the Disaster Victim Identification response from the Police and other organisations in regard to mortuary numbers? {There isn't a trigger number but rather the complexity of the response – needs to clarify in the plan}	3	2, 3, 4, 6, 7, 9
Clarity needs to be made in the plan that finance (from multiple organisations) needs to be involved in the response and coordination from the outset (especially on page 15 -16).	5	3, 6, 7, 8, 9, 10

No.	Recommendations	Comment from	Supported by
1	Add wording to reminder users that the protocol in valid whether the incident is on land or water.	4	3, 6, 7
2	To clarify the trigger of the plan is not based on numbers alone but complexity of the response.	3	4, 5, 6, 8, 9, 11
3	The lead local authority needs to have the appropriate finance personnel to make the financial decisions. The plans need to reinforce that that appropriate finance personnel (from multiple organisations) needs to be involved in the response and coordination from the outset (especially on page 15 -16).	5	ALL

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Item 2: Notification

Aspects that went well	Comment from	Supported by
Mass Fatalities Coordination Group followed the plan with regard to notification.	6	2, 3, 5, 7, 8, 9, 11
Good communication occurred between coroner and London Resilience Group	11	2, 3, 5, 7, 8, 9, 11

Aspects for improvement	Comment from	Supported by
Local authority needs to cascade and activate their personnel though their internal processes (Westminster)	7	8

No.	Recommendations	Comment from	Supported by
4	There is currently a cross cover system with the coroners across London and is being formalised. Once this has been formalised, this needs to be added into the plan for clarity.	11	2 – 10

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Item 3: Mass Fatality Coordination Group (MFCG)

	Aspects that went well	**Comment from**	**Supported by**
	The correct organisations were at the meetings (face to face or virtually).	9	2, 3, 5, 6, 7, 8, 11
	Meetings were recorded and the minutes were decision reason action logs recorded by London Resilience Group. The minutes were the correct length for ease of sign off.	9	2, 3, 5, 6, 7, 8 ,10, 11
	Frequency of the meetings was appropriate to the response.	9	2, 3, 5, 6, 7, 8, 10, 11
	The attendees of the meetings evolved throughout the response and was inline according to need	11	2, 5, 6, 7, 8, 9
	Compliments from London Resilience Group on the meeting content and process.	5	2, 7, 8 9, 11
	Standard agenda aided to covered all points within the meeting; therefore nothing was missed (as appendix)	11	2 – 10
	Aspects for improvement	**Comment from**	**Supported by**
	There were issues with communication equipment (i.e. bad lines)	5	2, 6, 7, 9
No.	**Recommendations**	**Comment from**	**Supported by**
5	For robust communication equipment to be made available for members of the group.	9	ALL
6	Pre-determined options need to be considered where the Mass Fatality Coordination Group will convene and provide protected space and facilities available.	11	1 – 10
7	Include NHS England on the attendees list, as they were helpful on this response (Appendix E).	11	2, 3, 8 – 10

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<table>
<tr><th colspan="4">Item 4: Finance Management Group</th></tr>
<tr><th colspan="2">Aspects that went well</th><th>Comment from</th><th>Supported by</th></tr>
<tr><td colspan="2">Once appointed, the personnel working on the finance issues worked well</td><td>9</td><td>7</td></tr>
<tr><td colspan="2">The task of organising logistics (i.e. accommodations) was performed well under pressure</td><td>9</td><td>2 7 8 11</td></tr>
<tr><td colspan="2">Good relationship and good will from suppliers and stakeholders helped in the response</td><td>7</td><td>2 3 8 9 10 11</td></tr>
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<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><th colspan="2">Aspects for improvement</th><th>Comment from</th><th>Supported by</th></tr>
<tr><td colspan="2">This group was not convened, despite repeated request for finance representative by the London Resilience Group from the outset.</td><td>9</td><td>2 5 6 7 8 9 10 11</td></tr>
<tr><td colspan="2">Understanding and raising awareness of section 24 Coroners Act (regarding finance issues)</td><td>11</td><td>2 3 5 6 7 8 9 10</td></tr>
<tr><td colspan="2">With regard to logistics, it would have helped to have MOUs/contracts in place (e.g. hotels)</td><td>10</td><td>2 6 7 8 9 11</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><th>No.</th><th>Recommendations</th><th>Comment from</th><th>Supported by</th></tr>
<tr><td>8</td><td>Map communication lines between Mass Fatality Coordination Group and other groups including associated routes of accountability.</td><td>6</td><td>3 7 8 9 10 11</td></tr>
<tr><td>9</td><td>The Finance Management Group must be convened and cannot be detached from the decision making.</td><td>7</td><td>2 6 8 9 10 11</td></tr>
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Item 5: Other			
Aspects that went well		**Comment from**	**Supported by**
Due to the correct people being present at the Mass Fatality Coordination Group, science, law and ethics could be discussed.		11	2 3 5 6 7 8 9
Due to having experienced multi-agency personnel, who had worked together previously (trained, exercised and real time incidents), the whole Disaster Victim Identification response worked well.		11	5 6 7 8 9 10
Aspects for improvement		**Comment from**	**Supported by**
No.	**Recommendations**	**Comment from**	**Supported by**
10	Staff welfare needs to be discussed on the first SCG and tasked to a sub group and appoint a lead.	11	2 3 5 6 7 8 9

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