

SUBMISSIONS ON BEHALF OF SURVIVORS, BEREAVED AND RESIDENTS
INSTRUCTING BLJ AND OLIVER FISHER SOLICITORS¹: CONCLUSION OF PHASE 1

1. In these submissions, we address the role of the LFB in two areas of its operations only: the evacuation of Grenfell Tower (the Tower) and the management of Fire Survival Guidance calls (FSGs)². We acknowledge at the outset that the burden placed on the LFB by a total failure of the building envelope together with failures of the active and passive fire protection systems within the Tower presented formidable obstacles for their response. Nevertheless, it is an important responsibility of this Inquiry to identify individual and systemic failures that caused or might have contributed to the scale of the disaster and/or to the loss of life and we invite the Chair to identify the consequences of the LFB's lack of preparedness and the failures of its operational response as a necessary aspect of his Phase 1 report concerned as it will be with what happened on 14 June 2017³. Chief among those findings, in our submission, should be conclusions that the deficiencies with the LFB's procedures, the failure to manage a rapid evacuation of the Tower (including failures to advise residents that they were not safe to remain), the persistence with ineffective firefighting strategies, and the miscommunication of information to and from imperilled residents were serious failings which contributed to the loss of life⁴. The identification of those failings at this stage will make a meaningful contribution to the prevention of similar fatalities without which meaningful change will prove illusory. The bereaved, survivors and residents have already waited 18 months. In due course the Chair will have an opportunity to expand upon his Phase 1 conclusions after additional evidence has been heard including with regard to the circumstances of individual deaths and from the Inquiry's experts in Phase 2, but we do encourage the Chair to use the current opportunity to draw meaningful conclusions from the evidence that he has heard to date; such conclusions will provide a framework for the work to follow.
2. Our submissions are developed in the following structure: (a) our clients' position in relation to the evidence heard; (b) the requirements of Article 2; (c) the failures of

policies and planning: evacuation and FSG management; (d) the failures critically to assess the situation on 14 June 2017 and to improvise a rapid evacuation; (e) The ineffectiveness of the rescue tactics relied upon and their impact; and (f) the failures of management of FSG call information at the incident ground.

Our clients' position

3. In our written opening⁵ we observed that in light of the obvious risks of external fire spread in high rise buildings and the attendant risk of compartmentation breach, it was a paramount responsibility of the LFB to develop an alternative evacuation strategy prior to this disaster and that the failure promptly to abandon "*stay put*"⁶ on the morning of the disaster undoubtedly contributed to the loss of life. In light of the additional evidence now available we reiterate, on behalf of our clients, the propriety of that submission and invite conclusions accordingly. Further, we invited the LFB to identify without delay, the significant strategic, tactical and policy failures of its response⁷. This call to candour arose in the context of the LFB's prior knowledge (including constructive knowledge) of the risks of serious façade fire⁸ and the failings that had been identified in its response to the 2009 Lakanal fire. An acknowledgement of the failures for which the LFB was responsible in relation to this disaster has not been forthcoming; the LFB has neither identified lessons learned nor the means by which the necessary changes will be implemented, other than to the very limited extent addressed in their 24 October 2018 position statement⁹.
4. Our clients have listened to the evidence with care. It has been and remains their position that they have not received a reasonable explanation for the failures to immediately encourage those who were becoming affected by fire, heat or smoke¹⁰ to leave, the failures to undertake a rapid evacuation of the Tower once it had become or should have become apparent that its compartmentation was compromised, and the failures which led to miscommunication with and about the circumstances of imperilled residents. Whereas - from the perspective of the LFB - the wholesale failure of every layer of safety within the building (save the structure itself) was not foreseeable; the risks of rapidly developing façade fires and the development of multiple FSG calls in high-rise premises were well known and/or should have been. Our clients reject Commissioner Cotton's assertion that training and planning for the

phenomenon of rapidly developing façade fires would “*have made no difference*”¹¹; it is our clients’ informed perspective that the “*suits of the LFB let us down*”¹².

Article 2

5. The Article 2 jurisprudence, both domestic and European, provides a framework for the effective investigation of alleged breaches of the substantive obligation to protect life. The Inquiry is to have a phase of investigation in respect of each deceased, so that the matters specified in section 5(1) of the Coroners and Justice Act 2009 (the 2009 Act) may be ascertained with the aim of obviating the necessity for HM Coroner to undertake separate inquests¹³. The matters specified in section 5(1) of the 2009 Act are who the deceased was, how, when and where s/he came by his or her death¹⁴. In the context of a disaster such as this, Article 2 and section 5(2) of the 2009 Act requires that the matters specified in section 5(1) of the 2009 Act should be read as including in what “*circumstances*” the deceased came by his or her death. It merits emphasis that the requirements of an effective investigation under Article 2, and thus the “*circumstances*” in which these deaths occurred, include the Article 2 procedural obligations to identify: (i) defects in the system that caused or contributed to death¹⁵ including within the regulatory framework¹⁶ and/or through the adoption of unsafe practice and/or failures by those in command to ensure that safe practices embodied in policy are carried into effect¹⁷; and (ii) the state officials or authorities involved in whatever capacity in the chain of events in issue¹⁸. In the context of endeavouring to prevent future fatalities, potentially causative contributions are as material as causative ones¹⁹. The failings addressed in these submissions fall squarely within the arena of substantive Article 2 violations²⁰. The Chair’s task is to find facts and to make judgments upon them²¹. As the proceedings are inquisitorial, they are unfettered by any fixed burden or standard of proof. We would invite the Chair in relation to any finding arising from an area of factual controversy to record the degree of confidence with which a particular finding is found²².

The LFB policies: evacuation and FSG processes

Evacuation

6. The MHCLG’s “*Generic Risk Assessment 3.2 – Fighting Fires in High Rise Buildings*” (GRA 3.2) of February 2014²³ provides, “*where a “stay put” policy is in place, it should be safe for occupants to remain within their own property in the event of a fire*

elsewhere in the building” but that *“occupants (if they are able) should self-evacuate when the fire, heat or smoke is adversely affecting them in their property”* (whether or not the fire has started in their own property or elsewhere)²⁴. This is the definition of *“stay put”* relied upon in these submissions. Further, GRA 3.2 obliged the LFB to plan for breach of compartmentation including rapid vertical and horizontal fire spread and the consequence that *“stay put”* would not remain a viable evacuation strategy²⁵. This operational guidance placed the onus on the LFB to: gather information with regard to systems within the Tower and cautioned that poor maintenance might render fire engineered solutions ineffective²⁶; ensure that the information was capable of being accessed²⁷; develop contingency plans including with regard to fire spread beyond the compartment of origin, develop *“an operational evacuation plan ... in the event the “stay put” policy becomes untenable”* including for the evacuation of disabled, immobile and injured residents²⁸; and to equip Incident Commanders (ICs) to understand *“when a partial or full evacuation strategy might become necessary in a residential building where a “Stay Put” policy is normally in place”*²⁹. The guidance also noted that ICs must recognise where building design and materials may be impacting on fire spread and made specific mention of plastic and aluminium window frames and panels.³⁰

7. Whereas the LFB’s policies³¹ envisage the possibility of a compartmentation breach and a means to ensure that information marshalled in the course of section 7(2)(d) visits are accessible³², the local policies – in contradistinction with the national guidance – did not equip ICs to evaluate the necessity of a partial or full evacuation of a premises nor did they envisage the development of a premises specific alternative operational plan to address circumstances in which *“stay put”* becomes untenable albeit that the responsibility is placed upon the Incident Commander (IC) in relevant circumstances to direct a change of advice to FSG callers to provide encouragement to leave the property³³.
8. We invite the Chair to identify system failures: to implement the MHCLG requirement as to an alternative evacuation strategy; to equip ICs with the wherewithal to identify the need for a full or partial evacuation³⁴; to marshal the information in respect of the Tower envisaged by national and local guidance; to ensure that such information as was marshalled was available to those responding³⁵; and to identify and remedy these

deficiencies. We develop further below at §14 – 43 how these deficiencies contributed to the failure promptly to evacuate the Tower and we invite the Chair to conclude that these were serious system failings that contributed to the scale of the disaster or may have done³⁶.

The FSG process

9. A key recommendation of the LFB's main report³⁷ arising from the 2009 Lakanal fire - where six residents died and sixteen people were hospitalised³⁸ - was that *"Operational policies should better reflect the need for two-way communication between Control and the incident ground when FSG calls are underway"*³⁹ (emphasis added) and this imperative was ultimately reflected in the consequent *"Fire survival guidance calls"/Policy 790*⁴⁰. The two overarching aims of Policy 790 are to provide trapped residents with appropriate fire safety advice and to provide information to ensure rescues are targeted in an effective and rapid manner. By systematically and rapidly communicating essential information from 999 calls, the FSG process should augment the IC's knowledge from the fire ground itself⁴¹. The process also entails the feeding back of information about rescue actions to the IC and onwards to Control so that CROs are in a position to ask the right questions and so that the IC can determine the right advice to be given to callers⁴². Policy 790 is thus dependent upon ensuring that: the information reaching the fire ground is provided swiftly, is accurate, and is kept up to date⁴³; at the fire ground the information is recorded accurately, kept up to date, and passed swiftly to the IC to assist in tactical decision-making and to the bridgehead so that resources can be allocated to where they are most needed⁴⁴; and that debriefings at the debriefings are communicated back to the IC and the FSG Command Unit, in order that the full situation can be reassessed, and to the control room so that FSG callers are properly updated⁴⁵. At all stages the IC has a pivotal role.
10. An *"FSG call"* is defined by Policy 790 as *"a call received into control where the caller believes they are unable to leave their premises due to the effects of fire, and where the control officer remains on the line providing appropriate advice"*⁴⁶. The policy also provides – in accordance with a correct understanding of what *"stay put"* entails (see §6) – that *"callers will be advised to leave their property if they start to become affected by fire, heat or smoke or redial 999 if they are unsure or need further advice"*⁴⁷ (emphasis added). Thus, callers who state that they have *started* to become

affected by smoke, fire or heat should be advised to leave their property unless they are unable to do so; and it is only the latter category that are properly categorised as “FSG calls”.

11. Further as to the pivotal role of the IC, where multiple FSG calls are received, it is for the IC to deal with their prioritisation because he/she should have “*situational awareness*” derived from being at the fire ground and it is his/her role to prioritise resources according to greatest risk⁴⁸ and to allocate the first arriving CU to deal with the management of the information flow⁴⁹. As soon as resources allow, the IC should appoint an FSG coordinator at the fire ground to “*collate, record and retain*” all information received regarding the FSG calls and “*the subsequent actions on the incident ground*”⁵⁰. An early action by this dedicated officer should be to speak to a supervising officer at control to gather the latest information about the FSG calls in progress⁵¹. It is “*vital*” that all FSG information and updates are passed to the search coordinator and equally he/she should keep the FSG coordinator informed of rescue attempts and their outcome, and in turn that information must be relayed back to control⁵². The policy makes clear that it is for the IC to consider changing the advice so that callers are encouraged to attempt to leave the premises⁵³. The role is placed with the IC in appreciation of the importance of situational awareness⁵⁴: “*no control room officer could have ... a comprehensive picture of [an] incident and its progress*”⁵⁵. The IC’s situational awareness should include awareness of the success or otherwise of rescues⁵⁶ and the information emerging from 999 calls⁵⁷.
12. By 2014⁵⁸, the LFB were aware that Policy 790 was itself not fit for purpose for multi-call incidents. SM Peter Johnson, formerly of the dedicated Command Unit section at Islington⁵⁹, provided stark evidence that the LFB knew that Policy 790 was not suitable for anything other than the handling of a small number of FSGs. Mr Johnson had recommended changes to senior LFB policy managers, but these had not been implemented by 2017⁶⁰. The proposed changes arose for SM Johnson’s realisation that whereas the policy was appropriate to what the LFB handled on a day to day basis; it was not adequate for a large-scale high-rise incident involving multiple calls and multiple casualties⁶¹. To illustrate the deficiencies, specifically, that the FSG policy “*is a very difficult policy that has many flaws*”⁶² Mr Johnson devised a training package⁶³ around seven FSGs (the number on the FSG poster provided with the

command units)⁶⁴. The exercise demonstrated – and was intended to demonstrate, *“how convoluted and difficult the policy was and how resource intens[ive] it would be”,* how the *“communication channels would ultimately be demonstrated to conflict with each other”* and *“that it would be impossible to pass [the intended] information on within the timescales of what [he] felt was a realistic progression of a high-rise incident⁶⁵”*. With FSGs emerging from just four flats the communication of the information became difficult⁶⁶; *“we found it was unrealistic – impossible in fact – to pass the information on within those timescales⁶⁷.”* The training was intended to demonstrate that the policy needed to be *“changed dramatically to ensure that if we did have anything over three or four, we could adequately deal with it⁶⁸”*. It was SM Johnson’s evidence that although *“all agreed it was a good package”* a decision was made by the LFB’s outsourced training provider, Babcocks not to permit it to be moved forward as it had been deemed not necessary or not relevant⁶⁹.

13. We invite conclusions that there were significant failings: in not encouraging residents to leave, in the inaccurate categorisation of calls, in the failures to prioritise, in the failures of the ICs to act as a pivot for information sharing and decision making, in the reliance upon *“stay put”* in the circumstances, all of which contributed to the overarching failure to proceed with a prompt evacuation of the Tower.

Failures to assess the situation and improvise a rapid evacuation

14. In this section by reference to the DMM⁷⁰, we consider the failures of LFB officers to assess critically the dynamic incident, to develop an alternative strategic approach both prior to and following the formal abandonment of *“stay put”*, to communicate plans and objectives and to control activity. The DMM is a simple, scalable *“tool for Dynamic Risk Assessment”* which provides a framework for decision making by *“all personnel at all levels”* in respect of *“any task or event”⁷¹*. It entails first, deciding by gathering and thinking about all available information, identifying appropriate objectives, defining a plan and evaluation followed by secondly, acting by communicating the objectives and plan, controlling the activity and evaluation. The intention is for decision makers including ICs to proceed through the model regularly with repeated re-evaluation⁷². We note that the Lakanal Coroner recommended that ICs training in relation to the DMM should be enhanced so as to *“enable ICs to analyse a situation, and to recognise and react quickly to changing circumstances”⁷³*.

The objective information

15. Externally, fire spread into the cladding at 01:08⁷⁴ placing the “*stay put*” strategy in jeopardy⁷⁵. A significant cladding fire developed in the minutes thereafter⁷⁶ such that the fire spread to L5 was obvious by 01:13⁷⁷ and a total of 8 flats by 01:21. An increasing number of flats were at a high risk of fire ingress⁷⁸. By 01:26 the external cladding fire had spread to L23 such that the occupants were no longer safe to remain⁷⁹. PC Sangha radioed MPS control seeking assistance with the evacuation of the building at 01:28⁸⁰. 20 flats were affected by the external flame front by 01:26⁸¹ with internal fires visible from the exterior by – at the latest - 01:44⁸². Large internal fires were visible from the exterior within F66, F76, F96 and F186 by 01:52⁸³ and within F46, F86, F106, F116, F126 and F136 by 01:57⁸⁴. By 02:10 there was significant external fire and multiple internal fires observable on the North façade⁸⁵. By 02:30 the east elevation was “*fully involved in fire*⁸⁶” with multiple internal fires visible⁸⁷. By 02:35 the east, north and south elevations were on fire⁸⁸.
16. Internally, Dr Lane observes that there was a close correlation between the external fire spread and the spread of smoke to the corresponding lobby; for example, smoke was first recorded in the lobby of L22 at 01:23 and fire had spread to the top of the east elevation by 01:26⁸⁹. In the period between 01:11 and 02:00, fire fighters observed internal smoke spread within the lobbies at L4 – L12, L15 – L16 and L20⁹⁰. Significant smoke was first observed in the stairwell by FF O’Beirne at L5 to L9 as he progressed up the Tower between about 01:30 and 01:38, with conditions at all observed levels (that is, up to L20) continuing to worsen in the period to 02:00⁹¹. In the period between 00:58 and 01:49 there were large numbers of self-evacuations (including from L20), there was then a lull before self and assisted evacuations resumed at 02:18 with residents from L9, L12, L14, L15, L17, L19, L20 and L23 evacuating in the period to 04:00.
17. At 01:01⁹² the LFB ascertained that they were unable to control the fire lift and there was no firefighting lift. It was clear that the internal passive measures and any lobby smoke control system were not preventing smoke spread to the lobbies (by 01:11)⁹³ or the sole staircase (by 01:30). It was FF O’Beirne’s evidence that he confirmed his observations in these respects to the bridgehead at about 01:38⁹⁴. There were other

significant obstacles to reliance upon traditional tactics including the location of the dry risers within the lobbies.

18. At control, by 01:30, there had been FSG calls reporting 15 adults and 3 children. By 01:40 several residents had reported to LFB call handlers that fire was directly impinging upon their flats⁹⁵. There was a significant increase in FSG calls in the period between 01:25 and 01:45 (26) with the majority (85%) attributable to flats above L13⁹⁶. By 01:50 some 33 FSG calls had been received with a surge of such calls (23) between 01:30 and 01:45⁹⁷. By 02:00, 45 adults and 16 children had been reported. By 02:15 there had been 49 FSG calls⁹⁸.

The incident commanders

19. WM Dowden acknowledged the importance of taking up a position outside the Tower to achieve situational awareness⁹⁹ and the importance of following the DMM¹⁰⁰ but expressed himself unconcerned at 01:12 – 13¹⁰¹ at a time when there was obvious fire spread to L5 (§15); at 01:19 he appreciated that the *“fire was developing outside that compartment on the external”* but could not recall discussing this with anybody¹⁰²; although he appointed CM Secrett to be his *“eyes and ears on the bridgehead”*¹⁰³ - he subsequently failed to achieve any meaningful report back as to the situation internally¹⁰⁴; he did not consider appointing a search coordinator at that stage nor did he consider evacuation because he did not know what was happening internally¹⁰⁵; he was unaware of the FSG calls in progress from 01:19¹⁰⁶ and he did not achieve awareness of the nature of the calls subsequently¹⁰⁷ - he had no contact with the Control room; he did not consider what he might do if the fire were to get out of control on the exterior¹⁰⁸; he concluded that he did not have the resources to effect a full evacuation at 01:24¹⁰⁹ - he considered this option *“impossible”*¹¹⁰ despite the self-evacuations that were occurring in this period¹¹¹; he became *“consumed in terms of what was happening in front of me”*, experienced *“sensory overload”*¹¹²; *“did not consider to what extent the internal of the building had failed”*¹¹³; did not effectively communicate the external presentation to the bridgehead¹¹⁴ nor to Control¹¹⁵; he did not re-evaluate the plan when he appreciated that persons were involved although this was a *“pivotal change”*¹¹⁶. As to his responsibility to consider a change in the advice to callers, he did not have information concerning the internal conditions sufficient to promote a reconsideration of *“stay put”*¹¹⁷, although it was his

responsibility to do so, he did not consider the need to do so when he met with SM Loft¹¹⁸ nor when he met with WM Watson at 01:29¹¹⁹ - despite an appreciation that the external jet was having no effect¹²⁰, when he made pumps 20 at 01:29¹²¹ nor when he handed over incident command to SM Walton at 01:50 – 01:57¹²². WM Dowden's plan – consistent with addressing a compartment fire in F16 and minimal external fire spread – was to seek to extinguish the fire in F16, to direct a ground monitor at the external fire and to get resources to the scene. As described by DAC O'Loughlin *"primarily his plan was to start to get to the fire survival guidance calls that were in place ... they didn't have a plan for the whole rescue and evacuation of the building"*¹²³.

20. As he assumed command of the incident, SM Walton's primary consideration was *whether the "fire was getting back in"*; if so, he would have declared a major incident appreciating that *"everybody in that building [would need] rescue, and I would have to deal with that."* It was his recollection that WM Dowden described having committed BA crews to determine whether there was fire ingress¹²⁴. WM Dowden was not able to clarify whether FSG calls were in progress because residents were in fact trapped or merely believed themselves to be; nor whether BA crews were reaching the flats from which FSG calls had been made nor whether the fire was getting back in to the Tower¹²⁵. SM Walton's first intended action was to send WM Dowden to the bridgehead to determine the conditions internally¹²⁶. Objectively, the internal of the building was by this stage seriously affected by fire ingress.
21. DAC O'Loughlin assumed incident command from SM Walton within a few minutes (01:56)¹²⁷. He did not discuss the viability of the maintenance of a *"stay put"* evacuation strategy¹²⁸ - it was his assessment that residents would self-evacuate from the north-east side of the Tower; he had no expectation that any other flats would be affected even at this stage¹²⁹ and at no point prior to his being relieved of his incident command at 02:43 did he expect *"the fire to spread around the building like it did on the outside"*¹³⁰; and *"it wouldn't have occurred to me that compartmentation has failed throughout the buildings"*¹³¹. His assessment was that *"people who were safe in their flats should stay safe in their flats, and the south-west side would be an example of that. There's no reason to believe they should've been affected"*¹³² but also that callers would *"be told to leave"*¹³³. He did not form a view as to whether the fire could

be contained or controlled in any way but relied upon an expectation of the *“fire burning out above the 12th to 13th floor”*¹³⁴. He considered that he did not need detail about the FSG calls to formulate a plan¹³⁵. He turned his Airwave radio off as he approached the Tower¹³⁶ although he accepted that information feedback from the various sectors was important for the purposes of adjusting plans¹³⁷. He did not have information as to conditions in the Tower¹³⁸ but formulated a plan to *“prioritise the people who are most at risk”*, those on the north-east of the Tower and the upper floors, and to thereafter search *“all the floors below that and evacuat[e] everyone”*¹³⁹ with the perspective that *“it would probably be safer to keep some of the people in the building until we had put the fire out”*¹⁴⁰. His expectation was that there would be smoke in the staircase but *“no issue”* with EDDB crews making progress in those conditions¹⁴¹. He considered that information would become available to him after he had established a fire sector¹⁴²; he did not ascertain from WM Dowden whether L4 – L6 had been evacuated and was not surprised that WM Dowden did not know whether BA crews had been sent up to the higher floors¹⁴³. He observed that everyone would have to be evacuated from a building affected by a 40-pump fire¹⁴⁴.

22. Consistent with the assessments of SM Egan, WM Harrison and GM Goodall (see below at §28), it was AC Roe’s conclusion that the *“stay put”* advice was *“absolutely unsustainable”*¹⁴⁵ when he arrived at 02:43: *“the first thing in my head was that we were no longer going to be able to reasonably advise people that they should stay put”*¹⁴⁶, *“we had a complete failure of the building”*¹⁴⁷ and assessed that the lobbies were likely breached because he *“could ... see through the building”*¹⁴⁸. He determined that the *“absolute priority”* was to *“really focus on getting everyone out of that building”*¹⁴⁹. AC Roe’s assessment was informed by his visual evaluation of the Tower and a *“snapshot”* of the FSG position¹⁵⁰. He proceeded to develop objectives - to regain control of the incident ground and a strategy - flooding the Tower with firefighters to ensure there was assistance for residents to escape¹⁵¹ and confirming the abandonment of *“stay put”*¹⁵² but he did not consider the means by which residents – including those who had been advised to remain and/or who considered themselves trapped but who were not in contact with Control – might be encouraged to evacuate. AC Roe’s decision making was based upon a belief that the staircase had insufficient capacity for simultaneous evacuation and fire fighters¹⁵³.

Discussion

Guidance

23. The GRA 3.2 matrix¹⁵⁴ itemised the eventualities that in fact materialised on 14 June 2017 and provided control measures in relation to them: (a) difficulties experienced by ICs and others in achieving confidence as to the extent of fire and smoke spread to be addressed by cross-checking information obtained from diverse sources (10); (b) fire on multiple floors to be addressed by considering the need for evacuation outside the fire sector (16); (c) smoke travel and the “*stack effect*” to be addressed by considering additional evacuation (21); and (d) An evacuation of the building made necessary by reason of “*stay put*” becoming untenable due to unexpected fire spread to be addressed by “*utilis[ing] other emergency services to aid movement of casualties/public to safe areas*” relying upon “*all means of contacting persons within building, such as intercom telephones, loud hailer etc*” (23).
24. The realities of the fire spread across the external envelope and into individual flats should have brought those control measures to the forefront of decision making and led to a strategy based upon rapid evacuation¹⁵⁵ supported by external as opposed to internal firefighting¹⁵⁶. Once compartmentation was breached evacuation was necessary to secure the safety from fire of those who remained in the building¹⁵⁷. It was also necessary to evaluate the potential contribution of “*defend in place*” firefighting tactics to the further compromise of the sole staircase¹⁵⁸. In Professor Torero’s opinion, the opening of doors to the stairs (an inevitable consequence of internal firefighting) would be “*the primary mechanism by which the stairs would be compromised*” as against failure of the stair doors¹⁵⁹. Such an eventuality was anticipated by the LFB’s local policy 633¹⁶⁰.

The incident commanders

25. WM Dowden had been ill equipped by the LFB to command an incident even close to the complexity with which he was faced; in his own words he had “*nothing to fall back on*”¹⁶¹. Specifically, he was ill equipped to respond to the negation of “*stay put*” by reason of the building failure¹⁶². LFB systems did provide for a “*monitoring officer*” to remotely monitor the incident and that role was assumed by SM Walton at 01:02:43¹⁶³ but there was in fact no support from him until his arrival at the fire ground. Further, it was intended that an officer of DAC rank assisted by a monitoring

officer of AC rank would assume responsibility for a 10-pump fire¹⁶⁴ but even WM Dowden's rapid escalation of pumps did not result in effective intervention from a monitoring officer nor assumption of command or remote support by a more senior officer within a reasonable period¹⁶⁵. Left alone to manage the response, he did not manage to gather sufficient information to formulate relevant objectives; he did not develop a plan that fitted the situation and he did not implement one.

26. The LFB has singularly failed to explain to the inquiry why the relevant procedures did not result in command being assumed from WM Dowden (in respect of whom the expectation was that he could manage a 4-pump fire only) – at least remotely – from an early stage. It was a significant institutional failing that WM Dowden remained responsible for decision making throughout the first critical hour of the LFB's response without his having had relevant experience and despite his training having been limited to the DMM without "*any practical training*" as to incident management¹⁶⁶. The consequences were that for this first hour the plan remained focused on putting out a fire in F16¹⁶⁷. The evidence that this was a systemic issue arises from the evidence of WM Dowden¹⁶⁸, SM Loft¹⁶⁹, SM Mulholland¹⁷⁰, WM Meyrick¹⁷¹, SM Cook¹⁷² and DAC Fenton¹⁷³.
27. WM Dowden was not alone in being ill equipped to reconsider "*stay put*" and implement an alternative evacuation strategy¹⁷⁴. It was only the more senior officers who reflected awareness of the limitations of "*stay put*" and appreciated that the alternatives were a managed full or partial evacuation¹⁷⁵. The transfer of command of the incident to DAC O'Loughlin afforded an opportunity to re-consider the strategy. The fundamental errors with DAC O'Loughlin's command arose from his failure to achieve situational awareness before proceeding to develop a strategy, his failure to contemplate breach of compartmentation¹⁷⁶ and his failure to re-evaluate his decision making: his actions were not informed by the nature and content of the FSG calls¹⁷⁷ although he accepted that it was not safe for anyone to remain if their flat was affected by heat, smoke or fire¹⁷⁸. Despite a raging fire across the east and north façade, multiple internal fires, large numbers of 999 calls¹⁷⁹ and with worsening internal conditions, he permitted three quarters of an hour to pass from his assumption of incident command before he passively accepted the change of policy from "*stay put*". It is of critical importance in this context that in accordance with

common sense and Policy 790 that it was for the IC to change the policy, for the IC to deal with the prioritisation of FSG calls and the deployment of resources, prioritised by risk (§4.2) and for the IC to implement evacuation by alternative means because only s/he was expected to hold “*situational awareness*” of the fire ground.

28. DAC O’Loughlin’s assessment of the fire event stands in stark contrast with the objective information and the impression of other LFB officers. SM Egan’s impression on arrival at about 01:55¹⁸⁰ “*by just looking at the building*” was that “*everybody’s lives were in danger – residents, firefighters, everybody and it was a case of they just needed to get out*”¹⁸¹, “*you cannot put that out*”¹⁸² and he appreciated that “*the compartmentation has broken down, so you need to get the people out*”¹⁸³. It was his view that efforts to put the fire out would be a waste of resources¹⁸⁴. WM Norman Harrison formed a similar impression at 01:42; it was his assessment that “*stay put*” did not apply because the residents were “*going to be affected by the fire, the flames, heat or smoke*”¹⁸⁵. Similarly, GM Goodall on his arrival at 02:04¹⁸⁶ and see AC Roe at §22 above. AC Roe did not consider the alternative means of evacuating residents nor the ineffectiveness of the firefighting and rescue tactics that were being relied upon (see further below at §39-43).

Failure to declare a major incident

29. There was inordinate delay in declaring this event a major incident¹⁸⁷; more than half an hour after the MPS. The *potential* for this to become a major incident was apparent from at least 01:21 when 8 flats were affected by fire¹⁸⁸. The JESIP guidance provides “*it is important that all individuals who could be first on scene for their respective responder agency are able to declare a major incident*”¹⁸⁹ but the evidence heard was that the LFB had not equipped WM Dowden to make a declaration with regard to this exceptional event¹⁹⁰. Significantly, “*once the Brigade has been alerted of a potential major incident, an initial Commissioner’s Group meeting should be convened (in person or via teleconference) to agree the Brigade’s response strategy and key response actions*”¹⁹¹. On the contrary the management of the incident remained with a junior officer.

Failure to establish a command structure

30. As to the designation of roles in accordance with the incident command procedures, DAC O’Loughlin noted that on his arrival there was no command structure¹⁹² and that

none of the whiteboards in CU8 had yet been populated¹⁹³¹⁹⁴. Whereas the non-appointment of a search sector coordinator appears to have been the subject of discussion within the Tower; there was no liaison with the IC in this regard¹⁹⁵. There were related deficiencies on the handing over of responsibility between ICs and from ICs to other officers; these were systemic failures¹⁹⁶.

Communication failures

31. Several witnesses acknowledged the importance of communication among LFB representatives within the Tower, command units and control¹⁹⁷ but the reality – as reflected most starkly in the evidence of WM O’Keeffe – was that critical information held at the bridgehead was not disseminated¹⁹⁸. During the first half hour of the incident WM O’Keeffe had not maintained contact with the IC; and the requirements for EDBA were unknown to GM Welch on his arrival at about 2 am. There were also stark failures – in contravention of local policy 790¹⁹⁹ to share vital information with Brigade Control of relevance to the handling of FSG calls. We refer more generally to the submissions of Howe + Co.

Viability of alternative evacuation strategies

32. The assessments of AC Roe and others, were not made in the context of an overview of the internal and external conditions, the pattern of successful self-evacuations, the ineffectiveness of the rescue strategy that was being relied upon (and the evacuation capabilities of the Tower²⁰⁰. The failures of planning and policy likely contributed to the flawed perspective. Dr Lane and Professor Purser have presented evidence that the capacity of the stairs was sufficient for the simultaneous evacuation of residents from all levels²⁰¹; with the possibility that this might have been achieved within 15 minutes²⁰². Dr Lane concludes that between 00:55 and 01:35 *‘the stairs appear to have been free of smoke and therefore tenable for escape’* and that prior to 01:35 the smoke affecting the stairs was insufficient to affect visibility²⁰³; the *‘hot zone’* may have inhibited use of the stairs for evacuation between L13 and L16 between about 02:00 and 02:30²⁰⁴. By 01:42 approximately 50% of those in the Tower had evacuated²⁰⁵ which should have been appreciated as a factor that would have made evacuation of the remaining residents more achievable. At this time, only the east elevation was affected by fire. Although the optimum window of opportunity for a simultaneous evacuation of the Tower was prior to 02:00, the multiple self-

evacuations in the period to 03:55 (including evacuations from above L16 in the period between 02:59 and 03:55), establish that encouraged and/or assisted evacuation was the best option.

33. The stairs did not become blocked by firefighting activity at any stage nor was there any reported occasion of residents being unable to evacuate by reason of congestion in the staircase notwithstanding the significant numbers of residents evacuating in the early stages. Most particularly, the decision not to encourage evacuation by whatever means was not informed by the reality that there FSG-driven rescues were not succeeding and crews were not being deployed to the higher floors in any significant numbers (see further below at §38 - 42). As to the opinions expressed that the stairs were such that it was safer for residents to stay put²⁰⁶, even after the LFB began to change the stay put policy from 02:35, a further 46 individuals evacuated of whom only 11 were directly assisted in their rescue by firefighters.
34. Rapid evacuation did necessitate communication with residents and there was no ideal means to communicate with residents, but opportunities did exist to do so²⁰⁷. It was the responsibility of the ICs to consider those opportunities and to at least maximise the possibility of every resident being notified, pressed and/or assisted to escape. In his evidence AC Roe identified the issues that would require consideration with a primary reliance upon common sense: identifying those at greatest risk who needed to leave first; and maintaining access for fire fighters whilst managing egress²⁰⁸. SM Egan had considered how a simultaneous evacuation might be achieved: pushing crews into the building with breathing apparatus but not firefighting media and he emphasised the importance of significant control and determined effort²⁰⁹; his awareness that the *“vast majority of the call were from the 11th floor”* would have lead him to send crews to *“bang on doors”* initially to L11, L12 and/or L13²¹⁰.
35. The options for communication with occupants included by means of public address systems²¹¹, loud-hailers and the intercom²¹² (as envisaged by GRA 3.2 – Fighting Fires in High Rise Buildings [LFB*1255]), via members of the public who were in communication with residents, through existing FSG calls and through calling back those with whom FSG calls had earlier been terminated. As to loudhailers, FF Murray stated that he used one initially to communicate to residents that they should not panic and should remain in their flats but on realising that the conditions had changed

(specifically, on realising that windows to the rear of the Tower were emitting “*darker and darker*” smoke), he used the loudhailer to communicate that residents should “*get out if you are able, exit the building*”²¹³. Rania Ibrahim’s live Facebook posting from L23 at 01:40²¹⁴ picked up this instruction to evacuate by loudhailer. NPAS helicopters were also equipped with PA systems designed to communicate with persons on the ground. Loudhailers were also used to communicate with Mr Bonifacio from nearby buildings as a prelude to his successful rescue at 08:06²¹⁵. The evidence of loudhailers being relied upon to reinforce “*stay put*” advice at about 02:30 – 02:45 is also relevant in this context²¹⁶. Notwithstanding their limitations, individually and collectively reliance upon the various forms of available communication would have resulted in the movement of a significantly larger numbers of residents²¹⁷. Methods of communication that facilitated the provision of direct advice to residents in relation to escape were preferred options²¹⁸. The evidence was that these possibilities were not even considered by relevant decision makers²¹⁹. The early systematic deployment of fire fighters to the highest point of safety for the purposes of systematically knocking on doors and encouraging occupants to escape, would have made a decisive contribution to the aim of achieving full evacuation²²⁰. As would the instigation of a system of identifying who had self-evacuated and who remained. Thereafter, resources – particularly EDBA resources – should have been marshalled to systematically mark up those flats from which evacuation had been achieved and forcing entry to those that remained²²¹.

Conclusions

36. There is compelling evidence from which the Chair should now conclude that the failures of the LFB to plan for a breach of compartmentation and to take decisive action to evacuate the Tower from 01:26 at the latest caused and/or contributed to the loss of life or may have done. Effective evaluation of the external presentation from 01:08 should have led to an earlier appreciation that the LFB had no ability to extinguish the external fire and appreciation that residents were or would likely soon become adversely effected by polymeric smoke, fire and/or heat. As the flame front progressed up the east façade, the internal conditions worsened, the obstacles to traditional “*defend in place*” firefighting crystallised and the nature, extent and volume of FSG calls materialised, it was rapidly clear that the objective of

extinguishing the fire and effecting rescues could not be achieved. There was a specific failure on the part of each of the ICs prior to AC Roe's arrival to re-evaluate the FSG advice in contravention of GRA 3.2²²² and local policy 790²²³. The gathering of the available information and its evaluation should have led to an early appreciation that none of the residents were safe to remain²²⁴, an alternative plan was needed and that the only viable option was an evacuation of the Tower encouraged by all available means of communication.

37. The failures to achieve situational awareness through the gathering and evaluating the available information led to the catastrophic decision to concentrate LFB resources upon internal firefighting allied with a rescue strategy which was intended to respond to imperatives emerging from FSG calls but which demonstrably failed to meet those objectives (§43 -62).

The ineffectiveness of the rescue tactics relied upon and their impact

38. In this section we address the BA Deployment Schedule and accompanying bar chart analysis provided to the Inquiry²²⁵.

WM Dowden's incident command 00:58 – 01:50

39. None of the crews deployed within this time frame were tasked with responding to an FSG call. The crew that sought to affect a rescue from F176 on L20 of its own initiative was unsuccessful. None of the crews were tasked by the bridgehead during this time frame to undertake search and rescue above L5²²⁶. There were no EDBA wearers deployed for the purposes of effecting search and rescue whether prioritised by FSG information or otherwise.

From the point at which WM Dowden (e 01:50) was relieved of his command to the assumption of command by AC Roe (02:43)

40. FSG-driven deployments resulted in completed rescues from two flats only (L3²²⁷ and L12²²⁸) and partially completed rescues from a further two flats (L20²²⁹ and L14²³⁰). The remaining deployments that were successful in assisting rescue, were not successful in achieving FSG-driven objectives: rescues of residents from the floor but not the flat to which they had been deployed were achieved by 5 SDBA crews (L19²³¹, L9,²³² L10²³³, L14²³⁴ and L10²³⁵) or from elsewhere than the floor to which they were deployed by 5 SDBA crews (L14²³⁶, L13²³⁷, L10²³⁸, L11²³⁹ and L20²⁴⁰) and 1 EDBA crew (L20 – L22²⁴¹). 12 SDBA crews reached the floors to which they were deployed (L10 –

L20). Between 02:15 and 02:43 only one crew was tasked by the bridgehead above L14²⁴². Only one EDBA crew was deployed during this period: the intention was to fight fire from the roof but only L22 was reached.

AC Roe's incident command from 02:43 to 04:15

41. FSG-driven deployments in this period did not result in a single completed or partial rescue from the flat to which the crews were deployed. 5 SDBA crews reached the floors to which they were deployed (L15²⁴³, L12²⁴⁴, L9²⁴⁵, L5²⁴⁶ and L5²⁴⁷) and 5 EDBA crews reached the floors to which they were deployed or higher (L8²⁴⁸, L5²⁴⁹, L4²⁵⁰, L7²⁵¹ and L11²⁵²). The only deployments that were successful in assisting rescue, were not successful in achieving FSG-driven objectives: rescues of residents from the floor but not the flat to which they had been deployed were achieved by 4 SDBA crews (L12²⁵³, L9²⁵⁴ and L11²⁵⁵) and 8 crews assisted with rescues of residents from a floor to which they had not been deployed (L18²⁵⁶, L18²⁵⁷, L12²⁵⁸, L12²⁵⁹, L10²⁶⁰, L8²⁶¹, L7²⁶², L11²⁶³, L7²⁶⁴ and L11²⁶⁵) of whom the majority were EDBA crews. After the bridgehead was moved to the ground floor at 03:08²⁶⁶ the first deployment was of an EDBA crew to L16 (they achieved L13)²⁶⁷, thereafter there were no deployments above L11.

Discussion

42. A reasonable command of this incident would have achieved awareness of the broad themes emerging from this analysis: FSG-driven rescues were not succeeding but firefighters were successful in assisting those individuals who had started to make progress from their flats (particularly in the case of EDBA crews when they started to be deployed in earnest from 03:05). This critical information should have been considered in the context of knowledge that the majority of FSG calls were from flats above L13 (see §18 above) and informed decisions to encourage evacuation so that those crews deployed in the Tower might have the best prospects of assisting rescue. The evidence was that the ICs including AC Roe did not acquire knowledge of these facts and/or apply them to their decision making. Specifically, there were failures to address the situation of those who would not learn of the abandonment of “*stay put*” through contact with Control²⁶⁸.

The failures of management of FSG call information at the incident ground

43. On the night, the abject failure to deal with information when it reached the ground and the inadequate provision for the management of a large volume of FSGs²⁶⁹ led to

a chaos of multiple ad-hoc FSG processes throughout the night; SM Johnson's predicted difficulties with the policy had crystallised. These chaotic systems were further impeded by physical communication difficulties²⁷⁰. There were significant difficulties in receiving, collating and updating information at all points. In the control room, there was resort to slips of paper and whiteboards²⁷¹. On CU8, CU7 and at the various other FSG staging points – the Sadler car bonnet, the wall inside the main entrance of GT, and the different locations of the bridgehead – attempts to record and communicate information involved slips of paper²⁷², sporadic radio communications²⁷³ and transfer of information serially from whiteboard to paper to wall chart²⁷⁴.

44. Critically, at all stages, information flow was almost entirely one way – from control room to the fire ground – and much of the retained information was misleading. It was out of date by the time of use because of difficulties in communication with the bridgehead and because of the almost complete absence of feedback relating to the success or otherwise of deployments or information relating to self-evacuations. As a result, incident command failed to appreciate the volume and nature of FSG information, which contributed to the failure to abandon “*stay put*” and delay in telling residents to get out. In addition, the FSG process was unsuccessful in facilitating rescues, with only five entirely or partially successful deployments consequential to the FSG calls that had been made from a total of 33 flats²⁷⁵.

Provision of inappropriate advice to callers

45. In the early stage of the disaster callers were advised to “*stay put*” without it being explored with them whether the circumstances were such that they were safe to remain²⁷⁶. Thereafter *all* calls were passed on to the Incident Ground as “*FSG calls*”²⁷⁷ without, in some 15 instances²⁷⁸, the possibility of their escape having been explored. The provision of advice to “*stay put*” in circumstances of individuals starting to become affected by fire, heat or smoke and the categorisation of calls as FSG calls without the possibility of escape having been explored, were in contravention of Policy 790 and Appendix 3 to Policy 539²⁷⁹. The consequences were that those managing the incident at the scene concluded that all callers were trapped without the possibility of escape as *all* calls had been characterised as “*FSG calls*”. Had the correct advice for those starting to become affected by heat, fire or smoke - to leave if they were able - been consistently given a significantly larger number would have self-

evacuated in the early stages. Moreover, had the data concerning the numbers so advised been relayed to the incident ground, the ICs would have become apprised of a significant number of advised self-evacuations which would in turn have shifted their tactics from one of targeted rescue to systematic evacuation.

Failure to achieve feedback in relation to deployments

46. It is of critical importance to the successful operation of an FSG process for information to be fed back as to the outcome of deployments – whether successful or not - from the bridgehead to the IC and from the IC to control²⁸⁰. This “*information loop*” is essential for the purposes of redeployment at the incident ground, reassessment of tactics and to inform CROs as to the appropriate content of FSG advice²⁸¹. On 14 June 2017 only about 50% of FSG calls led to targeted rescue attempts (see below at §48) but neither IC nor Control was informed of this fact and therefore it could not influence critical decisions.
47. SM Egan explained that for the information loop system to work, information regarding deployments in response to FSGs “*would [need to] go back to the person that was dealing with fire survival guidance so that they could tick them off that that flat is now completed. Through the whole incident,*” however, command “*did not get information back*”²⁸². Feedback from the bridgehead did not reach any of the ad hoc FSG points²⁸³ and GM Goodall accepted that the loop back of information was never really completed²⁸⁴. Contrary to Commissioner Cotton’s speculation²⁸⁵, the breakdown in that loop would not appear to have arisen from a failure of the rescue crews themselves to debrief at the bridgehead: in 31 of 32 BA deployments in response to specific FSGs, at least 1 BA wearer recalled giving some kind of debriefing at the bridgehead²⁸⁶. The explanation given by GM Goodall at the PRC meeting on 03/07/17²⁸⁷ was that the FSG process was itself “*overwhelmed*”. Those deployments were in respect of 17 FSGs but 13 rescue crews were unable to rescue any of the residents reported and 2 only rescued some²⁸⁸. The failure of the intended “*feedback loop*” from the bridgehead meant that there was no informational overview of missed deployments, unsuccessful deployments and/or deployments which only succeeded in rescuing some residents. Much information held at CU7, the staging posts and the bridgehead was hopelessly out of date.

Failure to achieve deployments to all FSG calls

48. The reality was that no deployment of rescue teams was made for about 16 (48%) of the 33 flats passed onto the fire ground as FSGs²⁸⁹. 11 of the 16 flats which did not receive a deployment were identified as “*priority*” flats by the FSG command established in CU7²⁹⁰; thus it would appear that the failure to attempt rescues to those 16 flats cannot be attributed to their having lost out within an otherwise reasonable system of prioritisation. Despite the best efforts of many, the FSG information regarding some of these flats appears to have fallen between the cracks in an ad-hoc and chaotic process.

The Hakim family

49. A particularly clear example of the failure of the process is provided by Flat 142. The residents of Flat 142 that night was the family of Mohammed Hakim. All five family members perished in the fire. At 01:29:02 they called 999 and reported to the police that smoke was coming into their flat. The MPS Operator informed them that he/she had spoken to the LFB and that someone was coming up to help them²⁹¹. The LFB were informed of the call by MPS at 01:38:02 and were informed that smoke was coming into the flat²⁹². This information was passed by Control to CU8 at 01:43:14²⁹³.
50. When no one came, the Hakim family made a further FSG call to the LFB at 02:27:12²⁹⁴. They spoke to a CRO and informed her that they had been waiting for an hour since their previous emergency call, the fire was right next to their window and they were afraid they were going to die. The CRO obtained their flat and floor number and the number of residents. She advised them that they were not going to die and that she would pass on this information to the LFB’s Command Unit. At 02:30:42 she passed the information to CU7.²⁹⁵ At 03:18:45²⁹⁶, the family made a further 999 call to the LFB and spoke to the same CRO. This time she advised them to leave, but when the caller said they were unable to do so, she advised that she would “*tell them on the radio*”. At 03:35:01 CU7 were informed by PC Jacobs that there were 5 people trapped in Flat 142, including 2 elderly people²⁹⁷. Despite three 999 calls and the information being passed first to CU8 and then to CU7, no rescue crew was ever sent to Flat 142.
51. At the time when the information derived from the first 999 call reached CU8 it was “*in the process of setting up*”²⁹⁸ at 01:43²⁹⁹. There was no system for the collation of FSG information at the Command Unit and some messages were being passed directly

to the bridgehead³⁰⁰. The information was apparently passed by WM Meyrick and recorded as “17th Fl, 142 FSC”³⁰¹ on the 2nd floor bridgehead wall at some time before 02:17, when the bridgehead was moved to the 3rd floor³⁰². There is no evidence that any rescue crew was deployed to Flat 142 and the information about Flat 142 on the 2nd floor wall appears to have simply become lost in the confusion of the move.

52. At around 02:13, WM Sadler³⁰³ set up a post for the management of FSG information on a car bonnet at the base of the tower with the assistance of CM Batterbee³⁰⁴ believing that he was responsible for discharging the role of FSG coordinator³⁰⁵. WM Sadler was provided with a list of FSGs, apparently on the back of an envelope³⁰⁶ by a watch manager. This list was passed on to WM Williams at 02:20:16 by CM Batterbee³⁰⁷. At this point, WM Williams was attempting to collate FSG information which had been received so far onto the ground floor lobby wall. WM Williams also understood his role at this point to be FSG coordinator³⁰⁸. He believed that the information he was receiving had come directly from a Command Unit³⁰⁹. In fact, information about at least seventeen of the twenty-six flats which WM Williams was to record on the wall came from WM Sadler³¹⁰. Flat 142 was not on the list of Flats obtained by WM Sadler, nor does it appear on any of the Control Information forms believed to be produced by him³¹¹. WM Williams did his best to cross-reference the information he had against the information that had come through before he began to systematise FSG information, however he was unable to do so with any degree of accuracy³¹². As AC Roe commented to the Inquiry, WM Williams “*was making every effort to record information in the face of a system that had basically failed him*”.³¹³
53. In the course of the confusion described above, therefore, the information passed on from the Hakim family’s first 999 call at 01:29 was lost. So had been the best chance of rescuing them. FSG information from the second 999 call came through to CU7, which was now the designated FSG Unit, at 02:30:42³¹⁴. WM Peckham noted the radio transmission on a control information form³¹⁵. At 02:32 it was added to a list that was being compiled on a laminated board in CU7³¹⁶. However, there is no evidence that the information from this second FSG call made its way from CU7 to the tower until much later³¹⁷ when WM Furnell took a photograph of the laminated board, including the Flat 142 entry, to the bridgehead at 03:13:10³¹⁸. Information from the third F142 call and the information passed on by MPS soon after, both made their way to the

incident ground, recorded on CIFs timed at 03:23 and 04:13. Thereafter, F142 was recorded on the ground floor wall while the bridgehead was located there.³¹⁹

54. It appears therefore that the first call for help from F142 at 01:29 had made its way through to the tower but not been actioned. Between 02:17 and at least 03:13, the information that there were people trapped in Flat 142 appears to have been lost to the FSG coordination system operating within the Tower itself. By the time the second and third 999 calls was passed on, it was too late for a successful rescue. The last crew to successfully reach Level 17 or above had been deployed at 02:51³²⁰
55. Sadly, the story of Flat 142 is not a unique one. It is important to note that of the fifteen flats to which no deployments were made as a result of FSGs, nine of their first FSG calls were made before 02:30, but they do not appear on WM Sadler's list nor on WM Williams' initial list on the wall of the ground floor lobby³²¹. In the case of flats like F142, the failure of the informational loop meant that neither Control nor incident command nor CU7 could know that rescue attempts had not been made despite early 999 calls and information reaching the ground.

The failures to appreciate the significance of the FSG calls

56. The unprecedented number of FSGs had only become clear to incident command at 02:41, when the nascent system in CU7 enabled that Command Unit to send a runner to DAC O'Loughlin to communicate their understanding that there were as many as 58 adults and 16 children trapped in the Tower³²². As DAC O'Loughlin explained to the Inquiry, this information came as a complete surprise to him³²³. It was at this point that he began to have concern as to the strategy being implemented because it was a "*horrendous number*" of rescues to be challenged with. The information was in fact already out of date, with the actual number of adults and children reported at 02:41 being 71 and 32 respectively³²⁴.
57. The spike in FSG calls in the period to 01:45 alone should have led incident command to realise that there was no realistic prospect of handling the volume of FSGs through targeted rescues. As Commissioner Cotton explained to the Inquiry³²⁵, "*when policy [790 was] written, it's in response to [the LFB] dealing with ... 2, 3 or 4 fire survival guidance calls*". Even experienced senior commanders had not dealt with the volume of FSGs that were evident by 01:45³²⁶, and in the context of this experience, the volume of FSGs reported by 01:45 should have caused an immediate reconsideration

of the need to maximise the number of people leaving the Tower. The lack of understanding of the volume and nature of FSGs was a feature of the failure to establish any system for the collation of FSG information prior to 02:13³²⁷. After about 02:10, DAC O'Loughlin directed GM Goodall to set-up the dedicated FSG unit at CU7³²⁸. CU7 became operational at 02:23, an hour and a half into the fire³²⁹. The critical or “golden” first hour of the emergency response had been lost³³⁰.

58. The failure to complete the feedback loop of information from the bridgehead meant that it was not until about 02:44, that the IC realised that FSG driven rescue attempts were not succeeding³³¹. The failure of incident command and senior supervising officers to abandon ‘stay put’ for between 70 and 80 minutes after it was obviously untenable led to a fatal delay in altering FSG advice to tell callers to do everything they could to leave. During this period of delay, *stay put* advice was given in 47 calls³³². For many, it was too late when the advice changed.

Discussion

59. The overarching aims of the FSG policy are to safeguard life and facilitate a robust and rapid communication of information to allow for optimal incident command. The FSG system failed in these central aims. The failure to achieve situational awareness of conditions inside and outside the Tower and to coordinate with critical information received at control led to a situation in which residents calling the LFB received confused, complex and erroneous information which impacted upon their ability to reach decisions with regard to their own safety³³³. From our analysis, only 3 rescues directed from 999 calls were completely successful³³⁴. Information flow failure impeded command decision-making leading to fatally flawed advice being given and the failure to change tactics at an early stage. Our predominant submission is that no reactive system of individual rescues could have been successful for the inferno that rapidly developed and that evacuation was the only realistic strategy from very early in the disaster. Despite strenuous efforts and acts of great courage the FSG policy was not fit for purpose for a multi-emergency call incident. Hindsight is not required: the deficiencies were already well known within the LFB. Multiple FSG incidents are thankfully very rare, but an emergency service must be prepared to respond to the unexpected. We invite conclusions that the multi-faceted failures of policy and operational delivery amounted to systemic failings.

Conclusion

60. Cumulatively the errors identified above amounted to systemic failings: failures to address through policy, training and supervision a means to ameliorate the risks to life safety from rapid fire spread across façades and multiple systemic and structural failures on 14 June 2017 to ensure that residents were alerted to their imperilment and their evacuation from danger facilitated. We invite findings accordingly upon the conclusion of Phase 1.

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6 December 2018

ENDNOTES

¹ For reasons of efficiency and economy the G3 have separated areas of responsibility and page count accordingly.

² Our focus is upon events prior to 04:00; the period within which the LFB had the greatest opportunity to make a decisive contribution to minimising the loss of life and events at the fire ground as opposed to Brigade Control (as we understand that the latter is being addressed by other BSR representatives).

³ We note that in opening Mr Millett QC [4/6/18 p 10] did not include within the issues for Phase 1 12(g) – the inadequacies of the LFB’s actions (including the application of the “stay-put” policy), however, there has been considerable examination of those matters such that the identified inadequacies can now be the subject of meaningful conclusion.

⁴ We invite the Chair to draw conclusions in relation to the consequences for individuals after the additional evidence phase of investigation touching upon the circumstances of each individual deceased (see further below at §5).

⁵ [53 – 54].

⁶ We address the definition of “stay put” relied upon in these submissions at §6.

⁷ [05/06/18, p 100 – 101] references in this format are to the evidential transcripts.

⁸ Foresight of such risks was eventually accepted by Commander Cotton in her evidence [27/09/18 p53]; contrast [p51 – p53] and see the evidence of AC Roe who indicated that the post-Lakanal training identified the risks of “vertical, horizontal and downward fire spread where elements of the building fail” [26/09/18 p180].

⁹ A lack of candour, institutional defensiveness and a culture of denial have been repeatedly identified as problems, in a series of Inquiries and Reports including: the Francis Inquiry into Mid-Staffs NHS Trust, The Equality and Human Rights Commission February 2015 report: “*Preventing Deaths in Detention of Adults in Mental Health Conditions*”, the Kirkup Report, March 2015 into failures in the Morecombe Bay NHS Trust, the July 2015 Harris Review, “*Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds*”, and the November 2017 Bishop James report into the Hillsborough disaster, “*The Patronising Disposition of Unaccountable Power*”, which promulgated the Bishop’s Charter requiring public authorities to act with candour in the aftermath of and investigations into disasters.

¹⁰ See §12 below.

¹¹ [27/09/18 p52].

¹² Evidence of Sid Ali Atmani [05/11/18, p156].

¹³ The Chair’s rulings of 20 December 2017 at [47], 28 March 2018 at [3 -4] and 12 September 2018 at [16-18], Mr Millett’s opening (Day 1, 040618, p103, ll 11 – 19).

¹⁴ The particulars required by the Births and Deaths Registration Act 1953 are not considered material for present purposes.

¹⁵ *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at [30 – 32 and 34 – 38].

¹⁶ *Oneryildiz v Turkey* (2005) 41 EHRR 20 at [94].

¹⁷ *R (Long) v Defence Secretary* [2015] 1 WLR 5006 at [27-8] cited with approval by Garnham J in *R (Scarfe) v Governor of HMP Woodhill* [2017] EWHC 1194 (Admin) at [49]. See also *R (Long) ibid* at [10] citing *Stoyanovi v Bulgaria* (Application No 42980/04) (unreported), “*Whenever a state undertakes or organises dangerous activities, or authorises them, it must ensure through a system of rules and through sufficient control that the risk is reduced to a reasonable minimum.*”

¹⁸ *Middleton*, *ibid*.

¹⁹ *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 at [28].

²⁰ We note the Chair’s statement that the Phase 1 evidence will collate much, if not all of the evidence, bearing on the state’s responsibility under Article 2 (Chair’s ruling of 12 September 2018 at

§16); although clearly, the evidence yet to be heard in Phase 2 will have a primary bearing on whether the state failed to comply with the substantive Article 2 duty to safeguard the lives of those resident in the Tower.

²¹ See *Middleton* *ibid* at [20], [31] and particularly, [37] and the application of that dicta in *R (Smith) v Oxfordshire Ass Dep Coroner* [2009] 3 WLR 1099 at [106].

²² See the approach of Sir Christopher Holland, Chairman of the Azelle Rodney Inquiry at [1.12].

²³ GRA 3.2 is one of a series of MHCLG documents produced to promote consistency of approach and outcome across Fire and Rescue Services nationally, and to assist them in complying with the requirements of the Management of Health and Safety at Work Regulations 1999 (see §1 of “*Fire and Rescue Service Operational Guidance: GRAs introduction – guidance for fire services*”). LFB was one of the key stakeholders involved in the drafting of GRA 3.2.

²⁴ [LFB*1255*30] and see also LFB “*Fire Advice to Tenants*” which states “*our guidance to “stay put”, unless your flat is being affected by fire or smoke, is based on the fire protection provided in the building and the walls and doors of each flat*” [LFB*220*2] (emphasis added) and the same advice set out in the ODPM Fire Prevention Handbook 2005 cited at §10 of the LFB main report responding to the fire at Lakanal [HOM*1124*4]. See also excerpt from BS991 2015 set out by Dr Lane at [3.2.48]. The LFB Organisational Overview [LFB81905*9] refers, in contrast, to such advice being given when callers are “*trapped by a fire and/or unwilling to leave the property without assistance*”.

²⁵ [LFB*1255*11, *19, *22].

²⁶ *Ibid* at [*8].

²⁷ *Ibid* at [*16].

²⁸ *Ibid* at [*17].

²⁹ *Ibid* at [*22].

³⁰ *Ibid* at [*30].

³¹ “*High rise firefighting*”/Policy 633 [LFB*1256], “*Compartment firefighting*”/Policy 793 [LFB*186] and “*Management of operational risk information*”/Policy 800 [LFB*705].

³² And see Rule 43 action plan in respect of Shirley towers and Lakanal at [LFB*3621*22].

³³ “*Fire survival guidance calls*”/Policy 790 [LFB *1257*1] at §8.7.

³⁴ Evidence of WM Dowden [25/06/18 pp 16, 32, 69, 78, 83-88, 91]; SM Walton [20/09/18 pp55-57, 60-63]; GM Welch [18/09/18 pp4-7]; DAC O’Loughlin [24/09/18 pp16-18, 25, 27]. AC Roe was aware of GRA 3.2 -25/09/18 p.150 – but had no expectation of an evacuation plan p158-159.

³⁵ See also the failures to comply with *LFB Policy 800 – Management of Operational Risk Information* [LFB*705] at §§1.3, 3.4, 3.5, 3.9, 3.10, 9.2, 9.3 and 12.1.

³⁶ For the avoidance of doubt, Dr Lane’s observation at [2.10.22] “*in the absence of notification of the risk the external wall posed, by the relevant stakeholders to London Fire Brigade, I am unclear what prior planning could ... have occurred*” was in context with regard to external firefighting and not a commentary with regard to the value of a pre-determined alternative evacuation strategy.

³⁷ [HOM*1124 *34].

³⁸ There had been fifty-nine 999 calls of which five were treated as FSG calls.

³⁹ [HOM*1124*55] – Recommendation 7.

⁴⁰ [LFB*1257*5].

⁴¹ *Ibid*, p2 [§4.2] emphasises the need for the IC to consider information passed by Control in decision making.

⁴² *Ibid*.

⁴³ *Ibid*, p3 [§5.5].

⁴⁴ *Ibid*. [§5.9].

⁴⁵ *Ibid*, p5 [§7.9, §7.10, §9.1, §9.3].

⁴⁶ [LFB*1257*2] at §2.1.

⁴⁷ *Ibid* at §2.2.

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- ⁴⁸ LFB*1257*2 [§4.2]. “Risk” is not defined but must relate both to proximity to the fire, smoke and heat and also to vulnerability.
- ⁴⁹ Ibid, p3 [§5.11].
- ⁵⁰ Ibid, p5 [§7.6]
- ⁵¹ There is a dedicated phone line for the purpose of passing “*life critical information*” between control and the CU [Ibid, §7.7 and §7.8]
- ⁵² Ibid. [§7.9-10, and §9.1-3]
- ⁵³ Ibid. [§8.7]
- ⁵⁴ [LFB*1257*2; 4.2] and see evidence of Joanne Smith, “Q: *But is it right that you're reliant on the incident commander and his or her understanding as to when a partial or full evacuation strategy might be necessary?* A. *Well, with regard to a partial or full evacuation strategy, you would be relying on individuals on scene. So, yes, the incident commander.*” [12/07/18 p 26].
- ⁵⁵ [HOM*1124*54; 3.12 & 3.13].
- ⁵⁶ [LFB*12571*2, §4.2].
- ⁵⁷ Ibid 2 (policy 790 4.2); Evidence of AC Roe: “Q: *Does that mean you would expect an incident commander... to collate information from within the building and from control and put it all together with a view to forming strategy?* A. *I would, but my caveat on that is that in the early stages -- so when an officer turns up in the early stages of an incident, they're in a very different position from me.*” [25/09/18 p183].
- ⁵⁸ Evidence of SM Johnson [04/09/2018 p198].
- ⁵⁹ Ibid. [p196].
- ⁶⁰ Given his experience, he had been asked for advice on the first draft of the post-Lakanal FSG policy Policy 790 [04/09/18 p197] and had devised a training package for a multiple-FSG incident [04/09/18 p 198].
- ⁶¹ Evidence of SM Johnson [04/09/18 p 203].
- ⁶² Ibid [p232].
- ⁶³ Ibid.
- ⁶⁴ Ibid. [p 223].
- ⁶⁵ Ibid. [p 225, pp 225 - 8].
- ⁶⁶ Ibid. [p 227].
- ⁶⁷ Ibid. [p 228].
- ⁶⁸ Ibid. [p 233]
- ⁶⁹ Ibid. [pp 220 - 231].
- ⁷⁰ [LFB*238].
- ⁷¹ [LFB*238*3].
- ⁷² See evidence of AC Roe, [25/9/18 p 182 – 183 “*hammered home to us from the start of your officer career ... one of the first lessons you're given as a crew manager*” and DAC O’Loughlin, [24/9/18 p24 explaining that the tool is relied upon in all the incident command training and exercise and that it provokes reassessment of the chosen tactics. See also WM Dowden’s familiarity with it [26/6/18 p 21].
- ⁷³ [LFB*3621*25].
- ⁷⁴ Dr Lane at [2.10.10].
- ⁷⁵ Dr Lane at [2.13.2]. Objectively compartmentation had been fatally compromised. Subjectively the LFB should have begun to evaluate the significance of the fire spread in the context of the “*stay put*” policy.
- ⁷⁶ See Professor Bisby’s video 1 [LBYS*2*1] at counter 03:45.
- ⁷⁷ Mr Cherbika’s video at [IWS*50]
- ⁷⁸ Dr Lane at [12.2.10].
- ⁷⁹ Dr Lane at [2.11.8].

⁸⁰ CAD 482; PC Sangha [MET*7837*2] *"I was in fear of my life and that of the occupants and survivors and felt a mass evacuation would now be imminent"*. Although PC Sangha believed he was viewing the north aspect of the Tower he was in fact viewing the east elevation; a similar perspective to WM Dowden [see LBYS2*1 and LBYS3*1]. See also MPS major incident declaration at 01:32 [MET*12593*15]. See also FF Murray advice to residents at 01:40 to get out (see §36 below).

⁸¹ Dr Lane Table 12.1.

⁸² Dr Lane at Figure 12.7.

⁸³ Dr Lane at [12.2.13].

⁸⁴ Dr Lane at [12.3.15].

⁸⁵ Dr Lane at [5.4.31].

⁸⁶ Dr Lane at [5.4.54].

⁸⁷ Dr Lane at [5.4.32 – 33].

⁸⁸ Dr Lane at [5.4.34].

⁸⁹ Dr Lane at [14.6.20].

⁹⁰ Dr Lane's table N.2: FF O'Hanlon (L4; e 01:11), FF Hippel (L4; e 01:17), FF Stern, FF Abell and FF Dorgu (L5; e 0:20-01:40), FF Stern, FF O'Beirne, FF Archer, FF Hippel (L6, e 01:20 – 01:30), FF O'Beirne (L7, e 01:21), FF O'Beirne, FF Dorgu, FF Badillo (L8, e 01:22.- 01:37), FF Bettinson, FF Gallagher (L9, e 01:50), FF O'Beirne, FF Bettinson (L10; e 01:23-01:42), FF O'Beirne (L11; e 01:23), FF O'Beirne (L12; e 01:23), FF Badillo, FF Dorgu (L15, e 01:27-01:55), FF Hippel, FF Stern (L16, e 01:30), FF Badillo, CM Secrett, FF Dorgu (L20, e 01:50 – 01:55).

⁹¹ Dr Lane's table N.1: FF Gilman (L3; e 01:56), FF Dorgu (L3 – L20; e 01:57), FF Merrion (L3/L4; e 01:52), CM Secrett (L3 – L20; e 01:55), FF O'Beirne, FF Murphy (L4; e 01:38 – 01:51), FF Murphy (L5; e 01:51), FF Lawson (L5 – L18; e 01:53), FF Archer, FF Bettinson (L6; e 01:40-01:41), FF Murphy (L7; e 01:55), FF Dorgu, FF Secrett (L8 – L20; e 01:35), FF O'Beirne (L5 – L9; e 01:30 – 01:38), FF Gallagher (L9; e 0:50), FF Bettinson (L7 – L10; e 01:41), FF O'Beirne (L10; e 01:35), FF Dorgu (L3 to L20; e 02:00); FF Dorgu (L11 – L20; e 0:45), FF Badillo (L15 – L20; e 01:55), FF Badillo, CM Secrett (L20; e 01:45 – 01:55).

⁹² [04/07/18 at p192. CM Secrett is unsuccessful in securing the fire lift. See also Dr Lane, [26/11/18 at pp115-119.

⁹³ See also evidence that WM Watson scrutinised the control panel at 01:34 but did not pay attention to it as he was looking for an alarm panel [24/7/18 pp 27 – 28].

⁹⁴ [3/7/18 p 20 – 28]

⁹⁵ Damiana Louis F96 at 01:24; Helen Bebremeskei F186 at 02:26; Katarzyna Dabrowska F95 at 01:27; Shahid Ahmed F156 at 01:27; Zainab Deen F115 at 01:29; Jescia Urbano-Ramirez F176 at 01:30; Mariem Elghwary F196 at 01:30; Farah Hamdan F175 at 01:30; Biruk Haftom F201 at 01:32; Abdeslam Sebbar F81 at 01:33. Dr Lane at table 12.2.

⁹⁶ See FSG Response Bundle provided on 4/12/18 but note that the figures provided here also take account of 5 additional calls (not included in our original analysis by reason of the precise flat number not having been identified) [LFB*459*2; LFB*662*2; LFB*678*1; LFB*312*2] and see also Dr Lane's analysis at [2.17.6] in respect of the period between 01:30 and 01:45.

⁹⁷ Dr Lane's report [14.4.178]

⁹⁸ Dr Lane [2.18.25].

⁹⁹ [26/6/18 p 31 – 32.

¹⁰⁰ [26/6/18 p 28 – 32].

¹⁰¹ [26/6/18 p 80].

¹⁰² [26/6/18 p 138].

¹⁰³ [26/6/18 p 32].

¹⁰⁴ [26/6/18 p 147 and see for example his failure to achieve a meaningful situation report from FF Badillo [LFB*24348*63] or CM Batterbee as they came out of the Tower and met with him shortly

after 01:30 (CM Batterbee, [27/6/18 p 40, [LFB*24348*63 - *65]. See also CM Secrett's evidence [5/7/18 p 53 and following].

¹⁰⁵ [ibid].

¹⁰⁶ [26/6/18 p 147].

¹⁰⁷ [26/6/18 p 154].

¹⁰⁸ [26/6/18 p 138].

¹⁰⁹ [26/6/18 p 160 – 1].

¹¹⁰ When he made pumps 10 [LFB*2921] and [26/6/18 p 161].

¹¹¹ He accepted at 26/6/18 p 162 that he just did not know.

¹¹² [26/6/18 p 138 – 139].

¹¹³ [27/6/18 pp 37 – 8].

¹¹⁴ See for example, CM Secrett at [5/7/18 p 27].

¹¹⁵ During his command the information provided by the fire ground to control consisted of make ups, a single informative message at about 01:14 [LFB*1914*20] describing the fire in F16 only and an indication that persons were reported at 01:28.

¹¹⁶ [27/6/18 p 11 and p13] where he describes seeing *"people were subject to smoke inhalation, that's a big change"*. His plan, in effect, remained one suitable for a fire contained within F16 only (see [26/6/18 p 39 – 40 and p 108 -109]).

¹¹⁷ [26/6/18 p 147 and see p 117; his evidence was that he did not receive a report from FF O'Beirne as to the conditions higher up the Tower. See also the evidence of WM O'Keeffe 6/7/18 p 40 and p 64.

¹¹⁸ On SM Loft's account, [5/9/18 p 137].

¹¹⁹ [LFB*24348*54].

¹²⁰ Ibid [*55].

¹²¹ [LFB*1914*4] and [LFB*4790].

¹²² Dowden at [27/06/18 p106]. Time [LFB*3117] and [LFB*24348*116]. See also the evidence of WM Williams as to the appearance of the external fire spread at about this time with diagonal spread, bright orange/red flames, heavy smoke and debris falling from the Tower [30/7/30 p 19 – 21].

¹²³ [24/9/18 p 117].

¹²⁴ [20/9/18 p 129 – 132, p139].

¹²⁵ Ibid.

¹²⁶ [20/8/18 p 133].

¹²⁷ See Dr Lane's Figure 5.25 which provides an objective image of the north-east of the Tower shortly before DAC O'Loughlin assessed the situation and assumed command.

¹²⁸ M Walton [20/9/18 p 161]; DAC O'Loughlin, [24/9/18 p 136 – 7].

¹²⁹ [24/9/18 pp 137 – 9].

¹³⁰ [25/9/18 p 55].

¹³¹ [25/9/18 p 59.].

¹³² [25/9/18 pp 62 – 3].

¹³³ [25/9/18 p 7].

¹³⁴ [24/9/18 p 72].

¹³⁵ [24/9/18 p 107].

¹³⁶ [24/918 p 65]. And see the submissions of Howe + Co in this regard.

¹³⁷ [24/9/18 p 32].

¹³⁸ [24/9/18 p 94 – 95, p 99]. See the related lack of awareness that the control room had been informed at about 02:30 of the difficulties in reaching the higher floors [25/9/18 p 1 – p2] and see AC Roe's lack of awareness [25/9/18 p 260].

¹³⁹ [24/9/18 pp 124 – 5].

¹⁴⁰ [24/9/18 p 122].

¹⁴¹ [24/9/18 p 165].

¹⁴² [24/9/18 p 113].

¹⁴³ [24/9/18 pp 131 – 2]. See also Dr Lane at [3.5.38], *“In the event the fire and rescue services determine that other occupants on that floor should evacuate, they should do this by knocking on the flat doors and requesting that people leave.”*

¹⁴⁴ Ibid at p 125.

¹⁴⁵ [26/9/18 p 26].

¹⁴⁶ [25/9/18 p 229 – 231].

¹⁴⁷ [25/9/18 p 147].

¹⁴⁸ [25/9/18 p 177].

¹⁴⁹ [25/9/18 p 133].

¹⁵⁰ [26/8/18 p 7].

¹⁵¹ [26/8/2018 p 8 – 9].

¹⁵² [25/9/18 p 257].

¹⁵³ AC Roe [26/9/18 at p36].

¹⁵⁴ [LFB*1255*41 - 52].

¹⁵⁵ Dr Lane at [12.12].

¹⁵⁶ Dr Lane at [12.1.3].

¹⁵⁷ Professor Torero [20/11/18 p 21].

¹⁵⁸ See §7.47 (a) of LFB Policy 633 High rise Firefighting which obliges an IC to consider *“the effect of firefighting tactics on evacuation (and vice versa),* Dr Lane at [14.4] in which she describes evidence as to the holding open of doors and their obstruction with hoses and at [19.6.97 and surrounding] where she attributes a likely cause of the ‘hot spot’ between L13 – 16 to fire-fighting activity between about 02:10 and 02:30.

¹⁵⁹ Professor Torero [20/11/18 p 199].

¹⁶⁰ [LFB*1256*3 – 7].

¹⁶¹ [26/6/18 p 120].

¹⁶² [26/6/18 p 38 & p 60]. See also WM O’Donovan [31/7/18 p 66]; SM Loft [5/9/18 p 119]; GM Patrick Goulbourne [12/9/18 pp 64 – 65]; DAC Fenton [17/7/18 p 25]; AC Roe [25/9/18 pp 186 – 187].

¹⁶³ [LFB*1914*10 – 11].

¹⁶⁴ [LFB*24348*1].

¹⁶⁵ When AC Roe was informed of the incident at 01:38 brigade control AOM May was unable to tell him who was IC [25/9/18 p 199] and although he was sent a photograph at 01:39 neither he nor any other more senior officer offered any guidance the IC until their physical arrival at the incident. See below at §29 as to the additional provisions in respect of major incidents.

¹⁶⁶ WM Dowden [25/6/18 p 20].

¹⁶⁷ DAC O’Loughlin [24/9/18 p 116-7].

¹⁶⁸ It was his understanding that where a fire requiring rapid make ups systems could not ensure early relief of IC responsibilities [26/6/18 p 142].

¹⁶⁹ He expressed himself confident that WM Dowden could carry on as IC [5/9/18 p 137 – 140].

¹⁷⁰ He was not surprised that WM Dowden remained in charge of a 20-pump incident although *“maybe [senior officers] had made contact with him”*. [1/8/18 p 29 – p 31].

¹⁷¹ He considered the transfer of command to be *“low down on the order of priorities”* [10/7/18 p 68].

¹⁷² Who considered his support to the IC was as press officer only [24/7/18 p 139].

¹⁷³ At 01:25 he believed the IC to be GM Welch with DAC O’Loughlin discharging the role of monitoring officer [17/7/18 p 36].

¹⁷⁴ See for example, SM Walton's assessment that when a building fails, "*an evacuation isn't possible*" [20/9/18 p 14], he had not had any training as to how an evacuation might be achieved [20/9/18 p 37 and p 64 and see p 146]; the *only* option available was to "*effect any immediate rescues where the fire is*" [20/9/18 pp 18 – 19]; evacuation was contemplated in respect of the compartment of origin and surrounding compartments only [20/9/18 pp 61-62] and it was SM Walton's view that there was "*no option to evacuate a building where the building principle has failed to the extent that the means of escape don't exist*" [20/9/18 p 146]. GM Welch remained committed to this strategy on his arrival at 01:57 as he had "*no reason to think that the building compartmentation would be failing and that fire would be spreading across that way because it's not something that we see ... I believed in [the "stay put"] policy*" [18/9/18 p 72] and he remained committed to the approach despite WM O'Keeffe seeking to persuade him of the need to abandon "*stay put*" as "*the event had outstripped our ability to rescue everybody*" [6/7/18 p 88]; the time is estimated to be 02:15 by reference to the time of GM Welch's arrival into the Tower [INQ*354] and WM O'Keeffe timing of this event to "*pretty soon after*" the EDBA deployment of the FRU line crew which was at 01:56:09 – 01:57:16 per [LFB*23327*1].

¹⁷⁵ DAC O'Loughlin accepted that it was necessary to consider a departure from "*stay put*" and specifically, whether the best approach was rescue or evacuation - as part of a risk assessment on behalf of the residents of any building with a fire [20/9/18 pp 24 – 25 and pp 27 – 28]; his error was to assess that the fire was entirely external on his arrival at 01:57 [18/9/18 p 72]. See also GM Richard Welch [18/9/18 pp 5 – 6]. AC Roe considered that a departure from "*stay put*" and the need to consider an alternative strategy to manage an incident was a possibility that might have to be considered in "*very extreme circumstances*" [25/9/18 p 158]; that the potential risks arising from a building that did not comply with the regulatory framework had been communicated in training [26/9/18 p 167 and p 48] but that he had not received any training as to how to effect a full or partial evacuation contrary to the building's safety principle [26/9/18 p 167 and p 48]. Only WM Norman Harrison had previous experience of achieving a full evacuation of a 6-storey block in the middle of the night – by firefighters knocking on doors [19/9/18 p 101].

¹⁷⁶ See Rule 43 Action Plan in respect of Shirley Towers and Lakanal at [LFB*3621*26].

¹⁷⁷ See for example [25/8/18 at pp 58 – 60; he was not aware that FSG calls were coming other than from the north-east side of the Tower such that it "*would not have occurred to me that compartmentation had failed throughout the building*".

¹⁷⁸ [24/9/18 p 124].

¹⁷⁹ By 01:45 there had been 27 calls, from 15 flats, across 10 different floors and spanning the entire horizontal layout of the Tower, that is flats *1 to *6. Even allowing for a relay delay this information - or a more up to date picture - should have impacted upon his decision making.

¹⁸⁰ S3 registered at 01:58:39 but that had been subject to delay [3/7/18 p 78].

¹⁸¹ [3/7/18 pp 148 – 9 and see 4/7/18 pp 17 – 18].

¹⁸² Ibid p 81.

¹⁸³ [18/7/30 p 86].

¹⁸⁴ [4/7/18 p 18]; see also his communication of his perspective in vociferous terms to GM Goodall, Welch and Goulbourne in this section.

¹⁸⁵ [19/8/18 pp 99 – 100].

¹⁸⁶ [3/9/18 p 196. Timed by his radio message at 02:03:34 [LFB*2542].

¹⁸⁷ MI declared at 02:06:03 [LFB*3015].

¹⁸⁸ See for example, PC Sangha's appreciation of the need for a total evacuation of the building at 01:28 (see §21 above).

¹⁸⁹ www.jesip.org.uk/command.

¹⁹⁰ AC Roe [25/9/18 p 202 – 203].

¹⁹¹ [LFB*729*4 at §5.1].

¹⁹² [MET*12563*11].

¹⁹³ Ibid, *12.

¹⁹⁴ See also the evidence of WM Beale that he acquired the responsibility for sector 4 “by default” and did not recall notifying the bridgehead or the command unit of this [2/8/16 p 50 - 51].

¹⁹⁵ GM Goulbourne [12/9/18 p 93].

¹⁹⁶ SM Loft from WM Dowden: SM Loft [5/9/18 p 149]; WM Dowden to SM Walton: WM Dowden [27/6/18 p 107 – 9; p 110 – 111, p 118 - 125] WM Beale [2/8/18 at p 43 – 49]; WM Dowden to GM Welch: SM Mulholland 1/8/18 p 32 – 36]; SM Loft [5/9/18 p 178 – 189]; GM Welch [18/9/18 p 32 – 33, p 36, p 69 – 70]. WM Dowden to DAC O’Loughlin [24/9/18 p 112 – 4; pp 116 – 121; pp 131 - 2].

¹⁹⁷ See for example, AC Roe [26/9/18 p 36].

¹⁹⁸ [6/7/18 p 83 – 87; p 113 - 114].

¹⁹⁹ [LFB*1257*5].

²⁰⁰ See Professor Purser’s evidence, [29/11/18 p 80 and following].

²⁰¹ Dr Lane at [19.6.71].

²⁰² Professor Purser at §303 [DAPR*1*84].

²⁰³ Dr Lane at [14.4.188]; Prof Purser at §297, §307 [DAPR*1*84];

²⁰⁴ [REDACTED] was rescued during this period and survived 20 levels of the stairwell; Flora and Farhad Neda may also have passed descended during this section of the staircase in this window.

²⁰⁵ Dr Lane at [Figure 2.1]

²⁰⁶ C Cotton [27/9/18 p 23, p 152]; DAC O’Loughlin [25/9/18 p 31].

²⁰⁷ C Cotton’s evidence that the only means was by physically knocking on doors is rejected [27/9/18 p 183].

²⁰⁸ [25/9/18 pp 186 – 187].

²⁰⁹ [18/7/3 p 85].

²¹⁰ [4/7/18 p 50].

²¹¹ The capabilities of the NPAS loudhailer was not considered. AC Roe’s reservations [26/9/18 p64] are noted. The LESLP Major Incident Procedure Manual provides for a “public address system (‘skyshout’) capable of broadcasting messages at a lower operating height” [than the NPAS helicopter] [LAS*5*37].

²¹² The intercom system afforded a means of communication with residents on a one by one basis, although it was not designed as a life safety feature and physical access to the system was compromised by falling debris by about 02:30 (albeit there was a measure of protection from the canopy (Dr Lane at [18.8.5 - .6] and [26/11/18 p 85 – 86].

²¹³ MET*10925.

²¹⁴ Video and time taken from <https://www.lbc.co.uk/news/london/west/kensington-chelsea/grenfell-tower-fire/mum-who-broadcast-live-on-facebook-during-grenfell/> 05:03 mins counter time [posted 15/06/17 and last accessed 15/11/18.] Note that the sound of the NPAS 44 helicopter which arrived at 01:44 can also be heard – confirming the time. And see [LFB*24348*100].

²¹⁵ Ibid.

²¹⁶ FF Collins at [MET*10086].

²¹⁷ See for example, the evidence of Professor Purser, [29/11/18 p 26] as to the value of LFB encouragement.

²¹⁸ See evidence of Professor Purser as to the value of using a wet face-covering, [29/11/18 p 191].

²¹⁹ See evidence of AC Roe, [26/9/18 p 21].

²²⁰ See the systematic top down approach suggested by DAC O’Loughlin [24/9/18 p 77 and p 161 – 2; albeit not one he put into effect and see SM Egan at 4/7/18 p 49 – p 52.

²²¹ See LFB Policy 803 – Search and Rescue Procedures within Structures at [LFB*733*7], §6.1 “*and the early use of Searched Tags, available within the Fire Initial Response Equipment (FIRE) Bag*” [LFB*733*4-5] and also LFB Policy 907 – FIRE Bag Technical Information [LFB*707].

²²² [LFB*1255*31].

²²³ [LFB*1257*5 at §8.7].

²²⁴ Dr Lane at [12.1.8].

²²⁵ An updated version of the BA Deployment Schedule and the bar chart analysis were provided to the Inquiry on 4/12/18.

²²⁶ FF Badillo, CM Secrett and FF Dorgu proceeded to L20 of their own initiative; FF Wolfenden, FF Felton, FF Tillotson, FF Bettinson and FF Gallagher investigated conditions and assisted evacuations of their own initiative.

²²⁷ FF Desforges and FF Mitchell.

²²⁸ FF Hill and FF Malik.

²²⁹ FF Williams and FF Fernandes.

²³⁰ FF Herrera and FF Orchard.

²³¹ FF Roots and FF Johnson.

²³² FF Saunders.

²³³ FF Batcheldor and FF Saunders.

²³⁴ FF McAlonen and FF Juggins.

²³⁵ FF Dwyer and FF Perez.

²³⁶ FF Cook.

²³⁷ FF Mitchell and FF Desforges.

²³⁸ FF Wright, FF Alassad and FF Bell.

²³⁹ FF O’Donoghue and FF Dauold.

²⁴⁰ FF Evans and FF Boxham.

²⁴¹ FF Harris, FF Gillam, FF Wigley, FF Gonzalez and FF Roberts.

²⁴² At about 02:30 DAC Fenton relied upon his knowledge that crews were “*unable to get above the 15th floor*” in relation to his decision to change the advice to FSG callers; this was not accurate. Although the crew comprised FFs Mitchell, Desforges, Wright, Alassad and Bell only succeeded in reaching L12/L13 when deployed at about 02:00; the crew comprised FFs Evan and Bloxham had reached L20 when deployed at about 02:24. In any event these were SDBA crews.

²⁴³ FF Nuttall and FF Whitley

²⁴⁴ FF Hoare and FF Tanner FF Aston O’Donovan and FF Green

²⁴⁵ FF Clark, FF Cardy and FF Beltrami

²⁴⁶ FF Wood and FF Lawrence

²⁴⁷ FF Page, FF Worman, FF Desforges and FF Mitchell

²⁴⁸ FF Rawlings (L7), FF Brooks (L7) and FF Morcos (L8)

²⁴⁹ FF Sime and FF Okoh

²⁵⁰ FF Mayne and FF Lundquist

²⁵¹ FF Peacock (L5), FF Harold (L6), FF Friend (L7) and FF Rice (L7)

²⁵² FF Gray, FF Holehouse, FF Hiscock, FF Hudson and FF Pegram

²⁵³ FF Hoare, FF Tanner, FF Aston-O’Donovan and FF Green

²⁵⁴ FF Cardy

²⁵⁵ FF Sonson and FF Cuthbert (L10)

²⁵⁶ Reddington and FF Upton (EDBA)

²⁵⁷ FF Pole, FF Cheesman and FF Mitchell.

²⁵⁸ FF Bate

²⁵⁹ FF Codd and FF Joseph (EDBA)

²⁶⁰ FF Wharmsley and FF Lowe

²⁶¹ FF Morcos (EDBA)
²⁶² FF Rawlings (EDBA)
²⁶³ FF Diana and FF Nelson (EDBA)
²⁶⁴ FF Friend, FF Rice, FF Harold (L6) and FF Peacock (L5) (EDBA)
²⁶⁵ FF Gray, FF Holehouse, FF Hiscock, FF Hudson and FF Pegram (EDBA)
²⁶⁶ Goulbourne MET*10759*3.
²⁶⁷ FF Diana and FF Nelson
²⁶⁸ [26/9/18 pp 26 – 27].
²⁶⁹ Ibid. [p203].
²⁷⁰ These are dealt with in detail by the Howe and Co submissions
²⁷¹ Re whiteboards see evidence of Jason Oliff [16/07/18 p71].; Re slips of paper, see for example [MET*17094].
²⁷² See for example [LFB*1968*12].
²⁷³ Dealt with in detail by the Howe and Co submissions,
²⁷⁴ Evidence of GM Goodall [03/09/18 p87-88].; Evidence of WM Harrison [19/09/18 p119].
²⁷⁵ See BLJ 'FSG Response Schedule' provided 4/12/18 and §38 - 42 above which analyse the position to 04:15.
²⁷⁶ An example of such a situation is given: a fire in a bin chute.
²⁷⁷ See evidence detailed at 'Methodology' tab of G3 FSG Response Schedule provided on 5/12/18 and [LFB*678*2] and [LFB*459*2].
²⁷⁸ See G3 FSG Response Schedule, served 4/12/18 which sets out all 999 calls reporting a specific flat number and accompanying analysis. For the purposes of that analysis, we had adopted a wider definition as to whether the CRO explored if the caller is trapped; a methodology favourable to LFB. For the figure provided here we included those instances where the caller has reported their level but not provided a flat number well – there are two such [LFB*678*2] and [LFB*459*2].
²⁷⁹ [LFB*737*16].
²⁸⁰ The importance of the "*information loop*" to the operation of Policy 790 was appreciated by AC Roe: "*The closing of that loop is a very important part of FSG.*" [24/09/18, p 247].
²⁸¹ Role and Actions of LFB Control in Lakanal; Summary of Policy 790 at Action 7 [HOM*1124*55].
²⁸² Evidence of SM Egan [03/07/18 p129].
²⁸³ Evidence of WM Sadler [25/07/18 p70-71] Evidence of WM Williams [30/07/18 p168].
²⁸⁴ Evidence of GM Goodall [03/09/18; P177]; AC Roe told the Inquiry that this was the area of Structure and Command that he would have liked to have done more efficiently [24/09/18 p245].
²⁸⁵ Evidence of Commissioner Cotton [27/09/18, p 195].
²⁸⁶ BLJ FSG Response Schedule provided 4/12/18.
²⁸⁷ [LFB*3112*12]
²⁸⁸ BLJ FSG Response Schedule provided on 4/12/18.
²⁸⁹ BLJ FSG Response Schedule provided 4/12/18.
²⁹⁰ See photograph of completed FSG grid [MET*8733*1].
²⁹¹ [INQ*264].
²⁹² [LFB*668].
²⁹³ [LFB*2726].
²⁹⁴ [LFB*354].
²⁹⁵ [LFB*2784].
²⁹⁶ [LFB*419].
²⁹⁷ BWC of PC Alice Jacobs.
²⁹⁸ [LFB*3078].
²⁹⁹ Evidence of WM Meyrick [10/07/18 p25].

³⁰⁰ WM Meyrick [100718; P25] recalls passing this message to WM Kentfield, whose evidence is that he delegated the job of communicating it to the bridgehead to another watch manager [MET*23051*14]. The path of communication to the bridgehead at this point in the evening is unclear and it could well be that the information was passed to the bridgehead directly via radio (See for example, the statement of Louisa De Silvo, who recalls receiving FSGs to the bridgehead directly via radio [MET*10913*6]). There is no FSG slip or other note to suggest that the information was passed via runner. This chaotic 'work around' was still happening at the point of DAC O'Loughlin's arrival at CU8 at around 02:10 [MET*12563*12].

³⁰¹ [MET*5789*1].

³⁰² From our analysis of the CCTV at this time, and also of the telemetry data of firefighters who describe the bridgehead moving, see for example, witness statement of CM Batchelor who describes the Bridgehead being on the 2nd floor when he goes 'under air', but on the 3rd floor at his 'tally out' [MET*7511*3], which telemetry data puts at 2:17:12 [LFB*23327*2]. The evidence of Justin O'Beirne is that the writing on the 2nd floor wall was written during the time when the bridgehead was at the 2nd floor [As put to WM Williams; p52/53].

³⁰³ He had been instructed to do so by a WM (probably WM Kentfield), who informed him that there was a high volume of FSG calls from the higher floors and his main point of contact would be CU7. Statement of WM Kentfield [MET*23051*14]; Nb. WM Kentfield is seen on CCTV Main System Cameras at 2:06-2:08 entering and exiting the tower. He is carrying a piece of paper which may be the 'envelope' list that is handed to WM Sadler.

³⁰⁴ Seen at car bonnet at 02:27; Body Worn Camera Footage of Inspector Thatcher.

³⁰⁵ The evidence of WM Sadler [25/07/18] is that he was in fact given a tabard insert identifying him as the FSG coordinator [P117].

³⁰⁶ Evidence of WM Sadler [25/07/18] *"Q: you mention an envelope... You say you were given it by the officer. Was that the same officer who had given you the instruction to set up the FSG point? A. ... I can't hand on heart say that is the case. But I believe so, yes."* [P41-42] However, from CCTV, the list appears to be on an A4 piece of paper [Using zoom function: MS Cams 3 and 4, 02:21:03].

³⁰⁷ CCTV MS Cams 3 and 4 [adjusted time].

³⁰⁸ This is clear from WM Williams' description of his role as facilitating the transfer of information and prioritising resources in response to FSG information [30/07/18; P57-60].

³⁰⁹ Evidence of WM Williams [30/07/18; P77].

³¹⁰ Cross reference between analysis of CCTV MS Cams 3 and 4 & movements of WM Williams, image of wall [MET*5771*1] and list photographed by WM Sadler [MET*16967*1].

³¹¹ LFB*1922*1,4,8,10,22,32,33,34; LFB*1942*1, 2, 5, 17, 18, 20, 21 LFB*1922*33, LFB*1968*47, LFB*1955*7.

³¹² For this reason, he asked CM Batterbee to make a note of the FSG information on the forward information board held at the 2nd floor bridgehead [30/07/18, p72]. However, it appears from CM Batterbee's note [MET*15731*1] that a number of FSGs that had come through at that point were missing from the forward information board. One of these was F142.

³¹³ Evidence of AC Roe; p 167.

³¹⁴ 02:22:54 LFB Radio transmission asking that all FSGs go through CU7 [LFB*2301].

³¹⁵ [LFB*1955*12].

³¹⁶ Apparent from BWC footage of Inspector Thatcher at CU7.

³¹⁷ During the time when WM Williams was writing on the wall on the ground floor lobby, F142 was not added to his FSG collation system. [CCTV MS Cams 3 and 4 (utilising backup player zoom function)] No information regarding Flat 142 appeared on the 3rd floor walls during the time when the bridgehead was located there [photographs of 3rd floor walls: MET*5794-5800, MET*8753*1, MET*15596*1, MET00015819*1].

³¹⁸ CCTV MS Cam 4.

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- ³¹⁹ Control Information Forms [LFB*1955*14, LFB*1961*1], photograph of wall at the ground floor bridgehead [MET*18739*1] timing of photograph appears to be 4.45 or 4.49, from ECB time display.
- ³²⁰ See G3 Analysis of BA Deployments provided on 4/12/18 (FFs Mitchell, Cheeseman and Pole).
- ³²¹ There is a further list that appears on the lobby wall, which is shown in photograph MET*15815*1 on the extreme left of the wall. The information contained on this list was written after WM Williams left the ground floor lobby at 04:22:44 (adjusted time) CCTV MS Cams 3&4
- ³²² Runner shown on BWC footage of Inspector Thatcher showing DAC O'Loughlin figures on his clipboard. DAC O'Loughlin then writes '58 adults, 16 children' on the whiteboard.
- ³²³ Evidence of DAC O'Loughlin: *"I was totally surprised by the number. Q. Did the number of FSGs that you saw on that piece of paper give you any cause for concern as to the strategy that you'd implemented? A. That number is an horrendous number to be challenged with. If all of those people are in flats they can't escape from then the task of getting to all those people and rescuing them is going to be enormous."* [24/09/18 p241].
- ³²⁴ See BLJ FSG Response Schedule provided on 4/12/18.
- ³²⁵ Evidence of Commissioner Cotton [27/09/18 p203].
- ³²⁶ See for example, the evidence of GM Welch [18/09/18 p86].
- ³²⁷ The only collation of FSG information at Command evident before 02:13 is a handwritten note taken by WM Meyrick while he took radio messages [LFB*1968*12], presumably for the purposes of a memory aid for him to pass on the information. It was not until around 02:13 that WM Sadler began his 'car bonnet' system [Evidence of WM Sadler p61] and WM Williams did not begin his 'wall' system until 02:15:51 [CCTV MS Cams 3 & 4].
- ³²⁸ Evidence of DAC O'Loughlin [24/09/18 p193].
- ³²⁹ 02:22:54 LFB Radio transmission asking for all FSGs to go through CU7 [LFB*2301].
- ³³⁰ See MPS Critical Incident SOP [MET*23289*5] for a reference to the *"Golden Hour principles"*.
- ³³¹ DAC O'Loughlin [25/9/18 p 78-79].
- ³³² BLJ FSG Response Schedule provided 4/12/18.
- ³³³ For example, CRO Howson receives call from F165/L19 at 01:56, advises the caller block doors and stay where he is and explains that the LFB will go door to door and make sure everyone is safe, advising that the fire is on the fourth floor. [LFB*24348*116].
- ³³⁴ G3 schedule of FSG responses.