

Grenfell Inquiry Phase One Report

Purpose of report

For discussion.

Summary

This paper summarises the findings of the Phase One report of the Inquiry into the Grenfell Tower fire and outlines the LGA's initial response to it.

Recommendation

That members note the report.

Action

Officers to take forward as directed

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Grenfell Inquiry Phase One Report

Background

1. The independent inquiry into the Grenfell Tower fire under Sir Martin Moore Bick published its [Phase 1 report](#) on Thursday 30 October 2019. The report focusses on the night of the fire. It is approximately a thousand pages long.
2. The bulk of the Report is devoted to establishing a narrative of events on the night of the fire. It does not look at how the building came to be in the condition it was in on the night of the fire. Instead it examines the response to the fire in detail and is extremely critical of London Fire Brigade's (LFB) response, accusing it of institutional failure. This criticism is focussed on the failure to prepare for the possibility of such a fire or to train crews to either fight it or evacuate the building effectively. The Report praises the efforts of frontline firefighters.
3. The LGA statement issued in response to the report is attached at **Annex C**. While the LGA has been critical of the phasing of the inquiry, the report highlights a number of issues around the emergency service response to the fire, which need to be addressed.
4. The National Fire Chief's Council's (NFCC's) work to address the Inquiry's findings and recommendations is summarised in the briefing note at **Annex D**.

Issues

Summary of the Report's narrative

5. The Report finds that fire started in the kitchen of Flat 16, almost certainly in a fridge-freezer as a result of an unidentified fault. The key point here is that such a fire is not unusual and the block should have been built and refurbished in a manner that did not allow the fire to get out of Flat 16.
6. The fire escaped through the window and/or its surround. It does not really matter which, as both led into the cladding system.
7. The Report concludes that the Aluminium Composite Material (ACM) cladding did not comply with the building regulations and was the major factor in spreading the fire, first upwards to the crown (the ACM arrangement around the top of the block which was of a design particularly conducive to fire spread), and then around the block in two directions as burning material fell from the crown (the fire did not actually spread sideways around the block so much as sideways around the crown and down from that). Combustible insulation and other combustible materials in the cladding system played a part.

8. The Report does not reach any conclusion as to whether the guidance on the building regulations in respect of cladding systems in Approved Document B was wrong or was not followed in this case – this will be looked at in Phase Two of the Inquiry.
9. One striking element of the Report's account is the speed at which a typical kitchen fire developed into a disaster. The initial 999 call took place at 00.54. The first fire engine arrived five minutes later. The Report finds that the firefighters sent to the initial incident dealt with it at a reasonable pace, but that by the time they entered Flat 16 at 01.20 to fight the fire 'it was already too late to stop the fire from escaping from the kitchen into the cladding' and the flames had reached the 10th floor. By 01.27 the flames had reached the roof.
10. It was inevitable that once the fire took hold in the cladding system it would find its way back into the building, because the windows could not be expected to withstand it, but this may have happened more quickly than would otherwise have been the case due to defects in window surrounds and fan units and because some windows were open.
11. The building then 'suffered a total failure of compartmentation'. As the fire spread back into flats, smoke from these secondary fires affected the lobbies due to a failure of flat front door fire doors and their automatic closing mechanisms. This affected the stairwell due to the need to keep lobby doors open for hoses.

The Report's criticisms of LFB

12. The Report criticises LFB's response to the fire. LFB is criticised in overall terms for having no plan to evacuate the residents in the event that 'stay put' had to be abandoned, and in particular for being too slow to abandon the advice to residents to stay put and failing to manage the information loop between the control room and frontline rescuers effectively.
13. The Report questions whether LFB is capable of learning the lessons of Grenfell.
14. These criticisms are relevant to all Fire and Rescue Services (FRSs) as the Report argues that they were consequences of a failure to understand the risk of cladding fires, provide proper training, develop effective plans or understand the role of the FRS under section 7(2)(d) of the Fire and Rescue Services Act 2004 (which requires services to make arrangements for obtaining information needed for the purpose of extinguishing fires and protecting life and property).
15. Acknowledging the difficulty of an evacuation, the Report concludes that it would have been preferable to do that than continue to attempt to fight the fire while telling residents to stay put, and argues that it should have become obvious to the incident commander that evacuation was necessary at some point between 01.30 and 01.50.

16. The Report cites a lack of training, experience or awareness of this type of fire and a lack of senior level support to explain this failure to order an evacuation. It concludes that the stay put policy was 'an article of faith within the LFB so powerful that to depart from it was to all intents and purposes unthinkable'. It implies that this remained the case during the inquiry hearings.
17. The Report argues that LFB did not recognise the risk of fire taking hold in the external wall system of a building like Grenfell 'despite the long history of fires involving cladding on high-rise buildings both in this country and abroad, a history of which some senior figures within the LFB were aware'. The Report cites this as an institutional failure.
18. Although the Report recognises that visits under section 7(2)(d) of the Fire and Rescue Services Act 2004 would not have revealed the cladding issues at Grenfell, LFB's response to the fire is presented in the context of a failure to conduct these visits effectively. The Report criticises the LFB policy document setting out what should be covered by these inspections. As a result the operational response database entry for Grenfell contained no floorplan, incorrect contact details, the wrong number of storeys and the Operational Contingency Plan section was blank.
19. The second specific criticism of LFB is the lack of an effective communication loop between the control room and the those on the ground, reflecting wider communication failures and a lack of planning. For example:
 - 19.1. Once the stay put advice was changed, the message that residents' only chance of survival was to leave the building was not consistently conveyed to those trapped.
 - 19.2. Outcomes of firefighters' attempts to reach those trapped were not properly recorded or understood by those despatching firefighters.
 - 19.3. Firefighters were despatched on the basis of wrong information.
 - 19.4. There is at least one case where occupants died because those sent to rescue them were instructed to engage in a different, less important task for reasons that are not understood.
 - 19.5. Ad hoc efforts were made to record the location of those trapped but there was no shareable or easily accessible version of this information.
 - 19.6. The three emergency services appear to have declared major incidents without telling each other or the Royal Borough of Kensington and Chelsea.
 - 19.7. Radio communication inside the tower was very poor. Various technologies failed and in several cases were known to be faulty before being deployed.

20. To illustrate the consequences, the Report provides the shocking example of five occupants of Flat 142 who all died. They first called 999 at 01.27. Despite three further calls in the ensuing two hours there is no evidence that anyone was ever sent to that flat from the bridgehead inside the tower. The Report concludes that this was probably not an isolated case, but one representing 'a fundamental failure of command and control'.
21. While the report focusses on the specifics of tackling fire in high rise buildings, the communication failures it highlights and the shortcomings it exposes in preparation must raise questions as to whether the emergency services in London as a whole are as properly prepared for any unexpected major incident as they need to be.

The Report's recommendations

22. The Report's recommendations fall into three categories:

22.1. Those that FRSs nationally will need to consider, for example: that all fire and rescue services ensure that their personnel at all levels understand the risk of fire taking hold in the external walls of high-rise buildings and know how to recognise it when it occurs.

22.2. Those that will inform the work the government is doing supported by the LGA and others to reform the system of buildings safety. For example, that the owner and manager of every high-rise residential building be required by law to provide their local fire and rescue service with information about the design of its external walls together with details of the materials of which they are constructed and to inform the fire and rescue service of any material changes made to them.

22.3. Those that are specific to LFB. The LGA has no view on these operational matters.

23. The recommendations of the report are listed at **Annex A**; the topics Sir Martin intends to address in Phase 2 are listed in **Annex B**.

The Fire Safety Bill

24. The Queen's Speech referred to a Fire Safety Bill that will be introduced in the next session as well as the Building Safety Bill. We anticipate that the recommendations of Phase 1 of the Grenfell Tower Inquiry will be covered by secondary legislation passed in conjunction with this Bill.
25. We anticipate that there will be a consultation on this legislation. The detail of the implementation of the Inquiry's recommendations will need to be considered carefully to ensure that the outcome dovetails with existing work around building safety in the wake of Dame Judith Hackitt's report.

26. Key additional issues for the LGA in considering the Fire Safety Bill are likely to include:

- 26.1. Without Government funding, any remediation costs in buildings with dangerous cladding systems (other than ACM, which is already being funded) will fall on leaseholders.
- 26.2. Currently building owners do not necessarily know what materials are in the cladding systems on their buildings (although they should) and the legal mechanism for requiring them to tell regulators is not as effective as it could be. In addition, the Fire Safety Order (FSO) does not convey the power to carry out works in default and its ultimate sanction is a prohibition notice, which has drawbacks as a form of enforcement against residential premises. If the FSO is going to accelerate the remediation of dangerous cladding these failings need to be addressed.
- 26.3. Any reform needs to facilitate close working between FRSs and councils in their capacity as the local housing authority.
- 26.4. The Bill is likely to impose significant new burdens on FRSs which will require funding.

Future direction of the Inquiry (Phase 2)

27. The principal focus of Phase Two will be on the decisions which led to the installation of a highly combustible cladding system on a high-rise residential building and the wider background against which they were taken. Points 3-8 in **Annex B** are really sub-sets of this primary aim.
28. The LGA has already expressed the view that these are the areas that should have been dealt with in Phase One. They are probably the right combination of inquiries, but they need to focus additionally on how companies can be held to account, whether the recommendations of coroners carry enough legal weight (the only requirement being to respond), and the responsibility of industry not to simply hide behind guidance.
29. In addition Phase 2 will question 'the way LFB is managed and those responsible at the highest level for its operation'. LFB has accepted the findings of Phase One of the Inquiry and will be working with the Inquiry.

Implications for Wales

30. Building regulations and fire and rescue services are devolved responsibilities of the Welsh Assembly Government.

Financial Implications

31. There are no implications for the LGA.

32. Some of the recommendations of the Inquiry Phase One Report have financial implications for councils and fire and rescue services.

33. The Fire Safety Bill is likely to have financial implications for FRSs and councils

Next steps

34. Members to note the report.

35. Officers to proceed as directed.

Annex A – full list of recommendations

This sets out the recommendations in the report along with details of the areas where Sir Martin Moore-Bick does not make recommendations in policy areas of interest to FSMC and the LGA, including the reasons why Sir Martin did not deem it appropriate to make recommendations in these particular areas.

Use of combustible materials

1. He adds his voice to that of the HCLG Select Committee that there has not been enough progress in remediating buildings with ACM and particular attention should be paid to decorative features composed of combustible materials.
2. He has been pushed to recommend that only Euroclass A1 materials are used on high-rise buildings, but hasn't said anything on this due to the government ban on combustible materials.

Testing and certification

3. In phase 2 he will look at the testing and certifying of materials and whether the current guidance on how to comply with the building regulations is clear enough.

FRS's: knowledge and understanding of materials used in high-rise buildings

4. The Report recommends:
 - that the owner and manager of every high-rise residential building be required by law to provide their local fire and rescue service with information about the design of its external walls together with details of the materials of which they are constructed and to inform the fire and rescue service of any material changes made to them;
 - that all fire and rescue services ensure that their personnel at all levels understand the risk of fire taking hold in the external walls of high-rise buildings and know how to recognise it when it occurs.

Section 7(2)(d) of the Fire and Rescue Services Act 2004

5. The Report recommends LFB review its procedures for inspecting buildings under s7(2)(d) of the Fire and Rescue Services Act 2004 including ensuring it is in line with national guidance and that officers from crew manager and above are trained in carrying out the inspections.

Plans

6. The Report recommends:
 - that the owner and manager of every high-rise residential building be required by law:
 - to provide their local fire and rescue services with up-to-date plans in both paper and electronic form of every floor of the building identifying the location of key fire safety systems;

- to ensure that the building contains a premises information box, the contents of which must include a copy of the up-to-date floor plans and information about the nature of any lift intended for use by the fire and rescue services.
- insofar as it is not already the case, that all fire and rescue services be equipped to receive and store electronic plans and to make them available to incident commanders and control room managers.

Lifts

7. The Report recommends:

- that the owner and manager of every high-rise residential building be required by law to carry out regular inspections of any lifts that are designed to be used by firefighters in an emergency and to report the results of such inspections to their local fire and rescue service at monthly intervals;
- that the owner and manager of every high-rise residential building be required by law to carry out regular tests of the mechanism which allows firefighters to take control of the lifts and to inform their local fire and rescue service at monthly intervals that they have done so.

Communication between the control room and the incident commander

8. The Report recommends:

- that the LFB review its policies on communications between the control room and the incident commander;
- that all officers who may be expected to act as incident commanders (i.e. all those above the rank of Crew Manager) receive training directed to the specific requirements of communication with the control room;
- that all CROs of Assistant Operations Manager rank and above receive training directed to the specific requirements of communication with the incident commander;
- that a dedicated communication link be provided between the senior officer in the control room and the incident commander.

Emergency Calls

9. The Report recommends:

- that the LFB's policies be amended to draw a clearer distinction between callers seeking advice and callers who believe they are trapped and need rescuing;
- that the LFB provide regular and more effective refresher training to CROs at all levels, including supervisors;
- that all fire and rescue services develop policies for handling a large number of FSG calls simultaneously;

- that electronic systems be developed to record FSG information in the control room and display it simultaneously at the bridgehead and in any command units;
- that policies be developed for managing a transition from “stay put” to “get out”;
- that control room staff receive training directed specifically to handling such a change of advice and conveying it effectively to callers.
- that steps be taken to investigate methods by which assisting control rooms can obtain access to the information available to the host control room.
- that the LAS and the MPS review their protocols and policies to ensure that their operators can identify FSG calls (as defined by the LFB) and pass them to the LFB as soon as possible.

36. Command and Control

10. The Report recommends:

- that the LFB develop policies and training to ensure better control of deployments and the use of resources;
- that the LFB develop policies and training to ensure that better information is obtained from crews returning from deployments and that the information is recorded in a form that enables it to be made available immediately to the incident commander (and thereafter to the command units and the control room).
- that the LFB develop a communication system to enable direct communication between the control room and the incident commander and improve the means of communication between the incident commander and the bridgehead
- that the LFB investigate the use of modern communication techniques to provide a direct line of communication between the control room and the bridgehead, allowing information to be transmitted directly between the control room and the bridgehead and providing an integrated system of recording FSG information and the results of deployments.

Equipment

11. The Report recommends:

- that the LFB urgently take steps to obtain equipment that enables firefighters wearing helmets and breathing apparatus to communicate with the bridgehead effectively, including when operating in high-rise buildings;
- that urgent steps be taken to ensure that the command support system is fully operative on all command units and that crews are trained in its use.

Evacuation

12. The Report recommends:

- that the government develop national guidelines for carrying out partial or total evacuations of high-rise residential buildings, such guidelines to include the means of protecting fire exit routes and procedures for evacuating persons who are unable to use the stairs in an emergency, or who may require assistance (such as disabled people, older people and young children);
- that fire and rescue services develop policies for partial and total evacuation of high-rise residential buildings and training to support them;
- that the owner and manager of every high-rise residential building be required by law to draw up and keep under regular review evacuation plans, copies of which are to be provided in electronic and paper form to their local fire and rescue service and placed in an information box on the premises;
- that all high-rise residential buildings (both those already in existence and those built in the future) be equipped with facilities for use by the fire and rescue services enabling them to send an evacuation signal to the whole or a selected part of the building by means of sounders or similar devices;
- that the owner and manager of every high-rise residential building be required by law to prepare personal emergency evacuation plans (PEEPs) for all residents whose ability to self-evacuate may be compromised (such as persons with reduced mobility or cognition);
- that the owner and manager of every high-rise residential building be required by law to include up-to-date information about persons with reduced mobility and their associated PEEPs in the premises information box;
- that all fire and rescue services be equipped with smoke hoods to assist in the evacuation of occupants through smoke-filled exit routes.

Personal fire protection

13. He rules out recommending that every flat and public space in a high-rise residential building should have a fire extinguisher and there should be a fire blanket in every kitchen, but as experts did not recommend it he has not done so.

Sprinkler Systems

14. He also rules out making recommendations about installing sprinklers at this stage on the basis that he has not looked at whether a sprinkler system might have suppressed the fire in flat 16 or stopped it getting into the cladding and he has heard no general evidence on their cost and effectiveness.

Internal signage

15. The Report recommends:
- that in all high-rise buildings floor numbers be clearly marked on each landing within the stairways and in a prominent place in all lobbies in such a way as to be visible both in normal conditions and in low lighting or smoky conditions.
 - that the owner and manager of every residential building containing separate dwellings (whether or not it is a high-rise building) be required by law to

provide fire safety instructions (including instructions for evacuation) in a form that the occupants of the building can reasonably be expected to understand, taking into account the nature of the building and their knowledge of the occupants.

Fire Doors

16. The Report recommends:

- that the owner and manager of every residential building containing separate dwellings (whether or not they are high-rise buildings) carry out an urgent inspection of all fire doors to ensure that they comply with applicable legislative standards;
- that the owner and manager of every residential building containing separate dwellings (whether or not they are high-rise buildings) be required by law to carry out checks at not less than three-monthly intervals to ensure that all fire doors are fitted with effective self-closing devices in working order.
- that all those who have responsibility in whatever capacity for the condition of the entrance doors to individual flats in high-rise residential buildings, whose external walls incorporate unsafe cladding, be required by law to ensure that such doors comply with current standards.

Co-operation between emergency services

17. The Report recommends:

- that the Joint Doctrine be amended to make it clear:
 - that each emergency service must communicate the declaration of a Major Incident to all other Category 1 Responders as soon as possible;
 - that on the declaration of a Major Incident clear lines of communication must be established as soon as possible between the control rooms of the individual emergency services;
 - that a single point of contact should be designated within each control room to facilitate such communication;
 - that a “METHANE” message should be sent as soon as possible by the emergency service declaring a Major Incident.
- that steps be taken to investigate the compatibility of the LFB systems with those of the MPS and the LAS with a view to enabling all three emergency services’ systems to read each other’s messages.
- that steps be taken to ensure that the airborne datalink system on every NPAS helicopter observing an incident which involves one of the other emergency services defaults to the National Emergency Service user encryption.
- that the LFB, the MPS, the LAS and the London local authorities all investigate ways of improving the collection of information about survivors

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and making it available more rapidly to those wishing to make contact with them.

Annex B - Future direction of the Inquiry (phase 2)

1. The principal focus of Phase 2 will be on the decisions which led to the installation of a highly combustible cladding system on a high-rise residential building and the wider background against which they were taken.
2. Questioning the way LFB is managed and those responsible at the highest level for its operation given the organisational failures on the night and in particular:
 - The poor communication between the control room and the incident and failure to learn the lessons from Lakanal.
 - Failure to understand the risks from cladding fires
 - Under its obligations to inspect buildings under s7(2)(d)
3. Examining the current regime for testing the combustibility of materials and cladding systems, particularly those chosen for use in high-rise buildings, as there is evidence they may be neither as rigorous nor as effectively enforced as it should be. Doubts have also arisen about the reliability of the certification of certain materials for use in high-rise buildings.
4. Grave concern inevitably arises simply from the fact that it was possible for highly combustible materials to be used for the purposes of refurbishing and cladding a building like Grenfell Tower. How that was possible is a question that may be relevant to many aspects of the construction industry, including manufacturers of products currently widely available on the market.
5. These concerns extend to the adequacy of the regulations themselves, the quality of the official statutory and non-statutory guidance currently available, the effectiveness of the tests currently in use, the arrangements for certifying the compliance of materials with combustibility criteria and the manner in which materials are marketed.
6. When it comes to the design and choice of materials on Grenfell Tower he will examine the relevant building regulations and the guidance to the construction industry published by the government in support of them.
7. Investigate whether the fire doors in Grenfell Tower complied with the regulations and guidance applicable at the time they were installed, whether they were able to provide appropriate protection against the spread of fire and smoke and if not, why that was so.
8. As there is evidence that in many cases self-closing devices were broken or had been disconnected, rendering the doors useless if left open in an emergency. It will be necessary to investigate how that situation came about and why it was allowed to continue.

Annex C – LGA Statement

LGA RESPONDS TO GRENFELL TOWER INQUIRY REPORT

Responding to the publication of the Grenfell Tower inquiry report today, Lord Porter, building safety spokesman at the Local Government Association, said:

“The tragedy that unfolded at Grenfell Tower and claimed at least 72 lives in such an unimaginable and heart-breaking way, must never be allowed to happen again.

“There are undoubtedly lessons that can be learned about how the fire service responded on that tragic night as it faced the worst fire in this country for more than half a century. However, the inquiry has made a fundamental error by examining the response to the fire before examining its causes. The consequence of this is to scapegoat the fire service while those responsible for the fire have yet to be exposed or held to account.

“It is clear that the fire was caused by a catastrophic failure of the building safety system in England. This has been proven by the number of public and private buildings with flammable material and the number of modern buildings which are behaving in unexpectedly dangerous ways when they catch fire. Reform of this broken system cannot come soon enough.

“Government has to ensure any new regulatory system not only covers high-rise residential buildings, but extends to any building where vulnerable people sleep like hospitals, care homes and residential schools. Those who live in, work and visit high-rise and high-risk buildings must be safe. We look forward to continuing to work with the Government at pace to deliver the much-needed reform to ensure residents are safe and feel safe.”

NOTES TO EDITORS

The LGA represents more than 350 councils in England and Wales and all fire and rescue authorities.

ENDS