Lakanal House: Prelude to the Grenfell Tower inferno—Part 1

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The following is the first of a two part series on the coroner's inquest into the 2009 tower block fire at Lakanal House in southeast London, which killed six people. Central and local government ignored the recommendations from the coroner, centred on implementing basic fire safety measures in high-rise buildings. This callous disregard for the safety of the public was a central factor in the Grenfell Tower inferno in west London.

Prior to the Grenfell Tower inferno of June 14 that killed at least 80 residents, the UK's worst ever tower block fire was at Lakanal House in southeast London. That fire, in July 2009, claimed six lives—three of them children.

Yet recommendations from a coroner's inquest handed down in 2013 were ignored by the Conservative government, local council authorities and the London Fire Brigade (LFB). The fire at Lakanal House, owned and managed by the Labour-controlled Southwark Council, was a direct prelude to the Grenfell Tower inferno. Many of the same fire safety breaches identified by the coronial inquest, along with problems in fire-fighting efforts by the LFB, re-emerged on a more terrifying scale just eight years later.

Sparked by an electrical fault in a television set in a ninth-floor flat, the Lakanal House blaze spread rapidly throughout the 14-storey tower block of 98 maisonettes built in 1958.

Three women and three children were killed. 31-year-old Catherine Hickman died from smoke inhalation and burns in her flat on the 11th floor. 26-year-old Dayana Francisquini, her six-year-old daughter Thais, and three-year-old son Felipe were found huddled together in the bathroom of flat 81, along with 34-year-old Helen Udoaka and her daughter Michelle, just 20 days old. They each died of smoke inhalation. A further 20 residents were injured.

When the first firefighters arrived on the scene, the fire was contained within two flats. However, flames spread rapidly and unexpectedly downwards as external cladding—installed as part of a 2006/7 refurbishment—caught alight. Falling debris from the upper floors caused secondary fires below.

There were no internal sprinklers and just one central stairwell, which quickly filled with smoke. Those inside were given conflicting advice, with brigade control operators urging residents, including those who later died, to follow the traditional fire safety advice—to "stay put."

The police and Crown Prosecution Service (CPS) investigated whether criminal offences had been committed. Despite the presence of hallmark features of the corporate manslaughter offence as enshrined in the Corporate Manslaughter and Corporate Homicide Act 2007 no criminal proceedings were initiated.

Both the contractors, Southwark Building Design Services (SBDS), which carried out the refurbishment of Lakanal House, and the Department of Communities and Local Government, owed a duty of care to the residents. This duty was breached as the direct result of how the parties managed their activities, causing the death of six people.

Despite the use of flammable external cladding by SBDS and the failure of Southwark Council to conduct legally mandated fire safety tests, the CPS claimed there was "insufficient evidence" to press charges.

In 2013, a coroner's inquest was convened. This was dubbed a "Super Inquest," with Judge Frances Kirkham appointed coroner. Judge Kirkham instructed the jury to reach a conclusion on four matters: Who were the deceased? And when, where and how did each of the deceased die?

Over 10 weeks, jurors heard evidence from more than 100 witnesses and experts, including 999 emergency calls, survivors, relatives of the deceased, firefighters, police, forensic investigators and scientists, the London Ambulance service, paramedics, representatives of Southwark Council, and company officials. The jury concluded that all of the deceased died from smoke and fire inhalation and identified fire safety breaches that caused the fire to spread:

a. The "boxing-in" under the stairs failed to provide 60 minutes fire resistance.

b. There was an absence of fire seals on flat doors and a lack of fire resistance in the panels above those doors.

c. A lack of fire stopping on internal pipe work from previous renovations.

The jury found these breaches contributed to a serious failure of compartmentation—meant to contain any fire to the original outbreak. They also concluded that if fire safety assessments had been conducted at Lakanal House, these hazards would have been highlighted for further investigation. The installation of a new heating system in the 1980s provided an opportunity to verify that the fire stopping on internal pipe work was adequate and that the segmentation within the suspended ceiling provided satisfactory resistance to fire. The 2006/7 refurbishment provided further opportunities for Southwark Council to ensure that Lakanal House was safe.

These failings exposed both the fire service, whose responsibility it was to enforce fire safety measures under the Fire Precautions Act 1971, and Southwark Council, which took over this role in October 2006 following the enactment of the Regulatory Reform (Fire Safety) Order 2005.

In 1999, the scheduled demolition of Lakanal House was cancelled by the Liberal Democrat and Labour-dominated council. Instead, each party rotated its assaults, occasionally with the help of Conservative councillors, stripping away the meagre fire safety that existed via two inadequate refurbishments, the latter completed in 2007.

The jury found that if panels above the doors to the flats had been fire resistant for 60 minutes, the spread of smoke and fire into the roof cavity of the 11th floor would have been greatly reduced. Had this been the case, the occupants—two women and three children—trapped in the upstairs bathroom of flat 81 would have been significantly less exposed to smoke and they would have had more time to escape to the east balcony via the internal stairs of flat 81. Firefighters would also have had greater capacity to conduct search and rescue operations, rather than active firefighting caused by rapidly spreading flames.

The preventable smoke-logging in the communal corridors and the secondary fires which erupted on lower floors, a direct result of flammable external cladding that funnelled smoke inwards, forced the bridgehead (the firefighters' safe position inside the building, used to co-ordinate both firefighting and search and rescue) to be moved downwards from the 7th floor to the 3rd floor, then outside the building completely.

Rescue attempts were significantly hampered by multiple demands on resources and manpower and the bridgehead's move to a lower floor meant firefighters had to travel further to reach occupants trapped in flat 81. Firefighters struggled for oxygen and their breathing apparatus (BA) equipment was unable to cope with the demands of firefighting and rescue operations on the 11th floor.

The inquest exposed major failings of the LFB in its fire safety assessments and inadequate familiarisation visits at Lakanal House in the years preceding the fire. This is the direct result of years of cuts to firefighters' jobs and fire stations nationwide that has jeopardised the LFB's fire prevention work. Firefighters were unaware of the exact location of flat 81 owing to the fact that there were no information boxes on site recording the building's layout. This meant those co-ordinating rescue efforts were unaware of the exact layout and numbering system inside the building.

Firefighters told the inquest their greatest regret remained their inability to obtain and communicate building plans to incident commanders sooner to allow trapped residents to be located and rescued before they inhaled fatal levels of smoke. Testimony by survivors and emergency personnel revealed chaotic scenes on the night, with one firefighter describing his shift as "the worst two hours of my life." There were conflicting reports about the residents' whereabouts, key information from brigade control operators failed to reach rescue crews on time and firefighters reported only "intermittent" communication due to faulty hand-held radio devices.

The jury concluded that the "stay put" guidance given to residents by the LFB would have been appropriate had residents not been affected by smoke or fire. Given the rapidly deteriorating conditions, brigade control officers should have instructed residents to explore potential routes of escape. Instead, they wrongfully relied on the assumption that those trapped would be rescued in time. Accordingly, the jury decided that the training of the brigade control officers failed to encourage active listening or the ability to react to dynamic and unprecedented situations.

The jury held that insufficient efforts were made to prioritise the trapped residents in flat 81 and to deploy a sufficient number of extended duration BA crews to this location. Throughout the inquest, firefighters of varying experience and roles testified that more extended duration BA crews and more aerial ladder platforms (only one was available at the Lakanal House fire) were required to adequately conduct active firefighting operations and save lives through more extensive search and rescue operations.

To be continued