NFCC REVIEW

Cathedral Yard Fire, Exeter
28th October 2016

Review Completion Date: 25th July 2019

This review was commissioned by the NFCC at the request of Devon & Somerset Fire and Rescue Service.

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Glossary

ALP	Aerial Ladder Platform
BA	Breathing Apparatus (Equipment to allow fire service personnel to enter smoke filled enviroment's)
CSO	Command Support Officer
CSU	Command Support Unit
D&SFRS	Devon & Somerset Fire & Rescue Service
FBU	Fire Brigades Union
FDS	Flexi Duty System Officer (Officers who provide a higher level of command at large, complex or serious incidents)
FRS	Fire & Rescue Service
FSHQ	Fire Service Headquarters
NFCC	National Fire Chiefs Council
NOG	National Operational Guidance (Guides to safe systems of work at an incident)
Ops Commander	Operations Commander (Position within the Incident Command Structure)
PPV	Positive Pressure Ventilation (Fan to remove smoke and hot gases from a location)
RCH	Royal Clarence Hotel
SSRI	Site Specific Risk Information
TofR	Terms of Reference

Executive Summary

The response to the fire in Cathedral Yard began at 0511hrs on 28th October 2016 and was declared a major incident by Devon & Somerset Fire & Rescue Service (D&SFRS) within the first 30 minutes of crews arriving.[1] Over ten days a significant number of resources were committed to dealing with the fire which has been described as the largest fire in Exeter since World War II. Following this incident a review and debrief was undertaken by D&SFRS which was designed to inform the public about the incident and also to identify any internal learning that could be abstracted from it.[2] Whilst it is common for Fire and Rescue Service's (FRS), as learning organisations, to undertake internal debriefing following an incident, rarely will they commission a report which scrutinises there actions at an individual incident. The report, which was made available to the public, put the spotlight onto D&SFRS which has subsequently seen a number of media reports and questions generated around the response of D&SFRS to this incident and the contents of the initial report. As a result, D&SFRS approached the National Fire Chiefs Council (NFCC) and asked for an independent review into its report to assess:[3]

- The process of compiling the report.
- The range of evidence gathered to substantiate the report.
- Whether any evidence corroborates the allegations that the command decisions ignored information that may have affected firefighting operations.

With hindsight, it would have been desirable for a terms of reference to have been drawn up at the time of the D&SFRS review which could have been used by the NFCC to benchmark the final report against. In the absence of a terms of reference for the D&SFRS review, the NFCC are unable to make a judgement as to whether the aims or objectives of the initial report were met other then through verbal confirmation from D&SFRS that it was. The NFCC review was undertaken over a seven month period and involved a literature review followed by 21 interviews with either personnel who attended the incident in key roles or individuals who witnessed it.[4] During the NFCC review, disclosures were made to the NFCC by two D&SFRS personnel which were not made to D&SFRS at the time of their review or debrief. As a result, information that is now known regarding conditions inside the RCH, along with the alleged reporting of these within the command structure, would not have been known by D&SFRS at the time of writing its report.[5] At the conclusion of this NFCC review, a general narrative of this incident has emerged which is detailed in section two. The focus of the NFCC review was the timeline between the first call to D&SFRS at 0511hrs, to 1100hrs, by which time the fire had esculated.

The fire originated in No.18, the Gallery, on Cathedral Yard which spread within the first half an hour to the roof apex of the front left section of the Royal Clarence Hotel (RCH) and within the first hour internally, predominantly to rooms 401 and 402 on the third floor. However, whilst the focus of firefighting activities at the RCH was to the front and front left section of the hotel, it is believed that the significant fire spread, seen by many on Cathedral Green at circa 1018hrs, spread from further back into the hotel in parts which were not being continually monitored or searched by crews.[6] Early on at this incident there were attempts, to some degree of success, to tackle fire spread from No.18 to the RCH where it was most visible at the front of the hotel. However, due to deteriating conditions inside the hotel the risk assessment justifying committing Breathing Apparatus (BA) wearers into the building to conduct offensive firefighting actions changed by 0614hrs, leading to more defensive firefighting actions being taken from the outside.[7] Whilst the risk assessment changed over the course of the incident up to 1018hrs which saw a committal of personnel back into the hotel for specific tasks, there was no continual monitoring of the RCH internally other then to the front and front left section of the hotel. This is where visible fire spread had occurred early on in this incident and is also where the initial sector 4 commander marked on a floor plan the location of firefighting actions taken early on at this incident (Figure 6 & 7). However, the esculation which saw the fire break through the roof of the RCH at circa 1018hrs did not occur at this location. Instead it occured further back into the RCH in an area the NFCC review team could find no evidence was being monitored on an ongoing basis up to 1018hrs

[1] Section 2.3
[2] Section 2.1
[3] Section 1.1 & Section 1.2
[4] Section 1.3 & Section 1.4
[5] Section 2.1
[6] Appendix c
[7] Section 2.3.2

or, had been searched in the initial stages of crews arriving.[8] Whilst the fire in No.18 looked to be under control, it is clear with hindsight that elsewhere, out of sight, the fire was esculating un-noticed before becoming visible to fire crews coming through the roof at circa 1018hrs.[9]

The hotel was under the control of a sector commander (Sector 4), whose responsibilities are detailed in Appendix B. Unfortunatley, whilst there was a good uptake of people willing to be interviewed as part of this review, two individuals which included the initial sector 4 commander did not wish to participate. A request from one of these individuals was made for all of the documentation D&SFRS submitted to the NFCC review team. Firstly, the information held on the Cathedral Yard fire is owned by D&SFRS not the NFCC so was not ultimately the NFCC's decision to make regarding its release. Regardless of the ownership of information, it was the first hand account of the interviewee and their actions which the NFCC wanted to hear. To provide information which the interviewee may have been unaware of at the time of the incident could have had the negative effect of influencing answers given during interview. However, where an individual had previously submitted a written personal statement to the D&SFRS review, this was made available to the individual where the NFCC review team were in possession of it. The absence of two key witnesses presented the review team with challenges as it could only go on the written statement and/or D&SFRS interview notes from these individuals taken shortly after the incident. Despite this, the NFCC review team are confident that the narrative presented in this report is reliable based on the information obtained during the literature review and interviews.

The fire's esculation into the RCH caught all crews by surprise as following an internal collapse in No.18 less then two hours of crews arriving, the fire from the outside in No.18 appeared to reduce in size and severity. As a result, many personnel interviewed during the course of the NFCC review stated a relaxed feel on the incident ground. Between 0900hrs and 1000hrs relief crews began to arrive at the incident to replace those who had been on scene since the first calls to D&SFRS. It was around the time crews were changing over that the fire esculated through the roof of the RCH, although it would have been burning for sometime before. The significance of the timing is that some crews who were being relieved would have been in the proccess of making up equipment and leaving the incident as they were replaced with fresh crews.[10]

When the esculation occurred a new tactical plan had to be developed which required communicating to personnel on the ground and the re-deployment of resources from elsewhere on the incident ground to the RCH. However, there were early attempts to fight the fire internally more offensively following the esculation at circa 1018hrs which would have been out of sight of people observing on Cathedral Green. This involved firefighters wearing breathing apparatus (BA) being committed into the RCH shortly after the esculation in an attempt to fight the fire. Sadly, the severity of the fire was to great and given the complex layout of the building along with the fact that there were no known persons inside, crews withdrew shortly afterwards. Whilst the initial plan was to save the bottom 2 floors of the hotel, being confined to external firefighting actions made this an impossible task despite further resources being requested.[11]

The NFCC review team would like to thank personnel from D&SFRS who participated in this review which has allowed the review team to build a picture of events leading up to the fire's escalation. It is clear that many of those who responded to the incident, or witnessed it, are still impacted today by what happened and the loss of a historic building to Exeter.

[8] Section 2.3.2
[9] Section 2.3.5
[10] Section 2.3.5
[11] Section 2.3.5

Where this report is referring to the review conducted by D&SFRS which lead to the D&SFRS report, this will be prefixed accordingly.

Introduction

On the 28th October 2016 a devastating fire occurred within Cathedral Yard in the heart of Exeter. Multiple calls were received by the control room at Devon & Somerset Fire and Rescue Service (D&SFRS) from members of the public both at the scene and in the surrounding area.[12] Whilst the initial call at 0511hrs was to reports of a fire in No.18 (The Gallery), by 1018hrs the fire had spread to the Royal Clarence Hotel (RCH) which would become fully involved in the fire. A significant amount of resources was committed to the incident over ten days with the first of these arriving in Cathedral Yard seven minutes after the first 999 call being received. The fire occurred at the same time as another significant incident in Exeter that morning, which had drawn resources away from the city. A number of crews and officers deployed straight from that incident to the fire at Cathedral Yard following the initial make up for resources.

The incident in Cathedral Yard has been described as the largest fire in Exeter since the Second World War and was declared a major incident by both Devon & Cornwall police and D&SFRS. On a number of visits to Exeter the National Fire Chiefs Council (NFCC) review team visited Cathedral Yard. It was apparent the attention the RCH still draws, with many passers by stopping to take in the sight of the hotel. It became clear to the team, all of whom live outside the county, that the current state of the RCH acts as a visible reminder of the fire in 2016, and the sense of loss of a historic building to the community and to the city of Exeter.

The NFCC would like to thank D&SFRS personnel and members of the public for their participation in this review. It was evident during engagement that this incident was not only a significant loss for the community, but an incident that still has an ongoing impact on many of those who attended and witnessed the fire.

Nothing in this report should detract away from the efforts of D&SFRS personnel sent to deal with the fire at Cathedral Yard.

[12] FC recordings

Incident Overview

This section has been compiled in order to assist the reader in understanding:

- Some of the key statistics of this incident.
- The roles and responsibilities of key positions in the command team (as per National Operational Guidance).
- The sectorisation plan put in place at this incident (as per National Operational Guidance).

Key Statistics

Total pumping appliances used (includes repeat visits by the same appliance)	231
Total number of firefighters that attended	1,186
Different fire engines that attended (does not include repeat visits by the same appliance)	95
Different fire service vehicles that attended	135
Different aerial ladder platforms that attended	5
Maximum number of firefighters on scene at the same time	207
Maximum number of fire engines on scene at the same time	38
Maximum number of fire service vehicles on scene at the same time	57
Total firefighter hours at the incident	12,094.61
Including total hours committed by on-call firefighters	9,931.97
Different officers who attended (does not include repeat visits by the same officer)	65
Officer hours at the incident	549.59
Maximum number of officers on scene at the same time	20

Timeline	Time	Time Elapsed
Time of call	05:11	N/A
First three appliances mobilised	05:12:33	00:01:20
First attendance (Exeter Danes Castle)	05:18:49	00:07:36
10 fire engines mobilised	05:24:21	00:13:08
15 fire engines mobilised	05:33:38	00:22:25
Fifth fire engine arrives	05:40:06	00:28:53
Tenth fire engine arrives	05:50:33	00:39:20
20 fire engines mobilised	05:59:17	00:48:04
15th fire engine arrives	06:04:16	00:53:03
20th fire engine arrives	06:35:07	01:23:54

Figure 1 - Key statistics

Incident Command

Sectorisation

Firefighting operations at large-scale incidents often occur in more than one location, for example, at the front, the sides and the rear of a building. In such cases the incident commander's span of control may be limited. If an incident commander is unable to effectively manage operations and supervise safety at more than one location, then sectorisation should take place. Sectors are introduced when the demands placed on an incident commander are high. Therefore responsibility for a geographical area at the incident is delegated to a suitable officer who undertakes the sector commander role. Due to the size of the incident in Cathedral Yard and its geographical footprint, sectorisation was implemented.

Figure 2 - Incident sectorisation

Command Structure

A description of the key positions in the command team and its structure at the Cathedral Yard incident is detailed below. Between 0511hrs and 1100hrs the personnel occupying these roles changed as;

- The incident escalated and supervisory managers were replaced with oncoming Flexi Duty System (FDS) officers.
- Officers occupying positions within the command team were relieved by a fresh set of officers prior to 1018hrs, as is common practice where an officer is at an incident for a prolonged period of time.

Incident Commander[13]

The incident commander has overall responsibility on the incident ground in order to resolve an incident assertively, effectively and safely. Appendix A details the roles and responsibilities of the incident commander.

[13] https://www.ukfrs.com/foundation-knowledge/foundation-incident-command?bundle=section&id=17011&parent=17016

Operations Commander (Ops Commander)[14]

The ops commander supervises and co-ordinates operations. This is to allow the incident commander to maintain a workable span of control. The ops commander is a member of the command team, and operates on behalf of the incident commander, and can approve changes to the tactical mode. The ops commander should avoid becoming involved in any other activities, such as command support, functional sectors or dealing with the media. This allows the ops commander to co-ordinate sector commanders to ensure that:

- Firefighting and search and rescue activities are coordinated.
- Support is offered to personnel on the incident ground.
- Resourcing issues are addressed.
- Risk assessments to support the priorities and objectives are performed at the right times.
- Assessments are of an expected quality and are appropriately recorded.

Sector Commander[15]

A sector commander may be appointed to be in charge of a defined physical, geographical or functional area of operations. The role of the sector commander is to control resources within their sector and report to the incident commander, or ops commander if in place. They will take responsibility for the resources and the achievement of objectives within their sector. The sector commander will mainly focus on implementing the incident plan, effective command and control, resource deployment, firefighting tactics and rescues. They have control on how they are going to meet their objectives agreed with the incident or ops commander. They need to set priorities and objectives for their sector working within the incident commander's overall objectives and incident plan. Importantly, they will focus on the health and safety of their personnel. Despite having control of resources within the sector, any change in tactical mode should have the explicit approval of the incident or ops commander. An exception however, is when they need to withdraw people due to an unacceptable level of risk. In such a case they should inform the incident or ops commander as soon as is practical and update the tactical mode for their sector. Full details of the roles and responsibilities of the sector commander can be found in Appendix B.

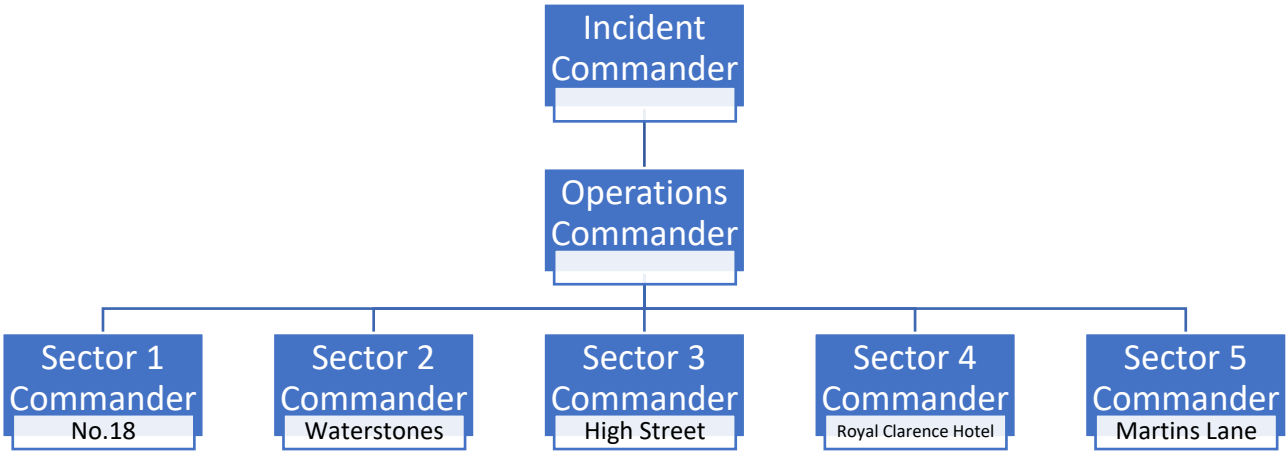


Figure 3 - Cathedral Yard fire command structure

[14] https://www.ukfrs.com/foundation-knowledge/foundation-incident-command?bundle=section&id=17021&parent=17023
[15] https://www.ukfrs.com/foundation-knowledge/foundation-incident-command?bundle=section&id=17020&parent=17023

Tactical Modes

The communication of the tactical mode is a way of recording a decision by the incident commander on the completion of the risk assessment and determination of the incident plan. It indicates the decision by the commander to deploy crews within the hazard area or not. All incidents require tactical modes to be declared at the earliest opportunity following arrival at an incident and at regular intervals thereafter. Where sectors are in place, a tactical mode for each sector is required. The declaration of the tactical mode at any given point of the incident describes the current level of risk exposure to operational personnel. There are two tactical modes an incident commander can declare:

***Offensive mode*:** This is where fire service personnel are working within the hazard area and exposed to greater risk, because the incident commander has decided it is appropriate following their risk assessment.

***Defensive mode*:** This is where commanders deal with an incident from a defensive position. In defensive mode, the identified risks are unacceptable and outweigh the potential benefits. No matter how many extra control measures could be put in place at that particular time, the risks remain too great to commit crews into the hazard area.

Section 1 – NFCC Review

1.1 Background to the Review

Shortly after the fire in Cathedral Yard D&SFRS undertook a review of the incident followed by a structured debrief, where upon its conclusion, a report was published which can be accessed using the link below. At no point did the NFCC or the Fire & Rescue Service (FRS) commissioned to undertake the review participate or play a part in the debrief or production of the D&SFRS report.

https://www.dsfire.gov.uk/News/Newsdesk/documents/CathedralYardReport.pdf

Since the report's release there have been a number of questions raised in publications, the media and following freedom of information requests about the response of D&SFRS to this incident and the contents of the D&SFRS report.

Whilst D&SFRS felt that its report was an accurate representation of the findings, a decision was taken to approach the NFCC and request an independent review of the report by a peer FRS who would have the capacity and technical expertise to review its content. The NFCC approached a metropolitan UK FRS who agreed to undertake the review, recovering the costs of doing so through the NFCC. An NFCC review team was assembled, supported by a single point of contact within D&SFRS who facilitated access to materials and other requests made by the review team.

The NFCC review ran from 3rd December 2018 until 25th July 2019 which was followed by fact checking and writing of the NFCC report.

1.2 Terms of Reference for Review

The initial meeting between the review team and D&SFRS was held on the 3rd December 2018, with the Terms of Reference (TofR) for the review agreed on the 10th January 2019. This period between the initial meeting and the agreement of the TofR was used to ensure that there would be sufficient evidence available to the review team to realistically achieve the aims of the review.

The TofR have been made publicly available by D&SFRS on their website and can be accessed below:

https://www.dsfire.gov.uk/News/Newsdesk/documents/Review-TofR.pdf

1.2.1 Aim of the Review

The aim of the review was to consider the official report issued by D&SFRS and report on:

- The process of compiling the report.
- The range of evidence gathered to substantiate the report.
- Whether any evidence corroborates the allegations that the incident command team ignored information that may have affected firefighting operations.

1.2.2 Structure of the NFCC Review

The review was carried out by a peer FRS through the NFCC to ensure that an unbiased but sector knowledge approach was taken. The review considered the official report that was released by D&SFRS, and the evidence relied upon to compile the report. This included statements, incident logs, photographs, video imagery and notes made by the initial D&SFRS review team. In addition, this review also considered the organisational learning gleaned from this incident and how that learning has been actioned since by D&SFRS.

The structure of this review was developed by the review team in a way that would give it the best opportunity of meeting the TofR, recognising that the incident occurred nearly three years ago. To achieve this the review was split into two phases, a literature review to determine key lines of enquiry (Phase I), followed by interviews with key witnesses (Phase II) identified during Phase I. Between Phase I and completion of Phase II there was a change of Chief Fire Officer in D&SFRS due to the return of a seconded officer to the service.

1.2.3 Scope of the Review

The review sought to answer the following questions:

1. Was the process used in compiling the official report issued by D&SFRS thorough, transparent and wide ranging enough to provide a comprehensive outcome?
2. Was the evidence gathered to compile the report relevant and of sufficient breadth to provide a solid basis for the report?
3. Has any relevant evidence gathered been omitted from the report?
4. Is there any evidence that corroborates the media allegations that command decisions taken during the incident ignored information that may have had an effect on firefighting operations?

The review team have presented the findings of the review to D&SFRS only, it will be D&SFRS to determine what, if anything, will happen with them and to this report.

Out of scope for the NFCC review was:

- To determine the cause of the fire or confirm how the fire spread into the RCH.
- To make any recommendations to D&SFRS regarding possible actions to be taken as a FRS or against individuals.

1.3 Phase I (Literature Review)

1.3.1 Approach

Phase I formally began on the 18th January 2019 and consisted of a literature review of all the documentation provided by D&SFRS to the review team. This was in excess of 532 individual pieces of evidence relevant to the incident between the hours of 0511hrs and 1100hrs on the 28th October 2016.

The purpose of the literature review was to ensure that the review team could not only become familiar with the incident, but also to allow for an informed view to be taken about who would be required for interview in Phase II. As this was a review and not an investigation, it did not warrant all personnel who attended the incident to be interviewed, only those who the review team believed would support the team in fulfilling the reviews TofR.

Prior to this review, D&SFRS had already collated a vast amount of evidence which was made accessible to the review team, with the breakdown of some of the types of evidence reviewed listed below:

- Statements
- Photos & Videos
- Reports
- Fire Control Logs & Recordings
- Information held on Cathedral Yard & Buildings Involved (No.18 & RCH)
- Organisational learning
- Debrief Transcripts
- Decision Log
- Analytical Risk Assessments
- Policy & Procedures
- Miscellaneous documents

Due to the significant amount of evidence available, there was a need for the review team to develop a process to determine how key lines of enquiry would be established. The first consideration was to place a timeframe over the incident which would be reviewed by the team given that the incident spanned 10 days. The timeline agreed was between 0511hrs and 1100hrs on the 28th October 2016 because this covered the time D&SFRS was first alerted to the fire at No.18, through to its spread and escalation[16] to the RCH. To assist in the process of establishing key lines of enquiry, the flow chart in Figure 4 was developed as an initial guide to determine the areas Phase II would be developed around. It must be stated, however, that there was an ongoing assessment of information and so whenever new information suggested a change in the relevance of an area, the review team responded where necessary.

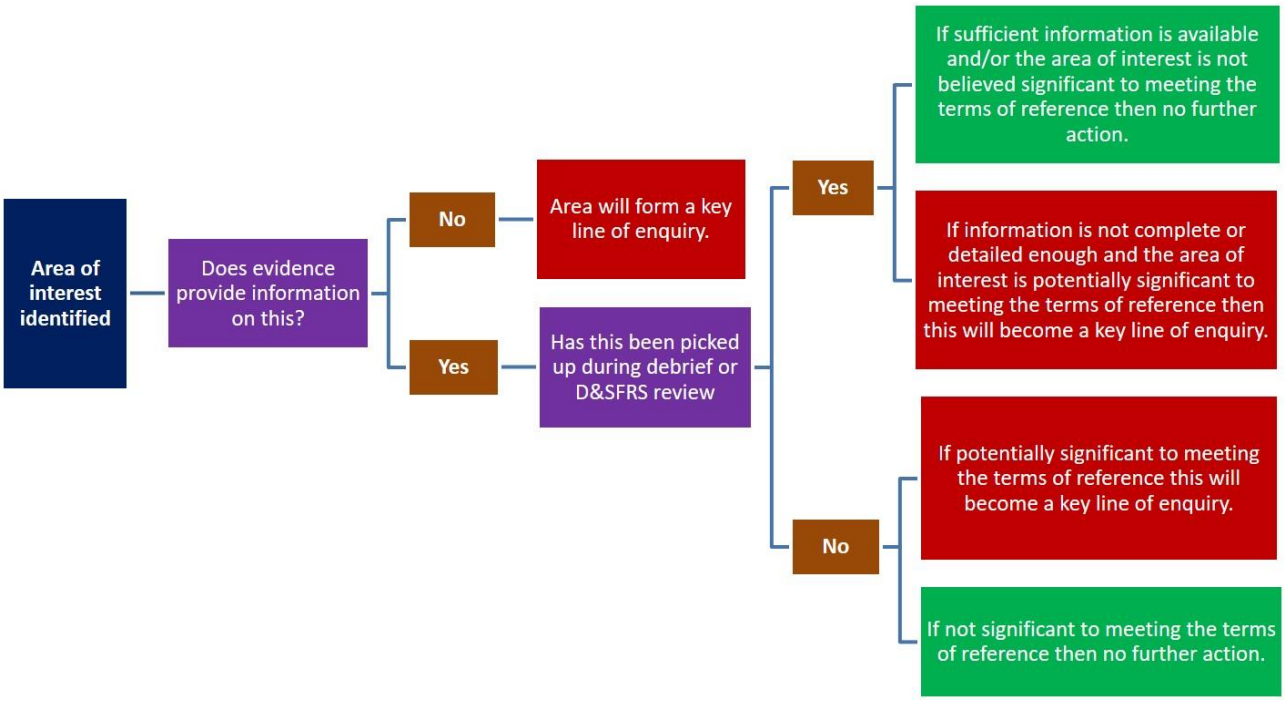


Figure 4 - Flow chart to determine key lines of enquiry

1.3.2 TofR Tracker – Phase I

After reviewing the available evidence provided by D&SFRS, feedback was given by the review team to D&SFRS prior to the commencement of Phase II. In order to track the progress of the review against the TofR, a traffic light system was adopted against each of the four questions the review sought to answer.

- A question was rated **red** where the review team were not satisfied the question had been answered.
- A question was rated **amber** where the review team required further information to form an opinion.
- A question was rated **green** where the review team were satisfied the question had been answered based on the information that was received.

The tracker was reviewed on an ongoing basis using the information obtained during the review.

1.3.3 Key Lines of Enquiry for Phase II

Following the process of assessing the information provided to the team in Phase I, three initial key lines of enquiry were established around the response to this incident. These were focused on:

[16] For the purpose of this review, escalation refers to the time of approximately 1018hrs where fire was observed breaking through the RCH roof.

- ***Sector 3 – The High Street to the rear of No.18 and the RCH.***
    - Interactions and communication between members of the command team.
    - Access to risk information.
    - Tactical plan for sector 3.
    - Use of Positive Pressure Ventilation (PPV).
    - Tactical ventilation plan.

- ***Sector 4 – The RCH.***
    - Interactions and communication between members of the command team.
    - Access to risk information.
    - Tactical plan for sector 4.
    - Firefighting actions taken in sector 4.
    - Dynamic risk assessments made in sector 4.
    - Conditions within the RCH.
    - Hand over to relief officers.

- ***Sector 5 – The road running alongside the RCH (Martins Lane).***
    - Interactions and communication between members of the command team.
    - Access to risk information.
    - Tactical plan for sector 5.
    - Firefighting actions taken in sector 5.
    - Dynamic risk assessment.
    - Hand over to relief officer.

1.4 Phase II (Interviews)

It was recognised that a literature review on its own would not provide the level of detail and clarity required for the review team to meet the TofR agreed with D&SFRS. As a result, a request was made to D&SFRS for access to key individuals who attended the incident who could provide first hand witness accounts of what they saw and experienced. This included a number of retired personnel who the review team were able to speak to along with a member of the public who witnessed the fire from Cathedral Green.

1.4.1 Approach

On conclusion of Phase I a number of key lines of enquiry were developed which would inform the engagement of key stakeholders as part of Phase II. A list of individuals was drawn up by the review team and provided to D&SFRS who then facilitated access to these individuals willing to be interviewed, which occurred over the course of four days (25/26th March and 19/20th May 2019). This discontinuous approach was to allow the review team the opportunity to assess the interview notes and amend the list of personnel to be interviewed, where necessary, if new information came to light. In addition to this direct approach to individuals, a dedicated NFCC email address was set up to provide an opportunity for D&SFRS employees to contact the review team confidentially if they wished. In total three personnel out of the 21 interviewed chose to contact the review team through this email within the timeframes set. When an individual contacted the team through this email, interview arrangements were made with the individual directly. While 17 of the interviews were conducted face to face at either Middlemoor fire station or D&SFRS headquarters (FSHQ), four were conducted over the telephone for logistical reasons.[17]

The total number of people interviewed was 21, with the breakdown of rank or role listed below:

- Firefighters: 5
- Supervisory managers (Crew/Watch Commander): 5

[17] The initial D&SFRS review team consisting of two people were interviewed together as one.

- Middle managers (Station/Ops/Group Commander): 7
- Strategic managers (Area Commander & above): 2
- Fire Brigades Union (FBU) representative: 1

There was also one member of the public interviewed as part of the review who was located on Cathedral Green when the fire at the RCH escalated.

D&SFRS arranged 17 of the interviews on behalf of the review team and individuals were allowed to attend with a trade union representative if they wished. In total four interviews were conducted with an FBU representative in attendance. For each person interviewed a framework was developed which provided a structured approach to the questions asked, while giving the review team suitable flexibility to adjust the questions where the answers given suggested other areas required further exploration. It was important for the review that during Phase II the information provided by D&SFRS personnel was a first-hand account of their personal experience and observations at this incident. Therefore, other than an individual's personal statement made during the D&SFRS review, no further information was provided prior to an individual's interview. This was to reduce the risk of a '*groupthink*' setting emerging and to avoid bias. However, information was released in a controlled manner during interviews where the information would assist a person in giving a response to questions or to clarify timelines. During the interview, notes were made by the review team which were then shared with the individual for agreement, to ensure the notes provided an accurate record of the discussion. Only when those notes were agreed, were they used to form the findings of this report.

Interviews were voluntary, however despite the majority of personnel approached agreeing to participate in the review, two identified key individuals declined to take part. These were:

- The initial sector 4 commander who was in charge of firefighting operations in the RCH before the incident escalated at circa 1018hrs.
- A station commander who was one of the first FDS officers on scene and would become the logistics officer at this incident.

These two individuals remain critical to the review and the impact of their absence is that whilst the review team was able to gain valuable insight to this incident and produce the findings in section 2, inevitably there remains a number of questions unanswered. Despite this, the review team are confident that the findings contained in this report, based on the information gathered in Phase I and II, are reliable.

Following Phase II there was a review of the evidence obtained to determine whether there had been enough gathered to draw reliable conclusions and to then present findings that would meet the TofR.

Phase II concluded on the 25th July 2019.

Overview of Findings

Overview
It was known within an hour of arriving at the incident that fire and smoke from No.18 had spread internally into the RCH. This was predominantly to the front left section of the RCH.
The main focus of firefighting efforts up to 1018hrs at the RCH were: • **Internally, in and around rooms 401 and 402 (Third floor) prior to the BA withdrawal &** • **Externally on the roof apex above rooms 401 and 402 via an Aerial Ladder Platform (ALP).**
When withdrawing BA from the RCH prior to 0640hrs due to the risk to D&SFRS personnel, it was known that crews had not extinguished the fire inside the RCH.
No evidence has been found by the review team that all areas of the RCH were either searched or periodically monitored throughout the incident prior to the escalation at 1018hrs. In the absence of ongoing monitoring throughout the RCH after the withdrawal, it remains unknown whether there was detectable fire spread elsewhere in the hotel which wasn't picked up.
Situational awareness: The review team found that no common recognised information picture existed between members of the command team, with: • **Different views between command team members as to what activity was taking place in the RCH.** • **Some officers in the command team being unaware on arrival that the incident had been declared a major incident by D&SFRS at 0542hrs.**
Interactions between command team & initial sector 4 commander found during Phase II: • **Two events were identified which indicate that the sector 4 commander was in possession of information about the conditions within the RCH and that he made reference to going to tell someone in the command team about it.** • **One event indicates that the sector 4 commander had passed on information about the conditions within the RCH to the command team.** • **One event indicates that the sector 4 commander was attempting to approach the command team just prior to the escalation at 1018hrs but was subsequently turned away.** *However, in all cases there are no witnesses who saw these exchanges take place between the initial sector 4 commander and command team (Incident or Ops commander).*
Based on the annotated floorplan the initial sector 4 commander submitted in his written statement to D&SFRS shortly after the fire, the location he highlighted on the plan was not the location where the fire broke through the RCH roof at circa 1018hrs. Instead, the location highlighted on the floor plan was the location where firefighting actions were taken early on in this incident and up to 1018hrs.

Table 1 - Key findings

Section 2 – Findings

The review team have determined its findings based on the available evidence obtained during Phase I and II, with the following areas of focus being addressed by this report:

- D&SFRS debrief & review.
- Information held by D&SFRS on the RCH.
- Timeline of events:
    - Declaration of a major incident.
    - Firefighting within the RCH (Pre-internal collapse of No.18).
    - Internal collapse of No.18.
    - Firefighting within the RCH (Post internal collapse of No.18).
    - Escalation of the fire at 1018hrs.
- Reporting of conditions inside the RCH to the command team.

2.1 D&SFRS Debrief & Review

The review team were asked to determine, as part of the TofR, whether any relevant evidence had been omitted from the D&SFRS report and that the evidence base from which the report was compiled was sufficiently comprehensive. When reviewing the approach taken to the debrief and the initial report produced by D&SFRS, these two processes were set up to achieve different things. The D&SFRS report was designed to be an informative, outward focusing document for members of the public, which discussed heritage and protection issues.[18] The debrief was internally focused and looked at the incident from the perspective of organisational learning which is undertaken regularly by FRS's post incident.[19] Therefore, the products produced by these processes differ in content, and information presented in the internal debrief to D&SFRS personnel may not have been included in the D&SFRS report made available to the public following the review. This approach will be common where learning organisations actively use internal debriefing to support continual improvement. Without a written TofR for the initial D&SFRS review to compare the contents of the D&SFRS report with, the absence of a benchmark makes it difficult to produce any findings around whether information was omitted from the D&SFRS report and whether it met the aims and objectives originally laid out for it.

Involvement of personnel in the D&SFRS debrief and review of the incident leading up to the initial report was voluntary and not compulsory for employees. When both reviewing the literature and interviewing key personnel who attended this incident, it was found that a number of individuals interviewed during Phase II were not involved in either the debrief and/or the review undertaken by D&SFRS. It must be stated however that the reasons for this ranged either from personnel being absent (due to leave or retirement) to individuals who chose not to participate in the D&SFRS review or debrief. The NFCC review team can state that significant information has come to light during this review which was not disclosed during the initial D&SFRS review. The impact of this missing information has been that the D&SFRS report, in part, did not go into the necessary detail to help the reader understand the narrative behind the timeline detailed within the report. It also fails to answer some of the allegations directed towards D&SFRS following this incident. The table below shows the personnel interviewed as part of the NFCC review and their involvement in the initial debrief and subsequent review conducted by D&SFRS.

[18] #15

[19] #15

NFCC Review Interviewee	D&SFRS Debrief	D&SFRS Review
#1	Yes	Yes
#2	Yes	Yes
#3	No	No
#4	Yes	Yes
#5	No	Yes
#6	No	Yes
#7	Yes	Yes
#8	Yes	Yes
#9	Yes	Yes
#10	No	No
#11	No	No
#12	Yes	Yes
#13	Yes	Yes
#14	No	Yes
#15*	N/A – Initial D&SFRS review team	
#16	No	No
#17	N/A	No
#18**	N/A	Yes
#19**	Yes	Yes
#20	No	No
#21	N/A	N/A
#22	Yes	Yes

Table 2 - List of Interviews

* Two individuals were interviewed together.
** #18 and #19 were not interviewed as part of the NFCC review but their written statement was used to compile this report.

2.2 Information held on RCH

The review team sought to understand what information was available to crews and officers attending this incident, whether it be through requirements under the:

- Fire & Rescue Services Act 2004.
- Regulatory Reform (Fire Safety) Order 2005.
- Provision of risk information through Site Specific Risk Information (SSRI).

SSRI – National Operational Guidance (NOG)

NOG helps interpret the requirements of the Fire & Rescue Services Act 2004 which states that Fire and Rescue Authorities must make arrangements to obtain necessary information for the purposes of:

- Extinguishing fires and protecting lives and properties from fires in its area.
- Rescuing and protecting people from harm at road traffic collisions in its area.
- Dealing with any other emergency function other than fires and road traffic collisions in its area.

UK legislation sets the requirement for site-specific assessments, with collating and disseminating SSRI involving a number of tasks:

- Selecting premises to be inspected.
- Assessing the nature and magnitude of the risk.
- Considering a proportionate response.
- Recording significant findings.
- Making sure information is available in a useable form.

A site-specific assessment takes account of current legislation on inspection information and creates site specific information on pre-planning and firefighting tactics. An SSRI is designed to be utilised by crews at an incident. It is designed to hold pertinent information which is usable in time critical situations where having to refer to detailed assessments would delay the application of firefighting actions. Access to SSRI is via a 'Mobile Data Terminal' on the fire appliance which can allow the information to be accessible on route and at an incident.

The RCH did have SSRI attached to it and there is evidence that this was accessed by some of those personnel attending this incident.[20] There was also evidence which indicated that a number of people occupying key positions within the command structure were familiar with the RCH due to their previous roles in D&SFRSs which had seen them visit the RCH on a number of previous occasions.[21] In addition to this, a number of crews at the incident knew of the RCH and there is also evidence that prior to the escalation occurring some made reference to the challenges of fighting a fire at the hotel.[22]

When reviewing the SSRI for the RCH, there was information held surrounding priorities. These were in terms of items of importance stored at the hotel and also an amended level of response to fire incidents, showing an ALP should be included on the initial mobilisation. An ALP was not initially mobilised to this incident, as the initial call received was not to the RCH. However, an ALP was requested shortly after the initial crews arrived at the incident. Also contained within the RCH's SSRI was reference to the risk of fire spread due to the close proximity of neighbouring properties. While the SSRI plan refers to the RCH's '*unusual, complex layout*', the review team could find no reference within the SSRI about inaccessible voids in the hotel, or the likelihood of fire spread through voids.[23] This information would only have been known to D&SFRS if they had been made aware of it, as the intelligence held within SSRI is normally based upon information passed about the building and observations of personnel conducting the assessment.

RCH – Grab Pack

The SSRI for the RCH referenced a 'g*rab pack*' that was held in the reception area of the RCH. It reportedly contained pertinent information that an incident commander could access to assist in resolving an incident at the hotel, which included a salvage plan. A crew member highlighted its existence to the command team early on,[24] with evidence that an FDS officer was seen with the pack as the incident developed.

Fire Safety Folder

The review team identified through Phase II that a request was made at approximately 0837hrs for the RCH's fire safety folder to be collected from a local fire station in Exeter and taken to the incident.[25] This task was given to an FDS officer who was asked to collect the folder at normal road speed (not blue lights). The officer arrived at the incident with the folder between 0915hrs and 0930hrs and gave it to the command unit. Evidence suggests that it was then passed around those officers present.[26] Contained within the fire safety folder was additional information on the RCH which would not have been contained within the SSRI. At this point however, the general belief on the fire ground was that the fire had either been extinguished or contained to the hotels apex roof above rooms 401 and 402 which was being well monitored at that point.

[20] #7
[21] #1
[22] #1, #2
[23] SSRI – 08/12/2015
[24] #20
[25] Incident log
[26] #12

2.3 Timeline

Following Phase I and II, it was determined by the review team that a more detailed account of the actions taken at this incident between 0511hrs and 1100hrs would be required. A significant finding of the review team has been that the D&SFRS report does not present a detailed account of events and actions taken prior to the escalation of the fire from No.18 to the RCH at 1018hrs. The absence of key information has left a vacuum which has subsequently been filled with many questions around the response to this incident, and how a fire that was seemingly under control in No.18 could have spread as it did. As a result, the review team believe that a more detailed account of the timeline of events, especially around the RCH, would go some way to answering the questions raised in the media, by employees of D&SFRS and from members of the public following the report's release.

2.3.1 Major Incident Declaration

The severity of this incident was evident early on, with the initial incident commander on the first appliance being approached by a police officer on arrival who stated that he had declared a major incident.[27] This would be consistent with occurring at around 0521hrs and is confirmed by a statement taken from the acting police sergeant who made the declaration.[28] Whilst Devon & Cornwall police had declared it a major incident from a police perspective, the formal fire declaration of a major incident by D&SFRS can be placed 21 minutes later at 0542hrs. This is when a major incident was declared to fire control and then subsequently recorded on the incident log.[29] When reviewing the D&SFRS report it states that a major incident was declared by the fire incident commander at 0521hrs, however when reviewing the fire control log there is no record of this on there. Regarding crews and officer's awareness of this declaration, during Phase II it was evident that not all the officers who attended the incident after the declaration were aware that it had been declared a major incident at 0542hrs.

Despite this, it is evident from the incident log and through Phase II interviews that the timings of these declarations did not have an impact on firefighting actions at this incident. Prior to the declaration of a major incident at 0542hrs, the incident commander had sent two assistance messages requesting further resources (0523hrs – Make pumps 10, ALPs 1 and at 0531hrs make pumps 15, ALPs 2).

2.3.2 Firefighting within the RCH (Pre-Internal Collapse of No.18)

During Phase II a number of personnel interviewed described the very early firefighting actions taken at this incident, which included jets being used in an attempt to prevent lateral fire spread from No.18 to the RCH.[30] This was focused predominantly on the RCH's pitched roofs above rooms 401 and 402. However, this was not the sole action being taken at the RCH, whilst actions were being taken externally to reduce fire spread to the hotel, internally, D&SFRS personnel were entering the hotel to assist the hotels staff with an evacuation.[31] This was carried out by a crew member who was initially supported by the hotel porter in searching the rooms to the front of the hotel up to the third floor.[32] In the vicinity of rooms 401 & 402 there was visible smoke and a rise in temperature which led the crew member to instruct the hotel porter to leave the hotel via a fire escape, this occurred approximately 10 minutes into the search, with the crew member exiting 10 minutes later.[33] During the Phase II interview of this individual, he stated he did not go into all areas of the hotel, only the residential rooms of the hotel to the front and front left of the RCH.[34] On exiting, he reported to an officer the conditions inside the hotel and the fact that he had not searched all the rooms so couldn't be sure that the incident was all persons accounted for.[35] Around this time, at approximately 0550hrs the incident was made '*persons reported*',

[27] #1, #16
[28] #1, #18
[29] #6, Fire control Log
[30] #16, #19
[31] #16, #20
[32] #20
[33] #20
[34] #20
[35] #20

a declaration used at any incident type by FRS's to indicate the involvement of people (non FRS) in the incident.[36]

Figure 5 - Fire at No.18

Supporting a notion that conditions inside the RCH posed a risk to firefighters was an early change in the control measures implemented by the initial sector 4 commander in charge of personnel operating in the hotel.[37] While initially crews entering into the RCH did so without Breathing Apparatus (BA), when they had to withdraw due to the conditions inside the hotel they were then re-committed by the sector 4 commander with BA.[38] The evidence provided by BA wearers[39] has confirmed that the fire had spread internally into the RCH within an hour of the first crews arriving at this incident, although a message sent at 0532hrs does refer to the spread of fire to the hotels pitched apex roofs.[40] With regards to the activity undertaken inside the RCH in these early stages of the incident, firefighting actions predominantly took place at the front left section of the RCH, in rooms 401 and 402 on the third floor above the Well House Tavern where images show the fire to have spread (Figure 5).[41] Figure 6 is a third floor plan of the RCH which was annotated and included in the written statement provided by the initial sector 4 commander during the D&SFRS review. The annotation visualises what was happening within the RCH and provides the location of where crews were working, which was verified by a number of BA wearers interviewed during Phase II.[42] In addition to this the sector 4 commanders written statement to the D&SFRS review also refers to the fire breaking through into the RCH on the second floor below room 402, which was subsequently knocked back by a BA team prior to them being withdrawn from the hotel (Figure 7).[43]

[36] D&SFRS report (Page 21)
[37] #19
[38] #2, #19
[39] #2, #3
[40] Fire control Log
[41] #2, #3, #16
[42] #2, #3
[43] #19

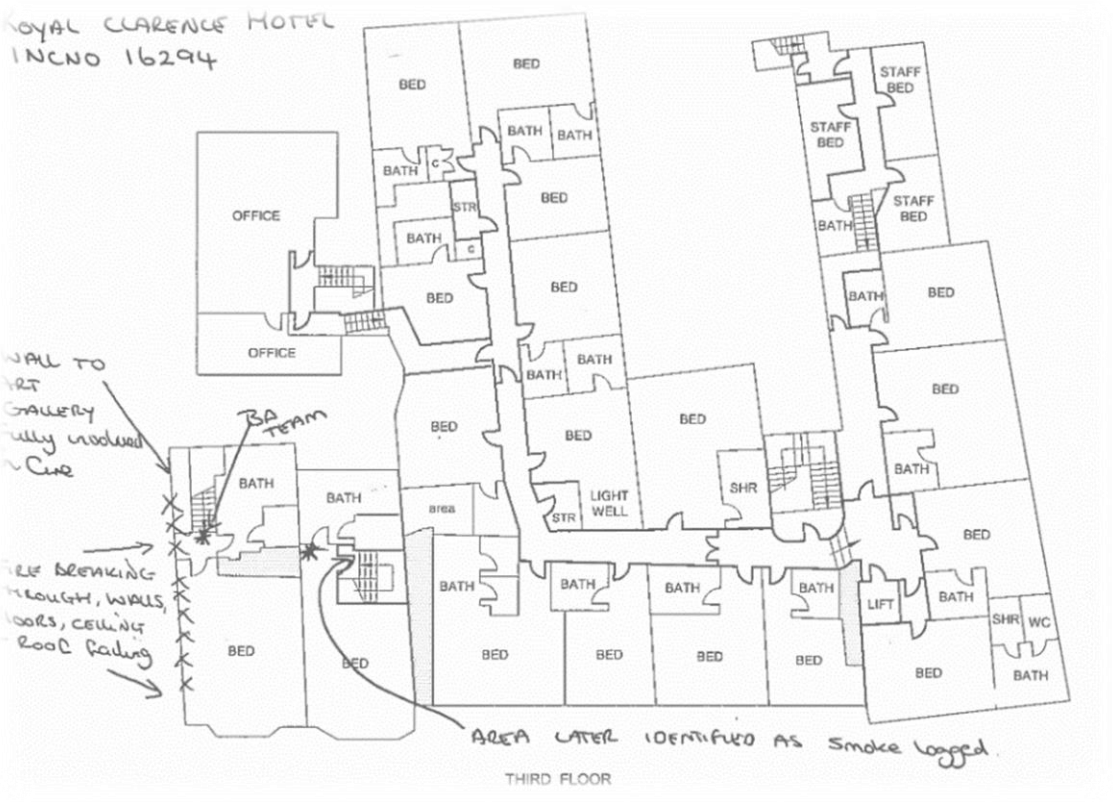


Figure 6 - Annotated third floor plan (taken from Sector 4 commanders written statement)

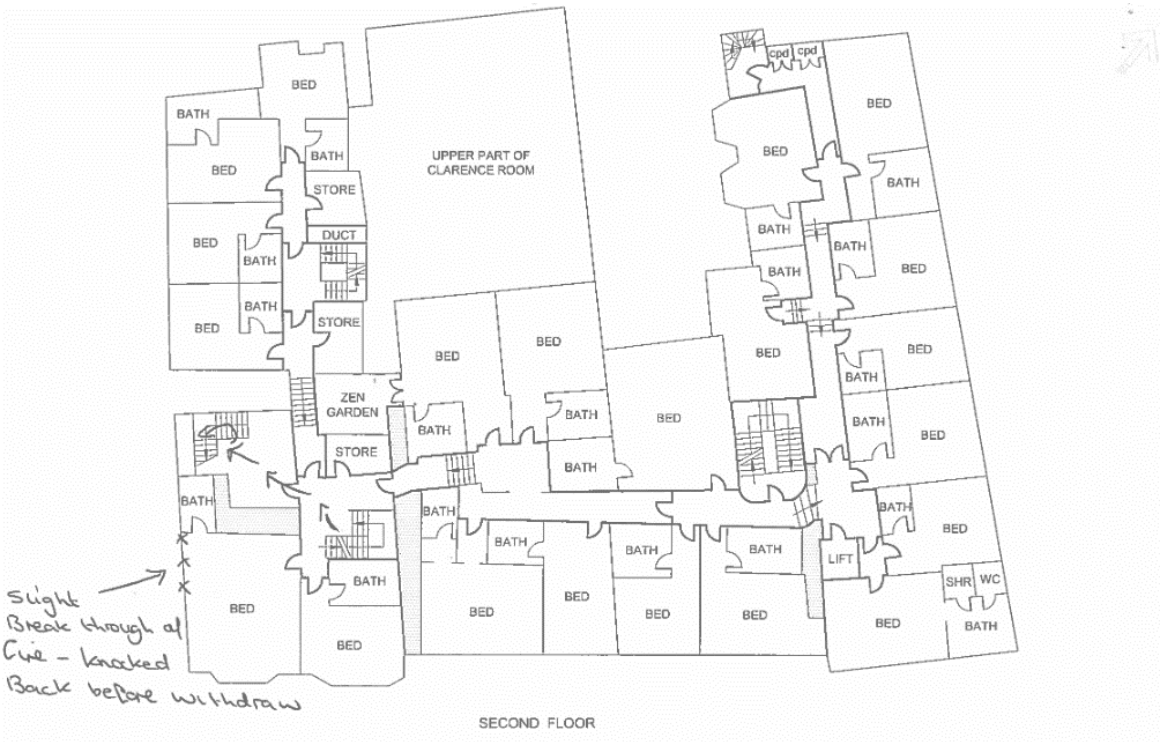


Figure 7 - Annotated second floor plan (taken from Sector 4 commander written statement)

Prior to 0613hrs, BA wearers coming out of the RCH reported a deterioration in the conditions within the hotel,[44] with those wearers reporting significant heat and fire in the area of rooms 401 and 402.[45] A noteworthy quote from a BA wearer to the review team was that the fire was '*above us, below us and all around us*'. Another BA crew member interviewed stated that he witnessed falling debris outside, through a small window in the hotel, when he went to room 402 in the apex section.[46] Further supporting the evidence of a deteriorating situation within the RCH was when a BA wearer placed their hand on the wall and it fell away, revealing fire. This had occurred by 0640hrs and resulted in the withdrawal of BA from the hotel on safety grounds.[47] At this point the incident was '*all persons accounted for*' on the basis that there were no known persons inside the hotel[48] so the risk of keeping firefighters in the RCH was greater than the benefits of keeping them in.[49] According to various sources this order to withdraw was given by the sector 4 commander on safety grounds.[50] Following this withdrawal, firefighting at the RCH was conducted externally using aerial appliances (ALPs). It was stated by a number of personnel during Phase II that when all resources had arrived at the incident, the increased requirement for water appeared, at times, to overwhelm the water supply.[51] This resulted in a delay in ALP's being brought into use and subsequently, the external attack on the fire.[52]

When reviewing the floor plans in Figures 6 and 7, an observation made by the review team is the absence of detail around what firefighting actions, or searches, took place elsewhere on the first, second or third floor in the RCH up to 1018hrs. In all the interviews conducted with BA wearers during Phase II, nobody stated that they had accessed the entire third floor, or any other parts to the rear of the hotel. This was because the focus of firefighting actions was on the pitched roof apex of the RCH to the front left of the hotel and internally within rooms 401 and 402. The complex layout of the RCH was highlighted to the review team when assessing the floor plans for the hotel and speaking to individuals during Phase II, where it would appear that the only access to rooms 401 and 402 on the third floor would have been from a separate staircase from the second floor (Figure 8).[53] As a result, and with no access to the rest of the third floor in the RCH from rooms 401 and 402, BA crews would have needed to have been specifically briefed to go to other parts of the third floor via a different route in order to carry out tasks in those areas. The external layout of the buildings occupying Cathedral Yard around No.18 was also highlighted as complex by an ALP operator, who stated during Phase II that the complex layout of buildings, or '*Labyrinth*' as he described, made it difficult to see what was happening further back on the roof of the RCH and surrounding buildings (Especially at the height of the fire in No.18).[54]

[44] #19
[45] #2, #6
[46] #3
[47] #2, #19
[48] D&SFRS Report (Page 21)
[49] #19
[50] #2, Debrief transcript, #19
[51] #4, #16
[52] #9, #16
[53] SSRI floor plan – 08/12/2015
[54] #16

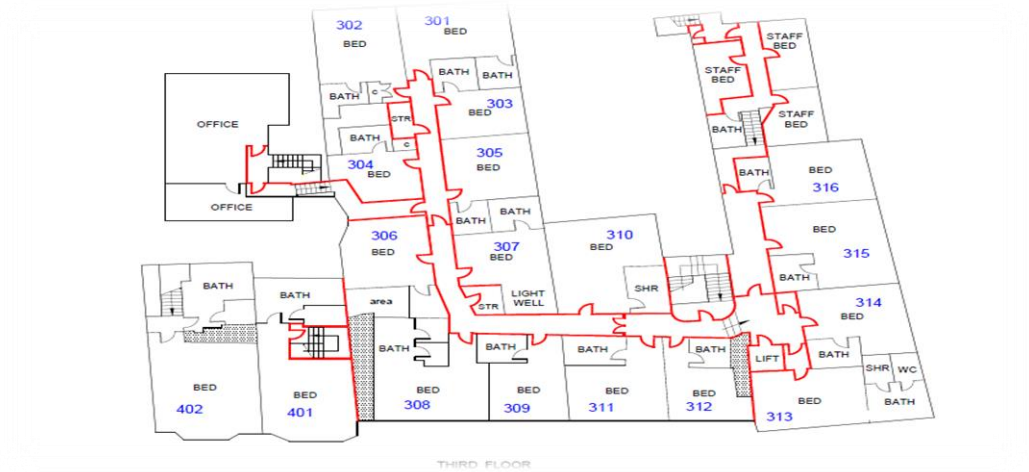


Figure 8 - Royal Clarence Hotel floor plan (Third floor)

As a result, there was no evidence to indicate that the rear of the RCH, especially on the third floor, was ever searched by the BA crews in the initial stages of this incident. The initial focus of resources, where the fire could be seen externally impinging the RCH pitched roofs, is significant. With no evidence that the rooms marked '*Office*' on the plan, or indeed other parts of the hotel were being monitored on an ongoing basis, it remains unknown as to whether there was any internal fire spread into these areas from No.18 prior to the escalation at 1018hrs.[55] Where this is relevant to the review is that it was an area further back into the RCH that the true extent of fire spread into the hotel was first observed by an ALP operator working by the apex roof above room 402, prior to the escalation. [56]

While there was activity taking place in and around the RCH, sector 3 was established on the High Street behind the hotel. Under the key lines of enquiry established for this review, the team looked at the use of Positive Pressure Ventilation (PPV) at this incident which was brought into operation for a couple of hours in shops within sector 3 during the early stages of this incident.[57] The review team is unable to identify any findings that the use of PPV at this incident had an impact on fire spread as it was used to clear residual smoke from a number of shops on the high street.

Command Support

At large scale incidents, the command team is supported by a dedicated team who are mobilised to support the command structure on scene at an incident. For this incident, the Command Support Unit (CSU) was mobilised to Cathedral Yard. From a command support perspective, historically the officer in charge of the CSU would undertake the role of Command Support Officer (CSO), in line with D&SFRS policy. Feedback from this incident suggested that some of the command decisions the initial CSO was expected to make, were beyond the training that they had received. This was due to the scale of the incident and the expectation of tactical decisions having to be made in the CSU. Since this incident, D&SFRS now mobilise an officer with enhanced command training with the CSU to carry out the role of the CSO.[58] This provides the appropriate level of accountability and responsibility, as well as the right support for the incident commander and CSU operatives at larger incidents.

2.3.3 Internal Collapse of No.18

Within an hour and a half of D&SFRS arriving at this incident there was a significant internal collapse of the floors within No.18 where the initial fire was located.[59] Following this, the fire inside No.18 notably reduced in size and as a result, the general feeling amongst a number of witnesses from D&SFRS was

[55] Debrief transcript
[56] #9, #11, #12, Appendix C
[57] #5, #6
[58] D&SFRS debrief report
[59] D&SFRS report (Page 21 & 27)

that the fire was being brought under control in No.18.[60] An ALP operator also stated during Phase II that once he had started to put water on the fire in No.18, it quickly began to have an effect in reducing its size.[61] Photographic evidence from the incident[62] supports the view that post 0650hrs, there was little fire and less smoke rising from No.18 when compared to 0518hrs when crews first arrived (Figure 5).

Figure 9 - View from Cathedral Green (Post internal collapse of No.18)

Whilst firefighting actions took place after the internal collapse, they were largely external in sectors 1, 2 and 3 prior to the relocation of an ALP to the front of the RCH (Sector 4).[63] However, due to the conditions inside the RCH, firefighters wearing BA had been withdrawn resulting in no firefighting taking place within the hotel and more defensive tactics being deployed. While a number of entries were reportedly made into the RCH, these were for specific purposes only and did not form part of a formal watching brief.

However, there was no alignment of understanding between different levels of the command team as to what firefighting activity was being undertaken inside the RCH. During Phase II interviews it became evident to the review team that no common recognised information picture was held between the command team, whose differing understanding as to what firefighting actions were, or had taken, place within the RCH impacted on their situational awareness of what activities were being undertaken in sector 4.

2.3.4 Firefighting within the RCH (Post Internal Collapse of No.18)

After the internal collapse of No.18 and BA crews being withdrawn from the hotel the evidence indicates that most firefighting actions were predominantly being taken from outside No.18 and the RCH. There was no evidence found during Phase II of the review that would indicate a plan was in place to continually monitor the conditions throughout the hotel up to 1018hrs.[64] There is reference in the initial

[60] #15, #16
[61] #16
[62] Figure 9
[63] #16
[64] Debrief transcript

sector 4 commanders written statement to the D&SFRS review that he checked the second floor and found no smoke or any '*smoke in the areas of the third floor the other side of the chimney breast*'.[65] This would have been an important area of discussion with the sector 4 commander if the review team were given the opportunity to speak to him, as there are a number of chimney stacks visible in Figure 10.

Figure 10 - Drone screenshot, pre escalation of fire into RCH

Although multiple entries were made into the RCH after the initial BA withdrawal, they were for specific purposes only, such as fire investigation[66] and to collect various personal belongings for hotel guests.[67] An ALP operator reported that during this time there were no signs of fire spread in the area he was working.[68] This was the roof apex above rooms 401 & 402 at the front of the RCH[69] where throughout the early morning the most visible external fire spread to the RCH had been observed, which is captured in many pictures taken early on during this incident.[70]

At approximately 0745hrs the attending fire investigation officer entered the RCH with the sector 4 commander. They proceeded up to the third floor as part of their inspection, noting that smoke could be seen within the hotel but no fire.[71] Just prior to exiting the RCH at around 0758hrs the fire investigation officer reports that the sector 4 commander left him in the reception area of the hotel, stating that he was '*going to tell someone about the smoke*'.[72] Due to the initial sector 4 commander not participating in Phase II, the review team have been unable to determine if the sector 4 commander carried this statement through, and if he did, who he reported the conditions to.

Between 0900hrs and 1000hrs entry into the RCH to retrieve some guest's items triggered a review of the risk assessment which led to BA being recommitted back into the hotel.[73] There is evidence that a plan was made to send a number of BA wearers into the RCH with the sole purpose of positioning themselves in the vicinity of the wall between No.18 and the hotel.[74] According to the ops commander however, the BA wearers returned stating that there was no smoke but the hotels layout was complex to navigate which had resulted in them getting lost. This resulted in a second withdrawal of BA from the

[65] #19
[66] #8, #19
[67] #5, #7
[68] #4, #16
[69] #4
[70] Figure 5
[71] #8
[72] #8
[73] #7
[74] #7

RCH, a decision made by the ops commander.[75] Again, the area of the RCH BA crews was working in was focused towards the front of the hotel above the Well House Tavern as opposed to other areas of the hotel.

Many people interviewed from D&SFRS during Phase II noted the relaxed feel on the incident ground prior to the fire escalating at 1018hrs,[76] with the fire having reduced in size following the internal floor collapse in No.18 which had occurred by 0650hrs, and the work of the ALP in putting water on the fire. There is evidence from multiple sources that many personnel had been sent to the Guildhall for refreshments and that the incident ground in sector 3 did not have many crews operating in it.[77] The feeling amongst many D&SFRS personnel right up until 1018hrs was that the incident would likely be scaled down and in some cases individuals were making personal calls home in preparation for leaving the incident. However, there is a discrepancy between what crews on the incident ground believed to be the case and what was described to the review team by senior members of the command team who instead state that the incident was not being scaled down. When reviewing the event log for this incident there is a declaration of '*Fire Surrounded*' which is a formal message used by incident commanders to state that there is no further risk of fire spread. When speaking to the incident commander at the time of the escalation it was stated to the review team that he communicated in a multi-agency briefing that firefighters had surrounded the fire but that this was not a formal 'Fire Surrounded' declaration.[78]

One consistency within all statements however is that personnel believed prior to 1018hrs the fire in No.18 appeared to be under control and that whilst there was still work to do they had '*got on top of it*'.

2.3.5 Escalation of Fire at 1018hrs

Based on the timeline contained within the D&SFRSs report, which places the escalation of the fire in the RCH at circa 1018hrs, it would appear that it was shortly before this time that the first signs of the true extent of fire spread into the hotel was recognised.[79] This was from the ALP operator working close to the front apex of the RCH above rooms 401 and 402 who noticed fire around a chimney stack towards the middle of the hotel.[80] Initially the ALP operator tried to raise these concerns to the command team via radio but did not get a response.[81] As a result, the operator returned to the ground and reported his observations to the command team face to face, before being asked to take aloft an FDS officer to show him what he had seen.[82] This FDS officer stated that he was not comfortable with what he saw which was fire coming out under the pitched roof towards the middle of the RCH under pressure.[83] By the time the ALP cage was returned to the ground and this communicated to the command team, the fire had escalated and became visible breaking through the roof of the RCH for all to see. The significance of where the fire was observed breaking through the roof is the absence of evidence in Phase II to suggest that this area of the hotel was being internally monitored periodically prior to the escalation.[84] The statements made during Phase II along with the annotated floor plan produced by the initial sector 4 commander for the D&SFRS review indicate that the focus of firefighting efforts and resources had been on the front face of the RCH on the apex roof, and internally in rooms 401 and 402 which is where the visible fire spread from No.18 was initially observed.[85] This would suggest that whilst there may have been the presence of undetected voids that could have allowed the fire to spread as described in the official D&SFRS narrative,[86] it is feasible that there was detectable fire spread elsewhere in the RCH which was not found due to no ongoing monitoring taking place in these areas of the hotel following the initial withdrawal of BA and more defensive tactics being deployed.

[75] #7
[76] #3, #4, #5, #12, #16
[77] #4, #5, #15, #16
[78] #13
[79] D&SFRS report (Page 29)
[80] #9
[81] #9
[82] #9, #12
[83] #12
[84] Appendix C
[85] #2, #3, #9, #19
[86] D&SFRS Report (Page 29)

When reviewing the actions of D&SFRS immediately after the escalation, the timing of this event is significant as a relief plan was being put into effect where crews who had been in attendance from the start of the incident were being relieved with a fresh set of oncoming crews. A 12 pump relief had been ordered to the incident ground to arrive between 0900hrs and 1000hrs.[87] Personnel interviewed during Phase II expressed a belief that an 'attribute' based mobilising system adopted by D&SFRS means that specific equipment must be returned to the appliance it is assigned to prior to an appliance leaving the incident and being relieved. Upon discussing this with D&SFRS managers, it is believed that what the firefighters were referring to was the inability of fire control to reassign an appliance call sign to another, therefore requiring appliances embedded into an incident to be rotated with a relieving appliance. This is critical for the command and control system used by D&SFRS fire control when identifying and mobilising appropriate resources and equipment to an incident. At the time of escalation at 1018hrs, this relief plan was in the process of being implemented. During this time, bystanders on Cathedral Green and the High Street will have observed crews making up equipment and moving vehicles in preparation for leaving the incident.[88]

It was stated to the review team that the escalation of the fire in the RCH caught everybody by surprise and was unexpected. This escalation was a significant development at this incident and changed the '*battle rhythm*' on the fire ground from one that was described as being '*relaxed*', in anticipation of moving into the recovery phase of the incident,[89] to the refocusing of firefighting efforts from No.18 to the RCH. Visually from the outside, prior to the fire's escalation at circa 1018hrs, the RCH did not look affected beyond the roof apex above rooms 401 & 402. Up to this point the focus and deployment of resources was predominantly to No.18 where the original fire was located and tackling the visible impacts of this fire in sector 2 and 3. Supporting this view was the Phase II interview with the sector 4 commander who relieved the initial sector 4 commander sometime after 0900hrs but prior to the escalation. He stated that when he took over sector 4 there were limited resources operating in his sector.[90]

The serious escalation of this fire and its spread to the RCH at around 1018hrs required:

- An understanding by officers and crews as to what they were witnessing.
- A new risk assessment to be formed and a plan of action to be formulated for the change in circumstances.
- A review of what resources would be required to carry out the plan.
- Redeployment of resources and equipment in attendance from other areas of the incident ground to the RCH.
- Key personnel to receive appropriate briefings, with new tasks and objectives focusing on the RCH being assigned.
- An enhancement in the level of commanders within the sectors.

On the incident ground this translated into:

- A make up for further resources including specialist appliances (ALPs) which arrived shortly afterwards, and in some cases, where crews who had been relieved but were then ordered back to the incident.
- A further change in the command structure with new sector commanders put into place consisting of FDS officers.
- The redeployment of resources on the incident ground to the RCH from other sectors.

Following the escalation there were attempts to commit BA back into the RCH for firefighting purposes, with discussions taking place in the sector on whether the ground and first floor of the hotel could be saved.[91] However, despite the best efforts of personnel, it became apparent within approximately 10 minutes of a BA crew being committed into the hotel that the conditions had become too dangerous and the BA crew was subsequently withdrawn.[92] From an observers' perspective, the committal of BA

[87] FC Recording between ICU and FC

[88] #17

[89] #4, #5, #15

[90] #14

[91] #14 Interview Notes (2017)

[92] #12, #14

would not have been obvious as evidence suggests it was the sector 5 commander based on Martins Lane who was committing BA into the RCH.[93] Therefore, whilst from Cathedral Green there would have initially appeared to have been limited actions being undertaken, offensive firefighting efforts were taking place internally within the RCH to tackle the fire spread. In addition to this, the review team has also found evidence that following the escalation of the fire into the RCH, crews on the High Street in sector 3 returned to their appliances parked there to collect BA sets to report to the front of the RCH on Cathedral Green.[94]

[93] #12

[94] #15

2.4 Reporting of Conditions within RCH

As part of the TofR for this review the team were asked to determine whether there is any evidence that corroborates allegations that command decisions taken during the incident ignored information that may have impacted on firefighting operations and/or did not act upon them. More notably this was focused around the interactions between the initial sector 4 commander who was responsible for the RCH and the rest of the command team.

Without the participation of the initial sector 4 commander during Phase II, the review team could only scrutinise the written statement this individual submitted as part of the initial D&SFRS review. Whilst the review team have not been able to verify parts of this statement as a result, there are some significant points made within it around interactions between the sector 4 commander and the rest of the command team regarding the conditions within the RCH prior to the fires escalation at 1018hrs.[95]

- At circa 0620hrs[96] the sector 4 commander informed an FDS officer that he had withdrawn crews from the RCH due to the conditions inside. Due to the FDS officer declining to take part in this review, the team have not been able to verify this statement made by the sector 4 commander.
- The sector 4 commander states that at the command point he circled an area of concern on a map of the RCH which he used to inform the incident and ops commander about the conditions within the RCH. At this point he expressed an opinion to these members of the command team that they needed to get firefighters back into the hotel somehow. This line of enquiry would have been followed up with the sector 4 commander had the review team been able to interview this individual.
- Finally, during what he believes may have been the handover between FDS officers of the ops commander role, the sector 4 commander states that he once again repeated his opinion that they needed to get firefighters safely back into the RCH. Interviews in Phase II confirm that the handover of the ops commander role was in the process of taking place, although due to the escalation in the RCH the initial ops commander remained in post due to having a good understanding of the incident to that point. Neither of these FDS officers can recall this exchange taking place with the sector 4 commander.

Based on the annotated plan submitted with the initial sector 4 commanders written statement during the D&SFRS review (Figure 6 and 7), the conditions he highlighted on this floor plan were focused to the front left section of the hotel and not anywhere else. The front left section of the RCHs roof apex was being well monitored externally to that point, with an ALP positioned above it stripping away tiles on the roof and exposing what was beneath (Figure 10). Interviews with the ALP operators, together with drone footage from above the RCH, shows that where ALP crews were working there did not appear to be any signs of fire spread into the roof.[97] Internally there were also a number of entries made into specific areas of the RCH prior to 1018hrs, which are detailed in post Internal collapse section of this report (Section 2.3.4).

Combining these pieces of evidence, it suggests that whilst the sector 4 commander highlighted fire spread on the floor plan in Figure's 6 & 7, this was not likely to be where the fire spread into the RCH which became visible at circa 1018hrs breaking through the roof.[98] A report by BRE would also support this view that the fire spread did not occur in the front section of the RCH, but to the main section of the hotel further back and out of sight from where crews were working.[99]

The review team were determined to explore the interactions further between the sector 4 commander and the rest of the command team. When speaking to the team who carried out the D&SFRS debrief and review, they worked towards a general rule that before information was included within the report it would undergo triangulation and verified against two other sources. For the NFCC review, the threshold was set lower as in some cases it would be difficult to achieve this standard which may result in

[95] #19

[96] Whilst this is the time stamp the statement has been annotated with it is an estimation only, the withdrawal of BA had occurred by 0640hrs.

[97] #4, #9, #16 Drone Footage

[98] Appendix C

99 BRE – Fire of Special Interest Report

important information being excluded from the findings. This was determined to be a more realistic threshold where the evidence of a single, credible witness is routinely accepted in such case.

During Phase II, the review team identified four events of note within the timeline prior to the escalation, regarding the reporting of conditions inside the RCH:

- Two events indicate that the sector 4 commander was in possession of information about the conditions within the RCH and had made reference to going to tell someone about it.[100]
    1. After the first withdrawal of BA crews from the RCH, a BA wearer stated that when they came out of the hotel, they told the sector 4 commander where they had been, what they had done and the fact that fire had spread into the RCH. Whilst this BA wearer did not witness this information being taken to the command point, to his knowledge that is where the information was going to be taken. The area crews had been working in is consistent with the annotated floor plan in Figures 6 & 7.
    2. At circa 0745hrs the fire investigation officer entered the RCH with the sector 4 commander and proceeded to the third floor where the fire investigation officer states smoke was seen within the hotel but no fire. Just prior to exiting at 0758hrs the sector 4 commander reportedly left the fire investigation officer in the reception, stating that he was '*going to tell someone about the smoke*'.
- One event indicates that the sector 4 commander had passed on information about conditions within the RCH to the command team.[101]
    3. Prior to the initial sector 4 commander being relieved sometime after 0900hrs, the sector 3 commander came across the sector 4 commander who appeared frustrated. At this point the sector 4 commander stated to the sector 3 commander that he had given some plans of the RCH to the command team (which he had marked to show where the fire was within the hotel), but that the command team did not seem to take it seriously.
- One event confirmed that the initial sector 4 commander was attempting to approach the command team but was turned away.
    4. Prior to the escalation of the fire within the RCH at 1018hrs, preparations were being made to do a live media interview, which coincided with a multi-agency briefing. At this point, it is referenced that the sector 4 commander made his way over to the command team but was subsequently turned away by a group manager due to him preparing for the media interview. This group manager does state however that he believes the sector 4 commander may have spoken to someone else in the command team, although this has not been verified.

The significance of the first three of these four events is that while none of them confirm what, if anything, was discussed between the command team and initial sector 4 commander, they do suggest that before the escalation of fire in the RCH at 1018hrs, the sector 4 commander was aware of the conditions in the RCH and made reference to another officer on one of these occasions to having attempted to report this to the command team.

During Phase II, none of the witnesses who provided information on these four events witnessed the exchange of information take place between the sector 4 commander and the command team. As a result, the review team are unable to determine whether the information about the conditions inside the RCH was actually passed on. The incident commander & ops commander stated during Phase II that they did not receive any information about conditions inside the RCH which would have led to an intervention that could have possibly prevented the escalation occurring at 1018hrs.[102] Unfortunately with the initial sector 4 commander declining to take part in this review, the team were unable to establish further information about these four events or whether the conditions the sector 4 commander was trying to report to the command team was in line with his annotated floor plan submitted to the initial D&SFRS review.

[100] #2, #8

[101] #5

[102] #6, #7

Learning

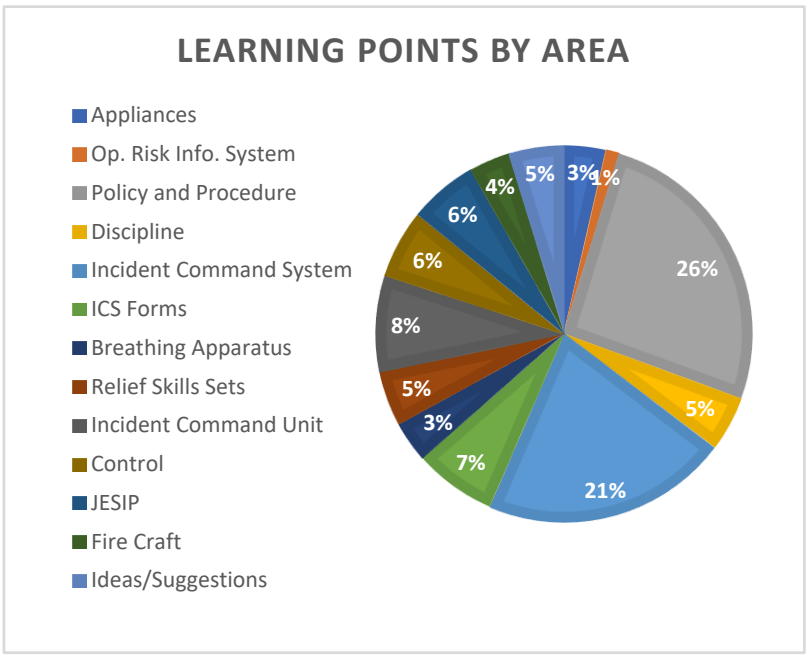
The D&SFRS debrief report set out the learning from the internal debrief of the Cathedral Yard fire, explaining the improvements that have been implemented and the continual work being undertaken to ensure that D&SFRS maintains its commitment to being a learning organisation and one that embraces shared learning.

The debrief was held over one day and was split into three phases, allowing for full participation from staff due to the large number of personnel involved. It allowed each phase to concentrate on specific areas of learning as the incident developed.

These three phases were:

1. The initial call up to the first relief of the command team.
2. First relief command team up to second relief of command team.
3. Second relief command team up to closure of incident.

Over the three phases of the debrief, a total of 81 learning points were identified by D&SFRS personnel. As well as specific learning, personnel provided a number of suggestions / ideas which were explored by D&SFRS. All of these were then sorted into 13 categories and this supported the flow of the learning through the correct departments within D&SFRS.[103] Out of the 81 learning points found, 12 were still open as of November 2018. In July 2019 the review team approached D&SFRS who stated that all of the 81 learning points had been closed.



Area	No. of LP
Appliances	3
Op. Risk Info. System	1
Policy and Procedure	22
Discipline	4
Incident Command System	18
ICS Forms	6
Breathing Apparatus	3
Relief Skills Sets	4
Incident Command Unit	7
Control	5
JESIP	5
Fire Craft	3
Ideas/Suggestions	4

Figure 11 - Learning points by area

[103] The term "discipline" in the table above refers to compliance with service policy at the time. The 4 'Ideas/Suggestions' are not considered learning points for this review.

Conclusions

D&SFRS review and debrief

In overview, the NFCC review team are satisfied that the D&SFRS's report provides a representative timeline of the events which occurred at this incident. However, what has become apparent is that the absence of detail in the timeline of events up to 1018hrs has left an information vacuum which has been filled with many questions around the response to this incident and subsequently the report itself. In addition to this, the review team are confident in being able to state that critical information has been disclosed to the NFCC team which had not been disclosed during the initial D&SFRS review or debrief. It is envisaged that the greater detail provided in the NFCC review can act as an addendum to the original report produced by D&SFRS.

The response

The review team cannot state that the findings of this review resulted in a less favourable outcome to the incident, especially around whether or not the RCH could have been saved had different actions or decision making taken place. It remains speculative as to whether the RCH could have been saved or whether the command team was in receipt of the sector 4 commander's observations or not.

However, the key findings of this review have revealed that whilst there may have been fire spread through undetected voids, the absence of a continual watching brief in all areas of the RCH following the withdrawal of personnel based on safety grounds does raise the possibility that there was detectable fire spread in the hotel which was not subsequently identified and necessary actions progressed. Alongside this there is evidence of an absence of a common recognised information picture at this incident, specifically in relation to what activities were taking place in and around the RCH and key information such as the declaration of a major incident, all of which will have impacted on the situational awareness of the command team.

Reporting of conditions inside the RCH

In relation to the question of whether the initial sector 4 commander passed on critical information about fire spread into the RCH or not, which the command team reportedly ignored, it is difficult to draw firm conclusions about this without speaking to the sector 4 commander who has chosen to decline to be interviewed. However, the review team have found four events of note during Phase II, one of which is seen as significant as it suggests that the sector 4 commander not only made reference to going to tell the command team about conditions inside the RCH but that on one occasion he had which is not detailed in the D&SFRS report as it was new information disclosed during the NFCC review. All of these events occurred prior to the fire's escalation at the RCH, although the command team state they did not receive information from the sector 4 commander regarding the conditions inside the RCH that would have prevented the escalation at 1018hrs. The annotated floor plan contained within the initial sector 4 commanders written statement to the D&SFRS review clearly shows that the area he was marking on the map was not the area in which the fire broke through the roof of the RCH at. Therefore, it remains possible that whilst the initial sector 4 commander believed the information he had to be significant with regards to the escalation of the fire at 1018hrs, it was not as significant as first believed as the area annotated on the map was being well monitored externally via an ALP and is not where the fire escalated through the roof of the RCH at 1018hrs.[104]

[104] Appendix C

Appendices

Appendix A – Role of Incident Commander

Fire & Rescue Service
Operational Guidance

NOT PROTECTIVELY MARKED

Operational Article
Incident Commander Level 2/3

Introduction

Information to assist the Incident Commander (ICL2/3) in carrying out that role within the Incident Command System

Role

The Incident Commander is the nominated competent and responsible person for that incident.

Responsibilities of Incident Commander (Level 2/3)

On arrival:

- Book in with Command Support and hand in tally
- Request contact with the current IC with a view to receiving a brief
- Obtain a radio and select the channel allocated

Briefing with current IC to confirm:

- Risk assessment, risk vs benefit analysis, tactical mode, and safe systems of work are in place
- Existing plan according to the incident priorities and operational guidance
- Resources are adequate and effectively deployed
- Communications are effective, well-structured and documented
- Command structure, ensuring manageable spans of control and the capability of those in role
- Welfare issues are addressed

On taking over the Incident:

- Don the appropriate tabard
- Ensure everyone is clear that you have taken over including Control
- Allocate a suitable role for the previous IC
- Continually gather information and assess risk
- Maintain control and provide direct and visible leadership to the incident
- Ensure all members of the command team are briefed regarding overall tactical plan, their allocated tasks, responsibilities and the IC's expectations
- Ensure that ARA's are carried out and recorded when appropriate.
- Continually review adequacy of available and requested resources
- Regularly review the risk assessment, command structure and tactical plan to ensure safe working and maintain effective operations
- Consider the wider implications of the incident (organisation, environment, community and infrastructure)
- Consider using the media to inform and protect the community

Inter/Intraoperability

- At cross border incidents be alert to potential issues
- Maintain effective liaison with other agencies utilising Joint Emergency Services Interoperability Principles and in particular the Joint Decision Model

Further Considerations

- Your rationale for taking over
- When taking/handing over an incident ensure you have sufficient information and a thorough brief is completed
- Ensure the decision control process supports and underpins decision making at the incident
- Relevant points for the debrief

The most senior officer does not need to take the role of Incident Commander. However, they continue to have organisational accountability, which cannot be passed to another person

Further Information

National Operational Guidance(NOG) Foundation for Incident Command July 2015

Version 1.0 – Feb 2016

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Fire & Rescue Service
Operational Guidance

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Operational Article

Sector Commander

Introduction

Information to assist the functional role of an appointed Sector Commander within the Incident Command Structure.

Functional role

- Sector Commanders (SC) have an operational responsibility to implement the IC's operational tactics, within a defined sector boundary.
- SC's are responsible for safeguarding against any potential developments within that sector by varying the tactics and safety measures according to the developing needs of the incident.
- The Sector Commander will principally focus on:
  - Command and Control
  - Deployment of resources
  - Tactical planning
  - Search coordination
  - Health, safety and welfare of personnel.

Initial duties

Upon nomination to the role of Sector Commander:

- Don the appropriate surcoat, obtain a radio and select the channel allocated.
- Assume the call sign of Sector (number/name) Commander.
- Receive brief from IC/Operations Commander to confirm the operational objectives.
- When taking over from an established SC ensure a hand over brief is received.

Responsibilities

- Establish control and provide direct and visible leadership within the sector.
- Create, maintain and review operational tactical plan within the sector against the incident objectives and risk assessment (RA) outcomes.
- Provide all personnel operating within the sector with a clear brief confirming tactical mode of the sector and incident.
- Request additional resources and specialist support as required (e.g. Safety Officer, Communications Officer).
- Co-ordinate completion and review of RAs within the sector:
  - Liaise with the Safety Officer to validate control measures and add comments to the RA form if necessary.
- Assess, report and mitigate the potential impact on the environment.
- Regularly report sector progress to IC/Operations Commander to enable them to manage the overall incident.
- Communicate any actions/operations that may affect other sectors.

Further considerations

- The SC has operational independence in determining how the objectives agreed with the IC are to be delivered.
- The use of a command support pack within the sector as an information point.
- If the SC has to leave their post they must be replaced by someone with appropriate competence and authority. Any such replacement must be communicated within the sector and to the IC/Operations Commander.
- Ensure thorough briefing is given when handing over sector command responsibilities.

⚠	Only the IC can change the tactical mode. However, if a safety critical event occurs, the SC can withdraw crews and default to defensive. This decision must be communicated to the IC as soon as practicable

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Protective Review – None

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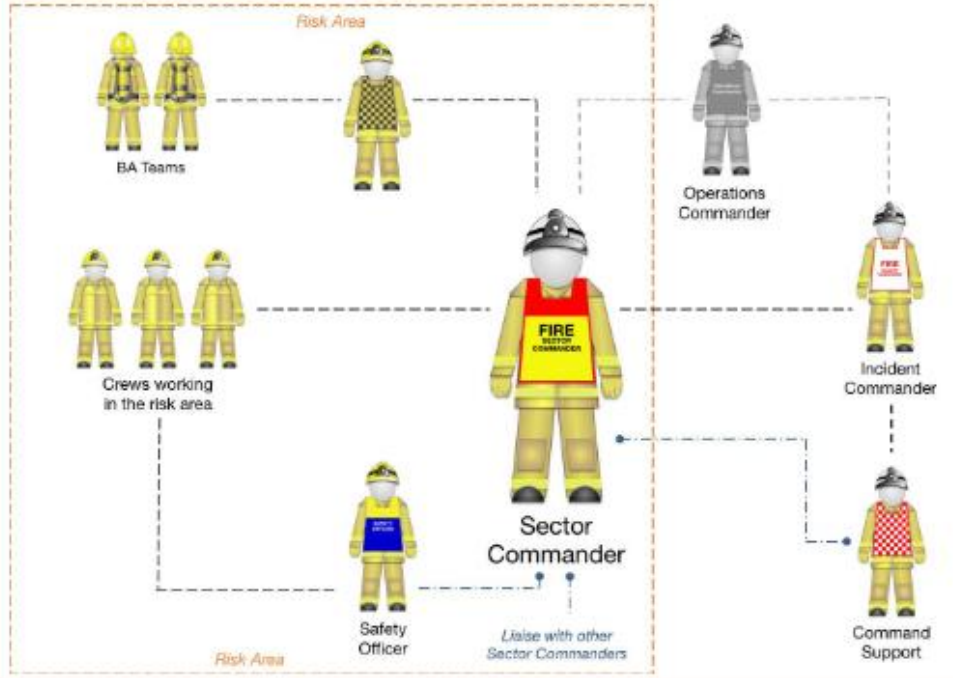
Location of the Sector Commander within Incident Command Structure



Appendix C – Pictures following escalation after 1018hrs