Introduction

My name is David Collins. I was the Chairman of the Grenfell Tower Residents Association (Compact) from its inception, until I moved out on 31st October 2016. I was heavily involved leading resident representations to the TMO, Rydon & the RBKC during the regeneration works and afterwards.

I wanted residents to receive decent treatment from the TMO, decent service, care, safety & security, and a good quality building regeneration project. As you are aware, residents did not receive those things. It has taken a tragedy for the investigation of the TMO, that 90% of residents asked for at the end of 2016, to take place.

The inquiry will cover far broader ground, and that is my reason for writing.

For twenty-three years, I have been a fascinated researcher and developer of organisation culture and human performance. I became a student of this area when (aged 20) I started to study how the perception of an individual or organisation leads to their effective or ineffective results.

During that time, I have worked with tens of thousands of individuals, from Executive Teams and Leaders, to Managers, Supervisors, and those who work on the front line. I have worked in the UK and Internationally, and with some of the largest construction companies in the UK and the world.

Over the last four and a half years around 80% of my work has been in safety, leadership and organisation culture. I have been working with organisations as they attempt to understand what an organisation culture look likes where we take care of one another and no one gets hurt; and how to I lead and act as an individual to deliver that.

Given my industry experience, within one month of first interacting with the TMO in 2014 I was very concerned about the organisation and its service standards. Within six months I was extremely alarmed about the quality of the improvement works, and appalled at how they treated individuals. The injustices that I witnessed, and how residents were treated and related to, is what had me take on the concerns and represent the people of the tower.

By the time I moved out of Grenfell Tower, I had interacted enough with the elected representatives of the Royal Borough of Kensington & Chelsea to understand why the TMO service standards were so poor, and why the TMO was able to get away with those standards and their poor treatment of residents. There was a vacuum of accountability, scrutiny, and care from the top down.

In preparing this response I consulted with Gill Kernick (who has separately submitted a comprehensive response to the inquiry) and Jim Wetherbee (formerly of NASA, who worked to implement the corrective actions after four major disasters in the last 25 years).

This submission I make as an individual. I feel I will be involved in the inquiry given my role with residents in the lead up to the fire, the one I am playing in the police investigation now, and the one residents suggest I need to play in the inquiry. Personally, I want to make sure things change as a result of Grenfell Tower, and that positive change comes about in society, business, and the public sector. In the public sector, change not just in Kensington and Chelsea, but across local authorities and national policies and practices.

Terminology

Given my experience, it is my view that the disaster was completely avoidable. The word accident should not be used during the inquiry. The word incident should be used by all participants. This distinction is critical. Accidents 'just happen', are unforeseeable, and unavoidable. Incidents have causes, and incidents are avoidable.

Beginning with the End in Mind

To have the inquiry be effective we must begin with the end in mind. For the process to be effective the recommendations and corrective actions proposed need to be implemented. For this to happen, several things will need to be in place from the outset:

1. One person will need to be accountable for implementing the recommendations and corrective actions which the inquiry raises. This person will need to have the position and the leadership capabilities to implement. They will be supported by a team, and able to provide the resources and political will to get the recommendations over the line. The public will need to be kept abreast of the application of the recommendations. Given the scale and scope of the disaster, it is likely this one person will need to be within Government. This will need planning now.
2. To ensure the recommendations are implemented, the relevant bodies who will need to make changes must be involved in the inquiry process (RBKC Council, TMO, DCLG, Building Control, regulators, social housing policy setters, etc). This is the only sure way to ensure their buy-in to the resulting actions.
3. The inquiry leader will need to develop strong relationships with the media and other public bodies. Many of the learnings from this disaster are cultural and behavioural, and how people perceive the learnings is what will drive change or no change.

For the inquiry to be truly successful it must help people to avoid the next disaster. Whilst there is a pull to assign blame, the advice I have received from those who have been involved in many disaster investigations is assigning blame does not lead to the learning required to prevent the next incident. I believe the record will show there were those in positions of accountability who were not being accountable, nor responsible. Whilst there may be individuals who need to be prosecuted for negligence and the like, those are criminal matters, and ideally these need to be dealt with by criminal prosecution. People are generally poorly motivated by fear [i,ii]. If the inquiry is to get to the truth then the atmosphere (at least at times) needs to be one where people feel psychologically safe: i.e. they feel safe to tell the truth. The judge/leader of the inquiry will need to be able to hold the tragedy and trauma of those impacted by the disaster, and at the same time the humanity and emotions of the people who took actions and made mistakes which led to the events and fatalities. If this atmosphere of safety does not prevail then it will be very hard to get to the truth of matters.

- There is a need for the boundaries of both to be clearly communicated to residents, interested parties, and the wider public
- It would likely be better for any criminal cases to take place in advance of the detailed inquiry to aid a safe atmosphere of truth telling

If the criminal investigations and prosecutions do not get to the heart of the matter, or if the inquiry is not getting truth or seeing change in attitude from the TMO, RBKC, Government Departments or other parties then Sir Martin Moore-Bick may wish to borrow on the tactics and strategy of Sir

Desmond Fennell, who chaired the public inquiry in the immediate aftermath of the King's Cross Underground station fire, which killed 31 people [iii]:

"Fennell began by interviewing the Underground's leadership, and quickly discovered that everyone had known – for years – that fire safety was a serious problem, and yet nothing had changed. Some administrators had proposed new hierarchies that would have clarified responsibility for fire prevention. Others had proposed giving station managers more power so that they could bridge departmental divides. None of those reforms had been implemented. When Fennell began suggesting changes of his own, he saw the same kinds of roadblocks – department chiefs refusing to take responsibility or undercutting him with whispered threats to their subordinates – start to emerge.

So he decided to turn his inquiry into a media circus.

He called for public hearings that lasted ninety-one days and revealed an organisation that had ignored multiple warnings of risks. He implied to newspaper reporters that commuters were in grave danger whenever they rode the subway. He cross-examined dozens of witnesses who described an organisation where turf battles mattered more than commuter safety. His final report, released almost a year after the fire, was a scathing, 250-page indictment of the Underground portraying an organisation crippled by bureaucratic ineptitude. "Having set out as an Investigation into the events of one night," Fennell wrote, the report's "scope was necessarily enlarged into the examination of a system." He concluded with pages and pages of stinging criticisms and recommendations that, essentially, suggested much of the organisation was either incompetent or corrupt.

The response was instantaneous and overwhelming. Commuters picketed the Underground's offices. The organisation's leadership was fired. A slew of new laws were passed and the culture of the Underground was overhauled. Today, every station has a manager whose primary responsibility is passenger safety, and every employee has an obligation to communicate at the smallest hint of risk. All the trains still run on time. But the Underground's habits and truces have adjusted just enough to make it clear who has ultimate responsibility for fire prevention, and everyone is empowered to act, regardless of whose toes they might step on."

Sections to the Inquiry

I believe the enquiry needs to have two sections:

1. An event based investigation. This is focused on understanding the sequence of events that happened:
    a. In the immediate aftermath of the fire (circa 4 weeks)
    b. On the night of the fire
    c. In the preceding two years
    d. During the time before this
2. A systemic-focused investigation. This is about understanding why and how people made decisions, and took actions, that resulted in the events. This stage is about understanding why the disaster could have happened.

An event based investigation is simpler in many ways. It is dealing with objective facts. In the language of health and safety, this is a technical or 'safety management' investigation. When systemic investigations are attempted, they are more complex and challenging, but much more valuable in creating and sustaining positive change.

It is harder to ascertain why things occur, because it involves an assessment of the subjective or internal world (as well as the objective). It is an inquiry in to attitudes and feelings, social pressures, stories and histories, myths, legends, the way we do things around here, etc. In the language of health and safety, we are talking about leadership and culture.

The event-based investigation will begin to touch on the systemic-focused one: why were decisions made. But on its own an event-based investigation will never get to the heart of the matter of why the Grenfell Tower disaster could happen. Neither can an event-based investigation illustrate why we must never let this happen again in quite the same way as a systemic one. Only a systemic investigation will lead to the kinds of corrective actions which will avert another tragedy like this happening again. As Rita Donaghy reported [iv]:

"… we should not continue to rely entirely on safety management to bear down on the number of fatalities each year. This will never eliminate fatalities or reduce significantly the number of serious accidents. There is an important distinction between safety management and safety leadership. Leadership and culture change are essential if we are to eliminate fatal accidents….."

It is the systemic investigation which will reveal the underlying cultural conditions, the beliefs, attitudes, assumptions, behaviours and systems which influenced people to think their decisions and actions were appropriate before the tragedy. It is by understanding these, with respect to "how do we prevent the next disaster?", that real opportunity for change will come about.

Distinguishing the Wider Cultural Determinants

Ascertaining the culture of the decision-making organisations in the run up to the disaster involves retrospective analysis. It will involve asking people how they believed things were at that time, reviewing documentary evidence, and drawing conclusions and theories from the data.

One of the reasons the inquiry will benefit from focusing on the immediate response by the authorities after the disaster, is because it will help the panel/leader to better understand the culture which was present in the run up to the disaster. The culture post disaster will be different to some extent, because of what happened. However, it is my belief that analysing the immediate response, including the RBKC/TMO leadership actions and statements, will give a profound insight in to how the culture was before the disaster. Whilst what happened prior to the disaster was seen by a relatively small number of people (probably thousands), what was seen afterwards was observed by millions. Because of this fact, discerning the objective facts, and the nature and effectiveness of the action on display, is far easier. This will add weight and insight to the systemic analysis of what happened before the fire.

For the inquiry to do this effectively it will require specialist support: individuals or groups who have experience and skill in distinguishing cultural determinants. In terms of disaster investigations, three individuals may be of interest: Jim Wetherbee, Sydney Dekker & James Reason. In terms of cultural analysis, I do not have names to suggest; this is partly the area I work in, but I know too well the people I work with to recommend them as independent.

What Went Right?

According to Sydney Dekker people frequently ask, "What went wrong?" when considering why a disaster occurred. He believes that the more useful question to ask is, "What went right?" It is his

experience that by exploring why people thought (at the time) what they did was the right thing to do (for instance, to fit the cladding) that one can begin to understand the reasons why they did what they did. By doing this well the corrective actions and inquiry recommendations will be more powerful, as they will address or redress the reasons why people made the decisions they did and which ultimately led to the disaster.

Scope of the Inquiry

What was allowed to happen at Grenfell Tower points to some of the worst aspects of our national culture, and for the inquiry to be successful it will need to be wide ranging in its remit. For instance, as Lord Falconer suggested the, "Grenfell inquiry should include treatment of social housing tenants". There are also the matters of housing provision in London, the turning over of public property to private developers, the balance of power (or the lack of checks and balances) in a council such as RBKC where there was effectively no political opposition), social cleansing, class structures, the drive for lowest possible cost in construction (particularly certain aspects of public funded construction), and the like.

Simply blaming a few individuals in certain roles will not answer completely the question of why this could happen. If people or state actors were negligent or worse, then appropriate charges ought to be brought against those individuals or organisations. If individuals failed to be accountable, and fail to show responsibility and remorse today, then the law must hold them to account. However, the drivers of why this happened cut much deeper than individual action or inaction, and speak to social and power structures too.

As Alexis Jay pointed out, in relation to the historical child abuse inquiry, there are vested interests who do not wish such an examination of social and political structures to happen. As she is demonstrating it takes courage, truth and fortitude to move through and beyond these social and political barriers of fear and protection. For real debate, reform and change, the terms of reference will need to include wider social, political and cultural issues.

Good Safety Equals Good Business

We live in a culture where people frequently say or think that safety is over the top, expensive, or anti-business in some way. It is my experience that good safety is good business. In fact, I have worked with many Chief Executives and Senior Managers who know it is. They will tell me that their most profitable sites are also the ones with the best quality, safety and environmental record. They say good leadership shows up across all metrics; good safety is intrinsically linked with getting things right first time, high levels of quality, low levels of rework, and high employee engagement, positivity – and low levels of absenteeism.

In analysing the safety culture of many organisations, speaking to thousands of people in the construction industry, and pouring over the statistical data from tens of thousands of people it is apparent that safety and quality are often negatively impacted because people believe they must do things cheaper or quicker. Or they believe they have no option but to deliver on time, and they do not have the time to stop and take care of things which are safety risks. In many organisations people do not believe they will be listened to if they do raise their safety concerns (or worse, they may be victimised), and so they do not bother. However, the cost when things go wrong is always astronomical. The human suffering when things go wrong is even worse.

Only a minority of people understand the distinction that good safety is good business, but it will be an essential distinction for the inquiry team to get to grips with and to own. The conclusions and recommendations from this inquiry will not only be good for the safety performance of housing, public bodies and corporations – they will also be good for employee engagement, business, productivity, profitability and quality. The inquiry team may need advice from someone who understands this.

My Opinion

It is my opinion that the disaster and loss of life would have been avoided if the TMO and Council had:

- Listened to the serious and fundamental concerns of residents (instead they chose to sideline, ignore and dismiss these)
- Fulfilled their duty of care to the residents of Grenfell Tower and North Kensington (some leaders had their self-interests above the care of residents)
- Fulfilled their duty to scrutinise the workings and the service standards of the TMO (some leaders had their self-interests above the need to scrutinise)
- Had proper checks and balances in place to ensure those in positions of accountability were accountable (the TMO operated an effective monopoly with no checks and balances, and there were leaders who did not want to rock their own boat)

The warning signs were all there in the lead up to the event itself, there was a reason we used to say, "There will need to be a catastrophe before they wake up", and I believe the documentation and evidence exists to show this. I have concluded the disaster was avoidable, and was only allowed to happen because of systemic and individual failings. I believe the record will show there were those in positions of accountability who were not being accountable, nor responsible. If residents had been treated with dignity and respect, if they had been listened to, this disaster could have been avoided.

There was a reason why 90% of the residents spoken to at the end of 2015, whilst knocking on the doors in the tower, wanted there to be an independent investigation in to the TMO and the refurbishment works. There must be reasons why RBKC ignored this call, the people and organisations leading and ultimately responsible for the regeneration programme must have believed something else was more important than meeting their duty of care, their obligation to scrutinise the TMO, and listening to the people whose lives were in their care.

Whatever the technical causes for the fire, why it spread so quickly, and the poor response afterwards individual and group attitudes, beliefs, and behaviours drove all the decisions which were made. It is only because of human attitude and behaviour that the mistakes, oversights, gaps in regulations, law breaking, failure to respond, and appalling outcomes came about. It is only by examining these we will come to understand what needs to change.

Appendix

When I woke up on the morning of 14th June 2017, and saw on my mobile telephone screen that Grenfell Tower was on fire, the first thing I wrote to the friend who had sent me the picture was, "It was a tragedy waiting to happen". I was shocked and appalled, but I was not surprised.

On that morning, I spoke to a number of television stations and Radio5Live, to get the news out that this was no surprise and that residents and their concerns had been ignored, dismissed and disrespected for years. At the time, I did not know Grenfell Action Group had published a blog predicting a fire in November 2016.

Later in the day I gave interviews to The Guardian and The Telegraph. The following text comes from The Guardian article of 15th June 2017. It is largely accurate, with a few facts needing correcting (for instance, I was not an administrator of the Grenfell Action Group blog).

People died thinking 'they didn't listen', says ex-Grenfell residents' group chair

Ex-chair of residents' association criticises 'inept' management and says tenants requested investigation 18 months ago

The former chair of the Grenfell Tower residents' association has said his warnings of the risks of a catastrophic fire were ignored because of a "vacuum of accountability" in the building's management.

David Collins lived in the building between April 2014 and October 2016. He was one of the administrators of the blog that warned extensively of structural dangers in the 24-storey block.

He moved out shortly before another member of the association wrote that a serious fire was a real possibility, and likely to be the only thing that would force change. After the devastating blaze that ripped through the building, killing at least 17 people, Collins said a public inquiry – which Theresa May announced on Thursday – was long overdue.

"It's what we asked for 18 months ago," he told the Guardian. "It's what we deserve now."

When Collins woke on Wednesday morning to the news, he said, "I was appalled, I was angry, I was upset – but I wasn't surprised. I wasn't surprised. The worst-case scenario was a fire. We knew there would have to be a tragedy before someone would do something."

Collins first made the call for an inquiry in January 2016, in a speech at a meeting of Kensington and Chelsea council's housing and planning scrutiny committee. He also raised residents' concerns over the conduct of the building's tenant management organisation (TMO) and its contractors.

The residents' association was formed after advice from Victoria Borwick, the local MP at the time, but tenants feel their group was not listened to or taken seriously.

At the meeting, Collins presented a survey by the association that found 90% of residents were dissatisfied with the manner in which improvement works had been carried out, and 68% felt they had been harassed or intimidated by the TMO or contractors.

Collins said managers from the contractors had come to his doorstep; other residents were told their tenancy would be under threat and their hot water and heating would be switched off unless they granted access to the TMO's contractors. Many reported receiving threatening letters from solicitors acting for the TMO demanding entrance to properties, when tenants had not denied entrance to the TMO in the first place.

Collins's calls were dismissed by the end of the meeting, with the council promising to convene a narrow working group with no defined deadline to look into matters. He heard nothing more.

"There was a vacuum of accountability," he said. "The TMO were not held to account for their poor service levels. They were left to self-regulate, and councillors didn't listen to us or hold them to account."

Collins and the residents felt each complaint about the conduct of the TMO was dismissed by the council, which accepted at face value the TMO's response that there were no issues, with no investigation or proper engagement with tenants.

Conditions in the block continued to concern residents during and after the recent improvement works, in which the outside of the building was re-clad for insulation and the ground floors were remodelled. Collins directed the Guardian to photographic evidence on the group blog of furniture, mattresses and other large objects dumped in stairwells and corridors, causing a fire hazard. He said it took multiple complaints for dumped items to be removed.

"We asked the council, are you waiting for a tragedy?" Collins said. "The council ignored our blog and the real concerns of everyday people." Collins could not remember a single fire drill being conducted in the two and a half years he lived in Grenfell Tower. He said other residents reported that the fire brigade had attended the block on the weekend before the tragedy to check on some aspect of the building.

But previous incidents in the block led residents to worry about the functioning of the building's safety systems in an emergency. There had been small fires before, and tenants had reported to the TMO that emergency lighting in the escape stairwell did not work on every floor. An eyewitness to Wednesday's blaze told BBC News that he escaped with his family, but when he reached the fourth floor the stairwell was pitch black.

Collins was keen to point out his feeling that the TMO was "incompetent and inept", rather than acting with malice in its dealing with Grenfell Tower residents, and that the lack of accountability and concern for tenants' views and experiences was the biggest problem. "[The TMO] weren't bad people, but the organisation wasn't true to their values: they said they were resident-led, but did not listen to the residents at all. The lack of accountability for the TMO, the lack of power for the residents, it was a contributing factor in this disaster."

Collins and other residents spoken to by the Guardian called for the independent inquiry they had asked for previously to be held now, to acknowledge the concerns they had raised for years and explain why they were not listened to and acted upon. "I just want people to know

that if they had listened to the residents, and acted upon what was told to them, it could have been different," Collins said. "It's impossible to know if this could have been avoided. But people lost their lives, and some jumped to their death and will have done so knowing the TMO didn't listen.

"There has to be an independent inquiry that talks to residents first," he added. "It's what we asked for. There was a systemic failure to react to security, safety and basic sanitation."

Collins said he had talked to one neighbour who lived on the same floor as him, but as we spoke realised an older neighbour was unlikely to have made it out. Many of the people in the block had mobility issues and would have adhered to the "stay put" fire safety procedure, because of the advice and the impossibility of descending 21 flights of stairs.

"Some of the people said: 'They don't care about us,'" Collins said. "Those people were trapped in their rooms, and they will have died thinking: 'They didn't care. They didn't listen.'"

[i] The Fear Free Organisation: Vital Insights from Neuroscience to Transform Your Business Culture, Joan Kingsley, Paul Brown, and Sue Paterson

[ii] Crucial Conversations: Tools for Talking When Stakes Are High, Kerry Patterson, Joseph Grenny, Ron McMillan, and Al Switzler

[iii] Text taken from "The Power of Habit: why we do what we do in life and business", by Charles Duhigg

[iv] One Death is Too Many: inquiry into the underlying causes of construction fatal accidents, Rita Donaghy, report to the Secretary of State for Work and Pensions