

Catastrophic risk and equality of voice – learning from the Grenfell Tower disaster

Regulatory attention needs to shift from blame to learning
argues **Gill Kernick**

Major accidents create imperative for change. The Piper Alpha explosion (167 deaths) and the Macondo well blowout (11 deaths and the industry's largest marine oil spill) were seminal events leading to lasting change in the oil and gas industry. The Grenfell Tower fire (72 deaths) offers the same opportunity. Yet, to be a catalyst for meaningful change, the current narrative needs to shift from a pre-occupation with blame allocation or avoidance to learning, and from a compulsion with providing quick, ready-made solutions to in-depth inquiry.

My interest in Grenfell is both personal and professional. I partner organizations in high hazard industries in building the leadership capability and culture to prevent catastrophic events. From 2011 to 2014 I lived on the 21st floor of Grenfell Tower. I watched it burn. Recently I sat with a survivor as she spoke of calls following the fire telling her the police had found another part of her brother's skull. He lived on my floor.

I have become increasingly disturbed at the nature of the post-Grenfell narrative – it tends to focus on blaming or offering over-hasty conclusions. Neither of which will lead to systemic change.

A fixation on blame, which invokes the need to defend and protect, runs counter to learning. That does not mean that those found culpable should not be held to account. But if we stop at human error, the complex systemic causes of tragedies, such as the Grenfell Tower disaster, will not be understood and tackled, and opportunities for lasting regulatory change will be lost. The individuals and organizations found culpable will be replaced by others in an unchanged context and system. In similar circumstances they will likely make similar decisions. Hence, we need to better understand who and what contributed to the creation of a system that enabled decisions to be made that ultimately allowed Grenfell fire to happen. That will take courage and a safe forum in which to engage in such analyses and likely discomfiting dialogues.

In other words, we need to move from over-hasty conclusions and quick fixes to proper inquiry. The current narrative is scattered with individuals and organizations offering their immediate analysis and solutions. Such reactive solutions will not solve deeper systemic issues. The sage advice 'if I had an hour to solve a problem, I would spend 55 minutes defining the problem' is pertinent here. The Grenfell fire is the output of a complex, dynamic system, and we need to invest time and resources to comprehend that intricacy, so that we can act on it.

Such a shift in focus will raise challenging questions about who we are and what we value as a society. Shifting the context to inquiry and learning may enable the Grenfell fire to be a seminal event leading to lasting systemic change. In this context, the following three lines of inquiry will be pertinent.

What prevents regulatory and legislative systems from learning?

Many argue that you cannot prevent catastrophic (low probability, high consequence) events because they are so rare. Andrew Hopkins (2009: 4, 72) dispels this myth revealing instead their 'depressing sameness', including a chronic inability to learn.

For example, on 11 June 1999, Alexander Linton died in a fire prompting a House of Commons Environment subcommittee investigation into the potential risk of fire spread in buildings via external cladding systems. Evidence given said 'the primary risk ... is that of providing a vehicle for assisting uncontrolled fire spread up the outer face of the building, with the strong possibility of the fire re-entering the building at higher levels' (Select Committee Report, 1998–99: 2; Inside Housing). The subcommittee concluded that 'all external cladding systems should be required either to be entirely non-combustible, or to be proven through full-scale testing not to pose an unacceptable level of risk in terms of fire spread' (Select Committee Report, 2010: point 19). Add to this the failure to learn from the tower block fire in Lakanal House in 2009 in London with six deaths (Guardian, 2017) and there is compelling evidence to suggest we suffer from an inability to learn. What stifled learning in these cases?

One issue relates to the nature of the public inquiries themselves that ensued from these events, the way they were conducted, and their subsequent recommendations implemented. Public inquiries make recommendations to ensure we learn from such disasters and prevent similar events from happening in the future. Yet, a recent report by the Institute for Government found that the formal checks and procedures in place to ensure that such inquiries lead to change are inadequate (Norris and Shephard, 2017: 3, 4). Since 1990, there have been 68 public inquiries in the UK, and only 6 of these had full scrutiny to hold the government to account for what it did with the recommendations.

How can we ensure the effective implementation of public inquiry recommendations? How can we move beyond understanding what happened to affect change? What factors

hinder regulatory change and learning? What role might siloed regulatory thinking and organization play here? Whose interests are served by not learning? And what can be done to promote regulatory conversation and capacity building across sectoral boundaries and hierarchies?

Regulation and the nature of catastrophic risk

There has been little debate about catastrophic risk and its specific nature after the Grenfell fire, and I would argue this is a critical area to engage with. Recent catastrophic events have occurred in high performing organizations, including BP's Macondo blowout (Dekker, 2014: 351). One lesson from such events is the need to view them distinctly from higher frequency, lower consequence events (e.g. slips, trips and falls). A major accident is not caused by a single event, it is a systemic outcome resulting from several latent (pre-existing and often hidden) conditions, often triggered by an active failure (e.g. an ignition source).

Maintaining a state of chronic unease – imagining and mitigating against the worst thing that could go wrong – is key to preventing these kinds of events. This includes consideration of the unintended consequences of decisions and regulatory actions. Prescriptive regulation and an increased bureaucratization and measurement of safety may have the unintended consequence of suggesting that risk is under control, of encouraging a sense of invulnerability, and, thereby, leaving us blind to catastrophic risk (Dekker, 2014: 351).

We need to create a culture of vulnerability, focused on making the right decisions regarding safety, rather than relying on regulations to keep us safe. How can regulation and regulators add to a sense of invulnerability? Regulations should never replace the accountability of those in power for making de-

isions that ensure people's safety. The Grenfell accident is, I believe, ultimately a failure of leadership and duty of care.

Ensuring equality of voice

In safe cultures all lives matter and they matter equally. And all voices count. Those in power work to ensure the voices of those with less power are both heard and count. Yet, investigations into major accidents often reveal cultures where people's voices are not heard. This appears to have been the case in the Grenfell fire. Those at the frontline of safety have a unique and tacit knowledge (Dekker, 2014: 352; Kernick, 2017), which regulators need to tap into. What biases, prejudices, and blind spots do regulators hold that prevent equality of voice and tapping into the tacit knowledge of those they regulate, e.g. residents?

The Grenfell accident provides a unique opportunity for change. Engendering such change will require rigorous, creative intellectual effort and courage. We must shift the context of the narrative to one of learning and inquiry. For the problems of today will not be solved by the same level of thinking that created them.

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