MODULE 3 OPENING SERVED ON BEHALF OF BINDMANS, HICKMAN & ROSE AND HODGE JONES & ALLEN

1. PREFACE

1.1 Module 3 is a tale of lessons unlearned, despite the teaching of successive cladding fires. The failure of the physical and managerial controls at Grenfell, which should have mitigated the extent of fire, was as predictable as it was preventable. Central to ensuring these controls are adequate are the statutory Fire **R**isk **A**ssessments (**"FRAs"**) required by the **R**egulatory **R**eform (Fire **S**afety) **O**rder 2005 (**"RRO"**) which should have informed **RB**KC and TM**O** of the measures required to prevent/mitigate fire, ensure a safe means of escape (**"MOE"**) and to facilitate evacuation. The principal managerial failures at GT included a failure to identify the occupancy profile coupled with a lack of any emergency/evacuation plan in place, still less evacuation plans for disabled people. Weaknesses in the physical controls such as compromised compartmentation, including defective fire doors, rendered the stay put strategy lethal and in turn impacted the MOE. These failings taken together materially contributed to the extent and severity of the disaster.

1.2 The bereaved survivors and residents (**"BSR"**) from whom the Inquiry will hear are but a few of the many residents who made up a richly diverse community. Their diversity is highly relevant to the Module 3 issues, since age, disability and ability to read **E**nglish, are all factors which should have informed both the assessment of the degree of risk and potential harm posed by a fire and, accordingly, the fire safety measures at GT, including M**OE** and critically, should have informed the assessment of the degree of risk of risk/harm to be caused by a fire as required of an adequate F**RA,** which TM**O** procured and was required to act upon. **A** significant proportion of residents suffered from some form of disability, or were vulnerable (children/visitors[1]) which should have been addressed when considering the MOE and evacuation strategy/emergency plan. In fact both the TM**O** and its fire risk assessor Carl **S**tokes, failed to identify the vulnerable residents at Grenfell, despite this being a recognised parameter in fire risk management, as the risk profile of a building is a function of its occupancy and fire growth rate[2]. **D**r **L**ane finds no evidence that TM**O** assessed the needs of any vulnerable person in GT in the event of a fire[3]. This failure resulted in TM**O** not being appraised of the fire precautions required by **RRO** in order to protect residents, including vulnerable residents, and failing to advise **LFB** of the need to assist the vulnerable. The lack of appropriate precautions is reflected in the deaths: a quarter of the 67 child residents present on the night died and 41% of the 37 vulnerable adult residents died[4].These groups suffered higher death rates than any other category on the night. Yet TM**O**'s spreadsheet emailed during

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[1] Lane refs: *"The management and maintenance of [GT]"* unless otherwise stated. Lane 6/5.3.2 **{BLARP20000034_0060}** Lane 6/ table 14-1 **{BLARP20000034_0238}**

[2] BS9999:20008 S6 **{RBK00010788_0043}** Lane 6/10.1.7 **{BLARP20000034_0150}**

[3] Lane 6/1.1.46-1.1.47 **{BLARP20000034_0010}**

[4] Lane 6/ table 14-1 **{BLARP20000034_0238}**

the fire showed only 10 out of 225 residents listed with disabilities[5]. In this respect, as in many others, GT shines a light on an aspect of fire safety which cries out for reform. As BRE noted in 2013, many of the 400 attendees at seven fire safety seminars *"indicated that 'if they had a magic wand, the fire safety problem they would like to solve' would be the need for a better understanding of the evacuation of mobility impaired people"*[6]. Dr Lane considers there is *"an urgent need"* for guidance and focus on the FRA's for the vulnerable in the event of fire[7].

2. THEMES SPANNING ACROSS THE TOPICS WHICH REQUIRE EXPLORATION

2.1 RBKC's prioritisation of cost over fire safety. The Inquiry will wish to examine RBKC's leadership, culture and purpose, insofar as they influenced fire safety and engagement on that subject with residents. RBKC's conscious weighing up of the costs of curing deficiencies in doors against the risks posed by failing to do so and failing to live up to its own standards for MOE for the disabled are contributing factors to the extent of the disaster. Appointing TMO as an arm's length management organisation ("**ALMO**") did not relieve RBKC of its common law duties as landlord, nor of responsibility under the RRO. RBKC's failure to show leadership and adopt a rigorous approach to fire safety management inevitably infected TMO's approach. It is well established that *"The first priority in striving for a successful safety culture must be leadership... Above all, Chairman and Chief Executives of companies must make continually clear to all their employees... a lasting commitment to improve safety performance"*[8]. The Council Leader and senior members bear the responsibility for ensuring the efficacy of scrutiny[9]. It has long been clear that good governance requires a clear articulation of a local authority's vision of their purpose and intended outcomes for their citizens[10]. Such articulation is the role of the leadership. RBKC accepted this principle by its *Bi Borough Corporate Fire Safety Policy* ("**2014 Policy**") which expressed its desire to champion fire safety through strong visible leadership[11]. This was

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5 D Noble email to T Brown/R Black and ors 14.6.17 @5.24 **{TMO00866001}** spreadsheet at **{TMO008866002}** and Lane 6/ 10.8.15**{BLARP20000034_0186}**

6 Crowder and Charters BRE Guide *Evacuating Vulnerable and Dependent people from buildings in an emergency* https://www.gloucestershire.gov.uk/media/2088362/evac_vuln_people_from_bldgs_in_emer.pdf

7 Lane 6/1.1.54**{BLARP20000034_0010}**

8 Lord Cullen's Part 2 Ladbroke Grove rail crash Inquiry Report para 5.11 and 5.21 https://www.jesip.org.uk/uploads/media/incident_reports_and_inquiries/Ladbroke%20Grove%20Rail%20Inquiry%20Report%20Part%202.pdf and see para 5.18 *"in order for safety to be considered as another key parameter, that type of conviction needs to come from the top, needs to be broadcast from the top, needs to be continually refreshed from the top..."*

9 *"Fundamentally success in scrutiny hinges on the commitment of those in leadership positions. It is about the mindset attitudes and values of those in decision making positions- about the council's political and organisational culture"* *https://democracy.york.gov.uk/documents/s82198/CIPFADeliveringGoodGovernanceinLocalGovernmentFramework1.pand*

10 *Delivering Good Governance in Local Government 2007 Framework* s3 p 11-12 https://democracy.york.gov.uk/documents/s82198/CIPFADeliveringGoodGovernanceinLocalGovernmentFramework1.pand 2016 Framework p16 https://www.london.gov.uk/moderngovopdc/documents/s58145/Item%206b-%20Appendix%20A%20CIPFA%20Delivering%20Good%20Governance%20in%20Local%20Government%20Framework.pdf

11 At para 2.3 *"The Council's strategy for managing fire safety is driven from the top through the designation of a lead bi borough director champion health and safety including fire safety... Key health and safety failings normally stem from poor leadership, poor attitudes and behaviours and poor risk management. The Council will endeavour to maintain strong visible and competent leadership and embed health and safety in the planning process"*. **{RBK00001655_0004}.** Covering email circulating the policy at **{RBK00001654}**

consistent with PAS 7[12] which the 2014 Policy incorporated (at paragraph 2) by reference: "*Top Management shall demonstrate leadership and commitment with respect to the [Fire Risk Management System]*". Contrary to PAS 7, which required[13] *"Top Management shall appoint a specific fire risk management representative(s)"* who was to establish and maintain the strategy and report to management on performance of the system and make recommendations for review, there is no evidence that such expert was provided. By November 2016, RBKC's Management Board noted that fire safety issues had arisen and noted the Adair and Hazlewood Enforcement Notices, albeit suggesting satisfactory completion of works[14].RBKC lacked strong/decisive leadership and purpose in the field of fire safety for its tenants. Far from championing fire safety as suggested by its 2014 Policy, it prioritised cost over safety (e.g. on leaseholder doors, door closers and sprinklers[15]). RBKC failed to prioritise fire safety in refurbishment, despite the Coroner's March 2013 rule 43 recommendations following the Lakanal House fire. Even though these recommendations were issued shortly before he became Leader, Cllr Paget-Brown failed to implement the LFB audit tool specifically designed to ensure fire safety was not compromised by refurbishments, despite the fact that it was sent to him directly and had been intended by the Lakanal House working group to be expressly adopted by councils[16]. This is not mere hindsight. RBKC was, realistically from July 2009[17] but at latest from 2013[18] onwards, acutely aware of the issues arising from Lakanal House. In March 2009, RBKC had been warned by LFB about *"non-fire resisting uPVC panels as part of replacement of window units"*[19]. In March 2014 RBKC's head of Building Control John Allen received notes presentation on Lakanal which included the warning there might be another Lakanal in other social housing and expressly referred to the cladding and *"overall worsening of conditions through years of neglect"*[20]. Despite these warnings RBKC does not appear to have issued guidance to its ALMO on such matters. In April 2017, RBKC's Laura Johnson received LFB's letter entitled *"Tall Buildings- External Fire Spread"* warning that spandrel and *"filler panels"* (sandwich panels) often did not comply with Building Regulations, were prone to delaminating and thereby becoming involved in the fire potentially spreading it from flat to flat. The letter concluded by encouraging RBKC to: *"consider carefully your arrangements for*

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12 Para 4.1 ***Leadership and Commitment*** {**BSI00000071_0016}**

13 Para 6.1 ***Resources*** {**BSI00000071_0019}**

14 RBKC Management Board Corporate Health & Safety six monthly update item 12 **{RBK00002038_0017}**

15 Caliskan 1/64**{RBK00035166_0015}***"Had the LFB made a firm recommendation or requirement for the installation of sprinklers in all blocks, I believe the Borough would have taken that very seriously".*

16 **{TMO10042979}** Tool at **{TMO10042956}** and Lakanal Working Group paper at **{LFB00049204_0045}**

17 Letter London Fire Commissioner to Derek Myers (CEO RBKC) 9.7.09 **{RBK00045588}** advising of RBKCs duties under the RRO including to undertake a suitable and sufficient FRA, and to implement the findings of it particularly following refurbishment/changes to compartmentation. Further the letter advised of the need to ensure adequate general fire precautions *"In particular this includes an evacuation strategy that is appropriate to the circumstances of the individual premises"*

18 L Johnson email 15.11.13 to Black and Wray suggesting Lakanal presentation worthwhile **{TMO10040146}.**Caliskan 1/66 **{RBK00035166_0015}** Training sessions in about 2013 on how lessons learned from Lakanal could be applied to RBKC housing stock and RBKC in receipt of coroner recommendations **{CST00001800} {CST00001802}**

19 Letter LFB addressed to*"The Chair"* dated 23.3.09 ***"Replacement windows"*** **{RBK00030046_0002}**

20 Thread Humphries (Brent Council) to Allen including notes from David Crowder's (BRE). Allen forwards to Hanson **{RBK00002607}.** J Allen **T/47/58:12 to 62:17**

specifying monitoring and approving all aspects of future replacement and improvement to building facades.... urge that you consider this issue as part of the risk assessment process for premises under your control" (emphasis added)[21]. Not only did RBKC fail to investigate how TMO and its contractors and designers ensured compliance of the facades, it also failed to require that facades should be included in future fire risk assessments as LFB had advised. RBKC failed to specifically investigate the compliance of the facade at GT, one of its highest risk properties[22]; instead, L Johnson simply forwarded LFB's letter by email to TMO, without instruction, saying nothing more than *"fyi"*[23]. Whether or not RBKC was aware of the demonstrably inadequate replies from Stokes, it should have been obvious that the investigation LFB had asked RBKC to conduct had not been undertaken at all in relation to procurement of facades in general, and in relation to GT's façade had not been adequately undertaken. The answers provided by Wray to Black were: *"[GT]... did have external cladding panels fitted as part of the recent refurbishment work, however our assessor investigated thoroughly the details of the installation with the contractor... when the works were on site and he is able to confirm that this complies with the requirements of the current Building Regulations*". That was forwarded by Black to L Johnson with the words *"Not sure we have to do anything but may be useful to update your scrutiny committee"*[24]. The investigation requested by LFB had not been caried out, so there was no data with which to meaningfully update the Scrutiny Committee. This lack of proactivity is extraordinary in a project RBKC witnesses describe as *"...a big deal... It was widely seen as a positive thing by RBKC officers"*[25]. It was only after the GT fire that RBKC issued a "*DRAFT Fire Safety Management System"* which finally acknowledged the need for Housing Management to comply with existing guidance, namely prepare fire strategies for existing buildings in accordance with PAS 911:2007 and *"...put in place a robust system of fire risk assessments (FRAs) to industry best practice... PAS79..."*[26]. The failure to have expressly required such strategies and systems before the fire, and to have ensured their implementation, is a serious failing given Dr Lane's opinion that it is not possible for the Responsible Person ("RP") to discharge their fire safety duties (which would in turn include the preparation of FRAs) without an existing fire safety strategy[27] and her view that the results of Exova's inspections feeding into the strategy would inform the significant findings which are required to be recorded in the FRAs[28]. Without a robust system for FRAs the RP cannot comply with RRO.

2.2 The Scrutiny function

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21 LFB letter concerning Shepherd's Court **{RBK00002860}**

22 RBKC HPSC 7.11.13 Mid Year Review of TMO Appendix 1 KPLs item 9 Health & Safety **{RBK00000336_0010}** *"TMO has facilitated familiarisation exercises for the LFB at some of the potentially high risk blocks – Trellick Tower and Grenfell Tower (familiarisations visits were recommended in the wake of the tragic fire at Lakanal House ... "*

23 L Johnson email 19.4.17 forwarding LFB letter to Black and Wray **{CST00001100}**

24 **{TMO10016673}**

25 Caliskan 1/50 **{RBK00035166_0012}**

26 Para 3.5**{RBK00029941_0007}**

27 **T/61/22:1-6 and 41:7-16**

28 The First Fire Safety Engineer Report par 5.4.19 **{BLARP20000003_0117}** removed in error from second version but Dr Lane wishes to reinstate it: **T/61/40:3-18**

2.2.1 ***The obligation to scrutinise.*** Despite the delegation of various of its functions, including health and safety and fire to TMO by virtue of s.27 of the Housing Act 1985, the Regulations thereunder,[29] and the form approved by the Secretary of State[30] namely the Modular Management Agreement ("**MMA**") 2005 (and as revised 2015), RBKC's legal relationship with its tenants/leaseholders and statutory, contractual and common law obligations towards them remained[31]. RBKC remained under an obligation under the Housing Act 2004 ("**HA**") to enforce against leaseholders whose premises/doors posed a hazard to other residents using the Housing Health and Safety Rating system ("**HHSRS**")[32]. RBKC was also obliged to scrutinise TMO's exercise of those functions delegated to it, in order to ensure compliance with, e.g. RRO and RBKC's common law duties. RBKC also had a scrutiny function under the Localism Act 2011[33]. RBKC councillors were aware from 2010 of their responsibilities to ensure the Fire Strategy was being complied with, to ensure FRAs were competently carried out, and not simply to rely on paper briefings from its ALMO[34].

2.2.2 ***The MMA as a vehicle for scrutiny.*** The Inquiry will wish to examine the degree of scrutiny required by legislation and the MMA, and the sufficiency of the provision within MMA for scrutinising TMO's performance in relation to fire safety. MMA clauses 4.2 and 6 (2005 and 2015) do not specify the degree of monitoring which RBKC is either entitled or obliged to carry out[35].Under the 2005 MMA[36] general indicators/achievement requirements were expressed in generic terms by reference to adult social care indicators known as "**KLOES**"[37]. Key Performance Indicators ("**KPIs**") were expressly listed and had been compiled by reference to specifically identified national Best Value Performance Indicators ("**BVPIs**").

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29 General Approval for Housing Management Agreements 1994 and 2009 and the Housing (Right to Manage) Regulations 1994 and 2012

30 Under s 4(10) of the Housing Right to Manage Regulations 1994 see Right to Manage Guidance MMA for TMO's **{RBK00002999}** and under 16(2) of the Housing Right to Manage Regulations 2012**{TMO10030827}**

31 MMA Vol 1 C1 clauses 2.2 and 4.2 **{TMO10030810_0012}**. S.27(13) HA 1985 providing for RBKC to remain liable for TMOs acts and omissions (save criminal) was excluded by clause 8 MMA **{TMO10030810_0016}.**

32 Such powers are only available against leaseholders not council tenants since in the latter case the council would be enforcing against itself **R v Cardiff City Council ex p Cross. [1982]** 81 LGR 105 QBD (1982) 6 HLR6, CA.

33 Schedule 2 Part 1 Localism Act 2011 incorporating *New Part 1A of the Local Government Act 2000* s9F(2)(c) This function within a Local Authority is *"vital to ensure effective and ethical decision – making ...by challenging assumptions, probing policy intent and testing viability" Local Government Ethical Standards – Review by Committee on Public Life January* 2019 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777315/6.4896_CO_CSPL_Command_Paper_on_Local_Government_Standards_v4_WEB.PDF

34 See email thread 1.3.10 {TMO100373793}in which Cllr Weale forwarded and asked to be tabled at scrutiny ***"Extinguishing the risk a councillor's guide to fire safety"*** **{TMO10037396}** ***"...****STRATEGY +ACTION = CONFIDENCE...****Strategy*** *... Your responsibilities as a LL whether of retained stock or via an ALMO are exactly the same as for any other landlord. In order to assure yourself that the fire strategy is being taken seriously in your housing strategy you will need to know the type of housing in your stock... paper briefings are useful, but you should not rely on them completely; you should also visit some of the premises and see for yourself...* ***Action*** *you will need to make sure that the person doing the risk assessments on your behalf is competent* ***Confidence..*** *There are no prizes for good fire safety management but the penalties are severe. You will only be confident if you regularly measure and keep on top of your performance on fire safety. This can be evidenced through local indicators developed for your areas such as the number of risk assesments carried out, reduction in fires ... and feedback from residents' surveys.* This was subsequently tabled at scrutiny 15.3.10 and approved under the heading "***legal implications"*** para 6.1 as representing RBKC's *"expectations... in relation to fire safety"* **{RBK00030060_0004}**

35 **{RBK00019007_0012} {TMO10030810_0013}**

36 **{RBK00053628_0119}**

37 Key lines of enquiry and prompts ratings and characteristics) produced by the Care Quality Commission

Following the abolition of the BVPIs and Reviews in 2008[38], the closure in January 2014 of the Audit Commission (which carried out inspections of Best Value Reviews) and the creation of a new system of audit for local authorities[39], local authority reporting changed. This was reflected in the 2015 MMA, which removed the express listing of BVPIs, albeit generic reference to KPIs contained in BVPIs[40] and KLOES were preserved[41]. The TMO was (both by the 2005 and 2015 MMA) permitted to propose KPIs in consultation with RBKC[42]. Under the Government's *Right to Manage Guidance* applying to both Agreements however, the KPIs were meant to be divided into those set by the TMO (Annex A) and those set by the Council (Annex B) and in each case a description of *"...the basis on which the Indicators have been set"*[43]. In fact, neither agreement contained an Annex B containing those KPIs set by the Council, nor did Annex A reveal the basis on which the KPI's were selected. From the 2015 MMA onwards, there was effectively a blank canvas, as although the KPIs would be an amalgam of any former BVPIs and KLOES, and also based on Housemark Benchmarking[44], specific KPIs were no longer listed[45]. The KPIs varied from year to year seemingly dependent on that year's *"themes"* such as rental arrears/collection of rent[46]. Despite the subject of fire safety in social housing becoming highly topical following the fire at Lakanal House in 2009 and the Coroner's recommendations in 2013, nevertheless there was at no material time a KPI for fire safety monitored by RBKC. Internally, TMO proposed that a fire KPI for itself be created in February 2015, repeated the intention in May and defined some proposed fire KPIs in 2016[47] albeit no such KPIs were in fact implemented/monitored[48]. Though it is inevitable that some KPIs might vary according to priorities from year to year, it is unclear why no core groups of KPIs was put in place relating to issues which are constants, such as fire safety, which was always a pressing criterion due to the vulnerable tenants housed by RBKC. There is a well-established link between vulnerable tenants and fire risks and outcomes[49]. In order to manage and monitor such risks, RBKC should have insisted upon KPIs

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38 Local Government and Public Involvement in Health Act 2007 s 139 & 140

39 The Local Authority and Accounting Act 2014

40 Replaced in 2008 by the National Indicators for Local Authorities and Local Authority Partnershipshttps: https://www.torridge.gov.uk/CHttpHandler.ashx?id=668&p=0

41 **{TMO10030811_0092}**

42 MMA (2005), Vol. 1, Ch. 8, para 1.3 {**TMO10030810_0087**} (unchanged in 2015 version: **RBK00046528_0087**} and Calisan 2/4 {**RBK00054409_0001**}

43 Right to Manage Guidance 2015 and 2013 **{RBKC00029999_0110}** and **TMO10030827__0016}**

44 https://www.housemark.co.uk/subscriber-tools/benchmarking

45 Possibly attributable to the abolition of the national indicators for local authorities on 14.10.14 (to reduce burdens on local authority reporting) and their replacement by the single data list https://www.gov.uk/government/publications/single-data-list

46 2013/14 **{TMO10039245_0022}** 2014/15 **{RBK00032466_0018}**

47 Health and Safety Committee meeting Feb 2015 ***"Performance"*** **{TMO00869479_0002}** H&S Operational meeting May 2015 **{TMO10009447}** paper 8; 19.1.16 **{TMO10011877}**

48 Lane 3 /4.9.62**{BLARP20000029_0093}**

49 See e.g.BS9999:2008 *Code of Practice for Fire Safety in the Design Management and Use of buildings* para 4.6 *Inclusive Design "Disabled people can be at particular risk in the event of a fire and need appropriate protection facilities..."* **{RBK00010788_0041}.** NFCC memo introducing its *Fire Safety in Specialised Housing Guidance.* Para 4.1**{CTAR00000038_0005}** Definition of Specialized Housing at par 3.4 **{ _0029}** to {_ **0030}** but includes categories of disability also shared by some residents in Grenfell e.g. cognitive difficulties, sensory impairment or mental health diagnosis which may sometimes be coupled with physical disabilities. For the impact see **{_0042}** and for increased risks see s12 and 13**{_0043 to _0048}**

concerning annual collection/updating of data relating to vulnerability/disability of residents[50], confirmation of compliance of fire doors, and fitting and re-inspection of door closers. TMO had recommended that KPIs be created for health and safety inspections, yet though RBKC was aware of this, none for RBKC were created[51]. This reflects a lack of direction and proactivity by RBKC in failing to identify the KPIs it required, rather than, as appears, simply accepting those proposed by TMO.

2.2.3 ***Inadequate scrutiny.*** The Centre for Public Scrutiny has established four core principles of good scrutiny[52].The Inquiry will wish to examine the quality of scrutiny in fact carried out, which on the face of it, does not appear to have been adequate in that KPIs were monitored by half yearly and annual performance reviews. RBKC's reports were essentially based on reports prepared by TMO themselves and accepted by RBKC in an unquestioning manner. There was an appearance of scrutiny, but it lacked substance[53]. Meaningful scrutiny of TMO should have probed the validity of their decision making and performance; it is not simply another layer of monitoring (*"check[ing] the checker"*)[54]. Scrutiny can identify shortcomings and prompt corrective measures, as can be seen from RBKC's April 2013 audit of TMO Health and Safety, triggered by a resident's complaint about fire safety, which albeit not a full audit of TMO's fire risk management system, led to a recognition within TMO at least (they chose not to advise RBKC) that *"there is a weakness in our management arrangements"*[55] and then prompted TMO to gather information about outstanding FRA actions[56]. The April audit also triggered an external audit procured by TMO Audit explained below. Sadly neither TMO's external Audit nor TMO's follow up December 2013 Audit[57] examined TMO's overall fire risk management system "**FRMS".**

2.2.4 ***Lack of technical knowledge.*** An obvious question is how effective RBKC's scrutiny could have been given that, as RBKC witnesses admit, those scrutinising lacked technical knowledge in various areas. This ran counter to advice contained within PAS7, which RBKC had by its 2014 policy adopted. It is an open question

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50 Accessibility for the disabled as a possible KPI was mooted within RBKC 2009: Ian Cann email to Pam Sedgwick 23.9.09 and her reply noting they should commit to expenditure on accessibility since *"... there are some serious brownie points to be gained in all this as Members understandably feel very strongly about disability and meeting need"* **{RBK00059465_0001}**

51 TMO Health and Safety Final Audit Report April 2013 circulated to L Johnson para 10 final bullet **{RBK00000808_0004}**

52 Now renamed *Centre for Government & Scrutiny* CIPFA Delivering Good Governance in Local Government, Guidance Notes for English Authorities (2016 Ed.) https://www.cheshirefire.gov.uk/Assets/1/cipfa_delivering_english_2016.pdf at paragraph 6.9 on p. 80 (1) *"Provides critical friend challenge to executive policy makers and decision takers"*
(2) *Enables the voice and concerns of the public"*
(3) *"Is carried out by independent minded councillors who lead and own the process"*
(4) *"Drives improvement in public services"*

53 As the current CEO of RBKC (Barry Quirk) is quoted as saying: *"[In an unhealthy organisational culture], self regard takes over and leaders end up spending their time looking at risk registers about reputational damage, rather than what the risks to the public are".*: page 101 *Local Government Ethical Standards – A Review by the Committee on Standards in Public Life January* 2019 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777315/6.4896_CO_CSPL_Command_Paper_on_Local_Government_Standards_v4_WEB.PDF

54 A Johnson 1/111**{RBK00033719_0023}**

55 Thread J Clifton TMO to M McGarvey RBKC 14.3.13 **{RBK00000685}** TMO Health and Safety Final Audit Report April 2013 circulated to L Johnson **{RBK00000808_0004}**Maddison to Jevans email 27.2.13 {**TMO10002223}**

56 **{TMO10039090}{{TMO10039093}**and see Lane 8/8.6 beginning at {**BLARP20000027_0155}**

57 **{RBK00000320}**

whether, had the relevant expertise been to hand, changes to TMO systems concerning FRA's and other aspects of fire safety would have been instigated which would have avoided the fire[58].

2.3 **TMO's fire safety management.**

The adequacy of TMO's administration and management clearly requires close examination. The entire responsibility for fire safety across RBKC's entire estate of some 9,400[59] properties rested on Janice Wray who had been independently confirmed as competent for the role of H&S manager, but never reviewed for managing compliance with RRO[60].This a significant burden but Lane considers Wray should have been capable ofi designing and delivering an FRMS and if not, should have sought assistance. Whilst Lane finds TMO's policy documents did address the relevant fire safety objectives, there is no evidence of detailed planning of those objectives to enable TMO to comply with their policy intent. Critically, TMO failed to identify a statement of intent in relation to occupancy profiling, and although some monitoring was done, Lane finds no evidence this was done in order to inform the FRAs .Furthermore TMO failed to articulate its intent as to the implementation of general fire precautions, control of construction work and adequate records of fire safety information for each building[61].As a result these activities were haphazard. These fundamental failures were compounded by TMO's reliance for all aspects of fire safety advice at GT on a single risk assessor, Carl Stokes, who lacked any professional registration, and had invented some of his professional qualifications[62]. TMO was clearly overwhelmed by the sheer volume of outstanding FRA actions, it seems due to TMO's failure to address how they should be actioned[63], to the extent that it sought to deliberately conceal this from RBKC. TMO's focus on completion of FRA action items without monitoring the level of risk is a critical failing[64]. This problem originated with Stokes whose FRA's did not state what the impact on risk level would be, if TMO failed to undertake the actions he identified within the required timescale[65]. In turn, Stokes failed to interrogate TMO's fire safety management or maintenance regime, which meant that his opinion of the consequences of a fire, and of overall risk level, could never be accurate. Critically, TMO failed to monitor Stokes' activities despite being aware that a different fire risk assessor had in 2014 taken a different approach, giving GT a *"moderate"* (as opposed to *"tolerable"* risk) pending resolution of his action items[66]. This should have alerted TMO to Stokes' failure to evaluate the risk posed by outstanding FRA action items. Stokes' failings were absolutely plain from

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58 C Caliskan 1/40**{RBK00035166_0009}** A Johnson 1/112**{RBK00033719_0023}**

59 RBKC Audit April 2013 para 2 {**RBK00000313_0003}**

60 Lane 3 /4.6.23-4.6.36 **{BLARP20000029_0079}**

61 Lane/3/5.6.3 to 5.6.5 **{BLARP20000029_0104}**

62 Lane 8/6.5.36 to 6.5.39 **{BLARP20000027_0091}**

63 Lane 3/Table 3-6 b) and e) **{BLARP20000029_0056}**

64 Lane 8/ 8.4.3 {**BLARP20000027_0145}**8.9.13 to 8.9.14 **{BLARP20000027_0181}**

65 Lane 8/ 9.12.23 **{BLARP20000027_0221}**

66 {**TMO10001286}** *"FRA"* tab columns 481-485

the time of the Adair fire in 2015[67] and Wray was acutely aware of these in January 2016[68] and May 2017 having received criticisms of him from the Southwark fire consultant[69]. Yet TMO failed to question the performance of the risk assessor on whom they were very heavily dependent.

3. TOPIC 1: COMPLAINTS

3.1 The role of complaints.

Complaints provide warning of problems otherwise left unseen. For management, they serve as intelligence on the organisation's true performance and a check on what they are being told internally. Disinterest, defensiveness and a lack of transparency breed dissatisfaction and distrust, causing a vicious cycle of further complaints and resident disengagement, making it harder to communicate important information and depriving the organisation of a valuable source of scrutiny. TMO and RBKC adopted a dismissive attitude towards residents' complaints, which was symptomatic of an approach to governance that created the conditions under which the fire could occur.

3.2 Identifying and classifying complaints.

TMO policies sought to distinguish complaints from "enquiries" or "service requests".[70] The May 2010 TMO complaints policy undertook to "clarify with the individual whether the issue they are raising is a service request or complaint"[71], but this was omitted from the 2015 version[72]. Evidence shows TMO sought to avoid classifying clear expressions of dissatisfaction as complaints.[73] In 2009-2010, a reported noted: "*More effort was made not to register enquiries and services requests as complaints*"[74]. In 2012, the complaints team were instructed not to log as complaints communications from the GTLA because "*these are project specific enquiries related to RBKC's KALC project and to the Grenfell Tower Regeneration Project.*"[75] Following a complaint management meeting with the Assets and Regeneration Team in November 2016, one action item was for the Complaints Team to "*ensure that TMO have been aware of the issue and that it is a service failure before logging*".[76] An

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67 Concerns about him were raised by IO Burton see her email 13.10.15 **{LFB00003439_0001}**.Asked if her concerns related to the doors only or the whole FRA she replied:*"It's more the approach of the Risk Assessor. It has recently come to my attention that different guidance documents are being applied to the same building.The approach should be to use the document which best suits the premises and apply one"*. In her second w/s [10]**{LFB00084098_0005}** Burton considers this comment related to Adair, for which Stokes FRA{**CST00011615_0019}** had openly stated door closers were not present, which he justified to LFB by relying on TMO's fire strategy which did not in fact justify his position (his email to Wray**{CST00008574_0002}**)
See also the criticisms of the FRAs conveyed to Wray during a meeting on 13.11.15: {**LFB00004659}**

68 6.1.16 Bi Monthly meeting with LFB **{LFB00000061_0003}**para 8 fire safety team leader Rebecca Burton "*...raised her concern that our Fire Risk Assessor sometimes makes statements which are not justified or supported and that FRA reports need to include justification for statements made ...*".

69 Email thread 25.5.17 Stokes/Wray/Raymond Hylton (TMO) **{TMO00894233}**

70 May 2010 policy, at 3.1 {**TMO00831399_0003**}; September 2015 policy, at 3.1{**TMO00837246_0003**}.

71 {**TMO00831399_0003**}, paragraph 3.1

72 {**TMO00837246_0003**} at section 3.

73 Other erroneous bases for excluding complaints from consideration were deployed: see e.g., email from Joanne Burke 16.8.13 {**TMO00838535**} which referred to a 1-year time limit for complaints that did not feature in TMO's May 2010 Policy. See also email GTLA to Burke, 25.9.13{**TMO00838635_0002-3**}Signed letter at**{TMO00838634}**

74 Report by Head of Strategy and Engagement for TMO Board, 13.5.10 {**TMO10037436_0019**}, para 8.3

75 Email from Mark Anderson 27.9.12 {**TMO10027165_0001**}

76 Draft email from Catherine Dack, 25.11.16 {**TMO00873939**}esp. point 3 at**{_0002}**

allegation that TMO had broken a promise to commission an independent investigation from a fire safety specialist[77] was classified as an "*enquiry*" and TMO sought ways in which they could "*say that this matter is not a valid complaint*"[78], obtaining legal advice on whether it had to deal with the matter[79].It incorrectly told the resident his complaint fell outside the scope of the policy because it related to "*commercial or contractual matters*"[80].The practice of mis-classifying complaints continued to March 2017, with residents being told that if they wished to report a "*service failure by the KCTMO we suggest that a formal letter of complaint is submitted*"[81]. Further, TMO policy recognised that complaints could be voiced by councillors on behalf of residents[82], yet it characterised these as "members' enquiries" solely by virtue of their source[83].

3.3 TMO's complaints policy.

TMO's complaints policy contemplated an investigation procedure of up to three internal stages.[84] There is evidence residents considered the process unduly cumbersome[85] and difficult to navigate.[86] During the GT refurbishment, residents were initially referred to Rydon before engaging TMO's own process, such that "*by the time that they get to the complain[t]s team, they are thoroughly fed-up*".[87] TMO's approach disincentivised complaints.[88] Moreover, it is doubtful the multi-stage process served its ostensible purpose. It gave the impression complaints would be considered independently and afresh at each stage. But responses were drafted by those that were the subject of the complaint to be issued by others[89] and a tightly coordinated approach was adopted, with "*all responses to be reviewed and agreed corporately*".[90] Stages 1 and 2 appear to have been amalgamated, with the Executive Team member (who would be responsible for stage 2) reviewing and approving the stage 1 response to "*make sure we are all on the same page*"[91], or the person responding to the stage 1 complaint also drafting the stage 2 response.[92] Stage 3 responses were subject to review by persons

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77 Email David Collins to TMO Complaints Team and Peter Maddison, 3.12.15 {**TMO00842848_0008**}

78 Summary of complaints, Exhibit YB/19, {**TMO00879710_0011**} and email from Maddison 6.5.2016 {**TMO00842848**} "*This matter has not been handled as a complaint to date. I have responded as an enquiry.*"

79 Email from Mary Walsh of Winckworth Sherwood, 27.5.15 {**TMOH00027402_0002**}

80 Email from complaints to David Collins 11.5.2016 {**TMO00842852**} referring to section 11 of the complaints policy at {**TMO00837246_0008**}(top of page).

81 Email from Sacha Jevans, 28.3.17 {**TMO10016490**} at {**0003**}. TMO's policy did not require a "formal letter of complaint" and complaints to be made in various ways: see {**TMO00837246_0002-3**} at section 2.

82 See paragraphs 2.6 and 2.7 of the 2015 policy, for example: {**TMO00837246_0002-3**}

83 For an indication of the numbers, seesummary at {**TMO00879710_0003**} under "Enquiries received from Cllr's".

84 September 2015 policy, paras 5.4 to 5.12 {**TMO00837246_0004-6**}.

85 {**TMO00846138_0003**}

86 See, for example, confusion surrounding whether a complaint could move to Stage 2 and when the Housing Ombudsman could be contacted: 21.1.16 {**TMO00836422**}

87 One-to-One Form for Joanne Burke, 8.2.16 {**TMO00852779**} at {**0003**} "*Grenfell Tower issues*".

88 See, for example, Jacqueline Haynes's evidence: {**IWS00001809_0005**} at para 17. Residents' exhaustion at dealing with the TMO extended beyond complaints to reporting problems with their properties: see email from Andrea Newton of Lancaster West Residents' Association 9.3.16 {**TMO00839652**} esp. at {**0005-6**}.

89 Email from Maddison, 28.11.13 {**TMO00833006**} relating to a complaint that power surges had posed "*an extreme fire risk for residents*" (complaint at **{_0003}** .

90 Email from Black, 17.12.14 {**TMO00857858**}; Email from Maddison 1.10.13 {**TMO00838635**} "*I will agree with Sacha how we will deal with this through Stage 2 and 3.*".

91 Emails between Jevans and Black, 22.12.14 {**TMO00857884_0001**}

92 See, for example, email from Maddison 7.1.15 {**TMO00852141**}

other than the panel.[93] Even where Board Members appeared to have considered the complaint, the Executive Team (including the very members who were the subject of the complaint) were the hand in the glove.[94] The goal was to "*close down*", "*close... off*", or "*shut... down*"[95] complaints, not genuinely consider them.

3.4 TMO's anti-complaint culture.

The complaints team was not viewed as a service that supported the operational teams to deliver and reduce complaints.[96] A "*defensive culture*" was present particularly within TMO's capital team.[97] TMO tended to respond to complaints in "*defensive/aggressive mode*".[98] Instances of TMO acknowledging the merit of a complaint and apologising to residents were vanishingly rare.[99] Resident concerns were dismissed as "*rhetoric*", as raising "*very few tangible issues*", or capable of being "*refute[d]... in a very detailed way*".[100] TMO's immediate response to fire safety concerns expressed by one resident (labelled "*scaremongering*") was to "*put out a clear statement*" assuring residents of safety, even before it had carried out a "*further belt and braces check on Fire Safety compliance in the block*". The concern was only to ensure the rejection of the complaint was sufficiently robust and "*clear*".[101] Only where TMO decided the "*issue isn't going away*" would concerns be actioned.[102] TMO had an especially negative attitude to residents, councillors or groups who made complaints regularly or in strident terms. Much of its ire was directed at the GTLA, Edward Daffarn, David Collins and Cllr Blakeman, with whom TMO considered it was engaged in a "*fight*"[103] to be approached "*tactically*".[104] TMO even heralded as "*a great outcome for us*" a finding of no maladministration by the Housing Ombudsman, rather than questioning what had gone so badly wrong that a resident had felt it necessary to elevate a complaint externally.[105] TMO's perceptions of these complainants coloured their approach to complaints more generally, making them combative and unwilling to acknowledge concerns.[106] TMO also sought to avoid external scrutiny over complaints. It rejected suggestions of independent reviews[107] and requests for independent experts to examine fire safety concerns. When RBKC's Internal Audit team, prompted

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93 Email from Maddison, 24.12.13 {**TMO10040542**}

94 Emails between Black and Birch 10.12.13 {**TMO00863580**} and 11.12.13 {**TMO00850219**} in relation to resident complaint re. fire safety concerns arising out of power surges; emails between Black and Birch 8.5.2017 {**TMO00879726**} in relation to complaint re. health and safety risks posed by gas riser installation (and as-sent version from Fay Edwards: 8.5.2017 {**TMO10016728**}).

95 Emails from Maddison 7.8.13{**TMO00855652**}, 8.8.13 {**TMO10026789**} and 4.5.16 {**TMO10047966_0021**}

96 Minutes of Executive Away Day: 2 October 2013 {**TMO00849893**} under *"Complaints YB"* at {**0008**}

97 One-to-One Form for Joanne Burke, 8.2.16 {**TMO00852779**} at {**0003**} *"Grenfell Tower issues"*.

98 "Some Suggested Learning Points from the Grenfell Tower Project", undated {**TMO10031046**} attached to {**TMO10031044**} dated 4.1.16. See in particular, item 13 at **{TMO10031046_0005}**

99 One rare example is Janet Seward upholding a complaint against Mr Maddison, 25.10.13 {**TMOH00004804**}

100 Emails from Maddison to L. Johnson 12 December 2014 {**TMO10042719_0003**}; Maddison to Burke, 11.11.13 {**TMO00831285**} and Black to Birch and Seward, 27.11.13 {**TMO00850219_0002**}

101 Email from Maddison to Wray 4.9.14 {**TMO10007353**}

102 Email from Maddison to Wray, 21.3.17 {**TMO10048881**}

103 Email from Robert Black to L. Johnson, 16.3.17 {**RBK00000149**}

104 Email from Maddison to Burke 8.8.13 {**TMO10026789**}

105 Email from Robert Black to L. Johnson and A. Johnson 2.5.17 {**RBK00031061**}

106 For example, see Black's response to Lee Chapman's concerns regarding the installation of a gas riser in the single escape stair: 28.3.17 {**RBK00002825**}; and Black to L. Johnson, 25.4.17 {**RBK00000172**}.

107 Email from Black 11.11.13 {**TMO00830482**}; email from Maddison to Burke 11.11.13 {**TMO10026922_0002-3}.**

by a Lancaster West resident, identified failures to service portable firefighting equipment at GT and issues with the integrity of inspection data held by TMO, its first concern was how to avoid "*flagging* [problems] *up outside the organisation.*"[108] TMO sought to discourage complaints being made through councillors.[109] Following a residents' petition asking RBKC to exercise scrutiny[110], TMO (with the complicity of RBKC officers and councillors) engineered a situation where TMO could "*deal with it itself*"[111], and avoid scrutiny from the HPSC. The resulting TMO Board report lacked independence and failed adequately to address residents' concerns.[112] Attempts by Cllr Blakeman to speak out against this were silenced on the basis of an alleged conflict of interest.[113] Where TMO was unable to control the flow of information from residents to RBKC, it would brief against residents by "*communicating* [its] *approach to the wide range of Ward Members that were regularly copied...*"[114]. That included making clear the complaint had been rejected and was without foundation and suggesting residents had acted unreasonably.[115] This effort to ensure councillors' perceptions of TMO were carefully managed was led by Black, who cultivated a relationship with L. Johnson that provided him with advice[116] and influence over councillors.[117]

3.5 The Council's role.

The Council enabled TMO's approach to complaints to develop and continue. First, RBKC councillors and officers shared in and encouraged TMO's negative attitude to complaints. GT was branded "*a bad tempered place*" with "*a general crossness* [that] *has lingered and is stoked by various intervals with their own agenda*", characterising at least some residents as "*a group of people who are moaning about minor issues*" who were "*not taken seriously*".[118] Even fire safety concerns were glibly dismissed.[119] This impacted upon the nature of the briefings given to councillors.[120] Councillors presumed against residents in favour of officers[121], sought to avoid scrutiny,[122] and briefed local MPs on TMO's position in relation to certain residents.[123] For one councillor, learning the lessons from the GT Refurbishment meant "*foreseeing what those with political*

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108 Emails from Moyra McGarvey 25.2.13 and from Maddison to Jevans 27.2.13 {**TMO10002223**}
109 Emails between Blakeman and Maddison, 29.6.15 and 2.7.15 {**RBK00003655**} attaching {**RBK00003656**}
110 Petition at {**RBK00029467**} and acknowledgement from RBKC 3.12.15 {**RBK00000560**}
111 Email L. Johnson to Mackover, 5.1.16 {**RBK00030744**}; item A4 of HPSC minutes 6.1.16 {**RBK00000338**}
112 Email Blakeman to Mackover 4.10.16 {**RBK00046507**}
113 Email Blakeman to Marshall 11 May 2016 {**RBK00052027**}; Minutes of HPSC meeting 11 May 2016, items A2 and A4 {**RBK00014436**}. TMO's report was shared with RBKC in Part B: see paper A4 {**RBK00052270**} at para 2.1, final bullet
114 Email from Maddison, 8.8.13 {**TMO10026789**}
115 Email from Maddison, 14.11.13 {**TMO10026922**}; email from Black 28.3.17 {**RBK00003273**}
116 For example, {**RBK00000148**}, {**TMO10013217**} and {**RBK00002340**}
117 For example, {**RBK00031098**}
118 Email L. Johnson to Black, 16.3.17 {**RBK00000149**}
119 Email from L. Johnson to Black, 24.3.17 {**TMO10016436**}
120 For example, email L. Johnson to Cllrs Feilding-Mellen and Marshall, 7.12.15 {**RBK00002078_0003**} and L. Johnson to Feilding-Mellen, 16.3.17 {**RBK00001856_0002**}
121 Email Marshall to Blakeman, 19.12.15 {**RBK00030741**} "*Equally, we must recognise our Officers disagree strongly with the assertion they have not responded fully to residents' complaints.*"
122 Emails from Feilding-Mellen {**RBK00002078_0003**} and Marshall {**0002**}, both 8.12.15
123 Email Condon-Simmonds to John Sweeney (Assistant to Victoria Borwick MP), 13.2.16 {**RBK00014605**}.

motivations will do to try and stir up problems and trying to minimise such opportunities."[124] Second, monitoring of complaints was inadequate. No KPIs were selected for complaints in 2011/12 or 2012/13.[125] In 2013/14 and 2014/15 a KPI entitled "*Complaints – No. of TMO Stage One complaints answered within target*" was introduced, with a target of 90%.[126] This was not monitored in 2015/16 or 2016/17.[127] Nor were any other complaints KPIs, notwithstanding that data on escalation was available and reported to RBKC.[128] KPI data alone would anyway not have enabled RBKC to monitor the *nature* of the complaints TMO was receiving (including whether they raised fire safety concerns) and the adequacy of TMO's *responses*.

3.6 Fire safety complaints.

Though residents were not experts in fire safety, they did identify matters which were a clear cause for concern. TMO ought to have considered residents' concerns carefully and thoroughly to identify fire safety issues that lay within. There are at least three such concerns that justify examination.

3.6.1 ***Gas riser.*** Following a leak in one of the gas risers in September 2016, TMO gave permission for a replacement riser to be installed in the stairwell.[129] Between March and May 2017 residents, including Lee Chapman and GTLA, voiced concern about the fire safety of installing gas pipes in their only escape route and repeatedly asked that an independent expert be engaged to report on the installation.[130] These concerns were well founded: TMO had been repeatedly warned to ensure that compartment penetrations were sealed and Building Control had approved the installation[131], but it failed to ensure adequate fire stopping[132] and relied upon vague assurances of compliance with Building Regulations.[133] No formal Building Regulations approval process was followed. For TMO, this was a National Grid project, such that TMO involvement would be *"minimal"*.[134] Resident concerns were treated with a mixture of derision and dismissiveness.[135] TMO had no intention of appointing an independent inspector.[136] It delayed consulting LFB for fear enforcement notices might follow[137] and repeatedly dismissed concerns rather than investigating them.[138] Getting nowhere with TMO, residents appealed to other bodies: RBKC directly (who were hand-in-hand with TMO), LFB (who

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124 Email Feildmg-Mellen to Maddison, 3.1.17 {**RBK00001807**}

125 Report on TMO Performance 2011/12 and TMO Performance Agreement 2012/13, 12 July 2012 {**RBK00030149**} at {**0016-18**} and Report on TMO Performance 2012/13 and TMO Performance Agreement 2013/14 {**TMO10039245**} at {**0018**}.

126 {**TMO10039245**} at {**0029**} and {**RBK00003649**} at {**0007**}

127 {**RBK00000589**} at {**0005-7**} and {**0023-24**}.

128 See Report on TMO Performance 2012/13 {**TMO10039245**}, section 5.2 at {**0006**}

129 {**TMO10036041**}

130 See in particular, {**RBK00003505**}, {**RBK00003577**}, {**RBK00014069**}, {**TMO10016323**}, {**RBK00002365**}, {**TMO00840257**} and {**TMO00843206**}

131 {**TMO10036041**} and {**TMO00831999**}

132 Report of inspection by Stokes {**TMO00829834**}.

133 {**TMO00830564**}

134 {**TMO00861343**}

135 See internal TMO emails {**TMO10046577**} and {**TMO10046579**} and L. Johnson's email {**TMO10046920**}, {**RBK00034192**} and {**TMO10049584**}.

136 {**IWS00001591**} and the internal responses at {**TMO00842987**}, {**TMO00842995**}, {**TMO00843004**}, {**TMO00843005**}

137 {**TMO00861832**}

138 {**TMO00861742**}, {**TMO10046920**}, {**RBK00034192**}

disclaimed responsibility)[139] and their local MP, who (while claiming she had expressed *"renewed concern to the Borough"*) had simply referred the matter to TMO.[140] Regrettably, this got residents nowhere and the problem was not resolved by 14 June 2017.

3.6.2 ***Doors.*** Reports of broken door closers should have triggered an immediate fire safety concern. After one such report in August 2014[141], the resident was told *"the matter could be resolved by pulling the door closed"*. The resident's complaint was rejected on the basis that TMO's response was *"a reasonable suggestion to make and would appear to have resolved the matter"*[142].This failure to pay adequate regard to the role played by flat doors in preventing fire and smoke spread was not isolated: TMO failed to seek evidence of the performance of new doors even where it knew they had been replaced.[143]

3.6.3 ***Lifts.*** The lifts at Grenfell Tower malfunctioned regularly and were the subject of persistent resident dissatisfaction, including from those with (or having family members with) disabilities that prevented them from using the stairs. Though the focus of these complaints was understandably on the inconvenience caused by breakdowns, they ought to have prompted TMO to consider more carefully the needs of residents with disabilities in the event of a need to evacuate. The existence of a 'stay put' strategy was no answer to this issue.

4. TOPIC 2: OBLIGATIONS OF RBKC AND TMO UNDER THE RRO {INQ0001327}

4.1 Background.

Prior to the introduction of the RRO, the fire safety requirements for premises were found in over 70 different statutes/regulations[144]. The purpose of the RRO was radical reform of an entire regulatory regime by simplifying and consolidating fire safety legislation into one set of regulations with a single enforcer and aligning fire safety legislation with health and safety law by imposing a duty on the person in control of the premises (as opposed to fire authorities) to carry out a fire risk assessment thereby reducing prescriptive requirements, and also the burden on business[145].

4.2 Requirements of the RRO.

The overarching requirement of the RRO is that the RP take steps to protect human life by risk assessments which identify people especially at risk, and the measures necessary to protect them. As the RRO applies to

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139 {**LFB00004667**}
140 {**TMO10048889**}
141 {**IWS00000169_0063**}
142 {**IWS00000169_0067**}
143 Lee Chapman 1st statement, paras 22-23 {**IWS00001000**}; 2nd statement para 15 {**IWS00001619**}
144 Para 48 House of Commons Regulatory Reform Committee Proposal for the [RRO] 2004 eleventh Report of session https://publications.parliament.uk/pa/cm200304/cmselect/cmdereg/684/684.pdf The most significant being the Fire Precautions (Workplace) Regulations 1997 and the Fire Precautions Act 1971.
145 Hansard HL vol 672 col 839 (7 June 2000) *"In summary the order will make fire safety legislation easier to understand for those responsible for keeping premises safe. It will remove the overlapping and conflicting legislation and for most premises replace it with a single regime and a single enforcer. Fire certification, fire safety conditions of licences and a myriad of other separate requirements contained in Acts and statutory instruments will cease. That means that those responsible for safety can act in the knowledge that by complying with this order they will not find themselves in conflict with other legislation on one, two or other enforcing agencies. That removes a sizeable burden from business".*

different types of building with differing occupants, it imposes *goal based*[146] functional requirements as opposed to being prescriptive or performance based. The Art 8(1) requirement that the RP take *"such general fire precautions as may reasonably be required in the circumstances of the case to ensure the premises are safe"* will require precautions unique to each building[147]. These include ensuring the MOE are safe and mitigating the effects of a fire[148]. The precise measures needed are identified by the FRAs (Art 9(1)) and known as the *"preventative and protective measures"* (Art 2). These therefore equate to *the general fire precautions* and the RP must implement them exercising the principles of prevention articulated at Schedule 1 part 3, including *"evaluating the risks which cannot be avoided"*. That necessarily comprehends evaluation of inherent risk factors in a building such as the presence of combustible cladding. The *collective protective measures* (i.e. those which protect a group of persons[149]) are to be given priority over individual measures[150]. Compartmentation, namely the walls of each flat including the external wall and doors, is one such protective measure[151]. If the external wall cannot act as a protective measure due to combustibility then it must be identified as a hazard in the FRAs as per Sch 1 part 3 of RRO (above)[152].

4.3 The RP/Person having control.

As defined by Art 3(b)(i) of the RRO, both TMO and RBKC qualify as RPs[153], since *"as occupier or otherwise"* both have control to a significant extent in connection with the carrying on of an undertaking, namely the provision of housing[154]. TMO in its Fire Safety Strategies consistently (from Oct 2012 to June 2017) described itself and RBKC as both being RPs[155].As RBKC had known since 2010, LFB regarded RBKC as an RP[156].Furthermore RBKC actively participated with TMO and LFB in the programme which began in 2009 seeking to improve fire safety of RBKC's stock, thereby acknowledging its responsibility as RP, and holding itself out as such.While TMO had tangible day-to-day control, the entity with ultimate control was RBKC[157], since TMO's funding entirely derived from RBKC. Being an RP brings with it the obligation to carry

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146 ODPM 2002 Consultation paper extract cited at Para 4.6.8 Lane **{BLARP20000023_0053}**

147 Lane 1/4.7.5 **{BLARP20000023_0055}**

148 Art 4(1)*(b) measures in relation to the means of escape from the premises*
(c) measures or securing that, at all material times the means of escape can be safely and effectively used....
(f)(ii) measures to mitigate the effects of the fire".

149 HSE Management of Health and Safety at work Regs 1999 ACOP L21 para 29(g)

150 Art 10 and Sch 1 part 3(g) at **{_0034}**

151 Lane 8/13.2.3-13.2.4 **{BLARP20000027_0299}**

152 Lane 10/ 6.1.16 **{BLARP20000032_0049}**

153 And indeed described themselves as such: TMO Fire Safety strategy at par 2.2 and 13 Nov 2012 **{TMO00830598_0001}** and June 2017 {**TMO00832724_0001}**

154 The CLG Guidance Note no 1 (October 2007) Para 40 acknowledges that there may be more than one RP **{CTAR00000031_0013}** and by par 45 of The RRO statement by ODPM 19.4.04 https://www.legislation.gov.uk/uksi/2005/1541/pdfs/uksiem_20051541_en.pdf extracted at **{BLARP20000023_0078}**

155 October 2012 para 2 **{TMO10001577_0001}** and June 2017 para 2.2 **{TMO10017036_0001}**

156 **{RBK00018545}**

157 Contra Lane who considers TMO was an RP ;1/1.1.15 but considers RBKC only having a degree of control under Art 5(3) **{BLARP20000023_0005}**and para 8.4 .in particular 8.4.80 **{_0110}**

out/procure the carrying out of FRAs, RBKC was aware of this obligation and adopted it as policy[158]. It fell to RBKC not only to make a commitment to fire safety, but to follow that up with a clear allocation of funds, based on need defined by TMO. RBKC should not have been exercising control, by making decisions about the necessary protective measures, unless it had also (through TMO and Stokes) both obtained and satisfied itself of the FRAs. Despite this, RBKC instead expressed themselves unwilling to carry out work critical to fire safety, such as periodic inspections of door closers on the grounds it would be a drain on the HRA account[159]. TMO should have identified for RBKC the costs needed to incur to comply with FRAs, yet it seems that TMO's budgeting processes are unclear[160]. RBKC however could and did exercise overarching control e.g. by its refusal to inspect door closers.

4.4 Residents with Disabilities

Art 8(1)(b) indicates that the measures required under Art. 4 to protect the relevant persons[161] must be such as to *"ensure the premises are safe"* for those persons. It follows from Arts 8(1)(b) and 4(1) that the MOE must be suitable for use by all residents, including those with disabilities. Art.9(7)(b) requires the RP, immediately following the preparation of an FRA, to record *"any group of persons identified by the assessment as being especially at risk"*.This includes vulnerable people[162].

4.5 Evacuation Plans.

Regardless of the evacuation strategy for the building (including a *"Stay Put"* strategy), Art 15 requires evacuation in the event of *"serious and imminent danger"*. Imminent danger arises if any occupant or group of occupants need to evacuate because their flats are affected by fire, heat and/or smoke. This is inevitable if compartmentation is breached either horizontally or vertically[163]. LFB's *"Councillor guide on fire safety for use during estate visits"* made pellucid the requirement for an emergency evacuation plan, noting that despite the fact that most purpose-built blocks have a stay put policy *"There should also be an emergency evacuation plan in place for each building"*[164]. Similarly, LFB's Councillor guide *"...for use during council meetings"* was to like effect[165].

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158 *Extinguishing the Risk* **{TMO10037396}** forwarded to RBKC councillors and raised by them at scrutiny and adopted as their policy see para 2.2.1 above). See also where LA is RP: *Councillor guide on fire safety for use during council meetings* **{LFB00001295)**

159 Johnson email 6.3.17 to B Matthews cc A Johnson and ors **{RBK00046603}**

160 Lane 8/8.4.68-8.4.69 **{BLARP20000023_0108}**

161 Defined by Article 2 as those lawfully on the premises /immediately in the vicinity of the premises (i.e. the residents in their flats).

162 As LFB guidance stated, Art 9(7)(b) *"ensure[s] that vulnerable residents in their own domestic premises are risk assessed for their needs in terms of evacuation and escape when and where required"*FSIGN 421 *Sheltered Housing* para 2.5 **{CST00006722_0003}**. The point made at para 2.5 is a general one re the RRO and is not confined to Sheltered Housing: that was made clear to RBKC by an email from LFB (Coombe) email to Wise (RBKC) *"...the RRO only covers the common area from a physical point of view but from the fire risk assessment point of view covers all relevant persons which the tenants or home owners/lesssees are"***{CST00006033_0001}**

163 This will inevitably arise in the case of a high-rise building which have no capacity to tolerate vertical fire spread Prof Torero Interim Recommendations report para 5.4 **{JTOI00000001_0010}**

164 GTI document date 25.6.14**{LFB00001294_0001}**

165 GTI document date 25.6.14 **{LFB00001295_0001}**

4.6 Overlap in legislation.

Fire precautions legislation historically applied principally to non-residential property, whereas fire risks in domestic property are primarily dealt with via the HHSRS under the HA. The overlap between these two pieces of legislation remains: the HA covers both individual flats and defined common parts including the structure and exterior, but RRO also imposes obligations concerning fire safety in the (substantially undefined) common parts of domestic premises[166]. This is undesirable in that it leaves the extent of the RRO's application unclear: it might be argued the box surrounding each flat (entrance doors and walls) are not covered by RRO[167]. Given that local authorities cannot enforce against themselves under the HA, council tenants are left unprotected against defective local authority owned doors[168], and yet it might be said that RRO did not protect them either if doors were not covered by it. This lacuna was not cured by any of the approved RRO guidance (LACORS simply assigned responsibility to LFEPA/RBKC jointly in purpose built blocks) and given the criticality to compartmentation of doors, this is a serious lacuna[169].The issue was resolved in practice by doors being treated as the RP's responsibility under RRO, because they are essential to the Art 14(2)(b) safe escape route: LFEPA issued deficiency/enforcement notices against RBKC under Art 17 (1) for failure to keep equipment *"in efficient working order/good repair"*. This is consistent with Dr Lane's approach that the correct focus, especially in a building with a stay put strategy, is on the overall package of *general fire precautions* and the *preventative and protective measures* required as opposed to seeking to artificially divide the building between domestic and non-domestic, which ignores the criticality of compartmentation to the safety of the common parts[170]. Any aspect of the building which has the potential to negate the functional measures required by the RRO and which means that relevant persons using the common parts are not safe, can put the RP in breach of the RRO. Logically all doors on the protected route must be inspected in any FRA for that reason[171], and the Local Government Association "*Fire safety in purpose-built blocks of flats*" (first published July 2011) ("LGA **Guide**") makes clear that flat entrance doors are *"critical to the safety of the common parts in the event of a fire within a flat. The doors must be self-closing and afford an adequate degree of fire resistance"*[172].The

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166 See Art 6**{INQ00011327_0006}** stating the Order does not apply to domestic premises and the Art 2 definition of *"domestic premises"* which excludes the common parts save those *"..used in common by the occupants of more than one... dwelling"*{**_0003}**

167 Indeed, LGA Guide suggests **{CTAR00000033_0044}** *"it is normally only necessary to consider the common parts to satisfy the FSO"* but this contradicts PAS79 (which LGA incorporates by reference at App 2) as explained in para 4.7 below

168 Therefore council tenants are unprotected from the effect of defective council owned doors since the council would be enforcing against itself **R v Cardiff City Council ex p Cross. [1982]** 81 LGR 105 QBD (1982) 6 HLR 6, CA

169 The definition of common parts was described by CLG *Guidance Note No 1 Enforcement* as a *"complex area"* on which further guidance would be forthcoming para 19 **{CTAR00000031_0010}** but it never materialised. A cure is proposed by s1 of the Fire Safety Bill, which proposes revisions to s.6(1)(a) of the RRO and a new s 1A to clarify that the RRO applies to all doors separating domestic flats from common parts and external walls (including doors/windows therein)

170 Lane para 4.8 19- 4.8.22 **{BLARP20000023_0063}**

171 Supported by Lane par 13.3.44 who considers flat entrance doors a "*collective protection measure*" and that irrespective of contractual obligations, Stokes had a "*duty to ascertain enough information to assess the protection available by means of these doors, to therelevant persons"***{BLARP20000027_0305}**

172 The 2011 version is at **{LFB00048607}.** Para 29.2 of 2012 edition at {**CTAR00000033_0042**}

suggestion that only a sample might be inspected derives from LGA Guide[173] but is contradicted by the DCLG's fire safety risk assessment guidance on *Sleeping Accommodation* ("**Sleeping Guide**")[174]. In any event, the RP is required to make a *"suitable and sufficient assessment of the risks to which relevant persons are exposed"* in order to ascertain what fire precautions are required. There is no limitation of the risks to be considered to only those risks which lie in the common parts. Application of that principle avoids the disagreement between the Inquiry's experts as to whether the common parts as defined by RRO extend to cladding[175]. Given Art 2 defines common parts as *"used in common by occupants"*[176] it seems artificial given that definition, to describe cladding as common parts[177]. However, the point is academic given the requirement to *"[evaluate] risks which cannot be avoided"* which include the combustibility of the external walls which is a *"given [risk] factor"* to be taken into account in the Significant Findings to represent the overall risk posed by the building[178].

4.7 Approved Guidance.

4.7.1 ***Overview of guidance.*** Art 50 RRO provides that the Secretary of State ("**SS**") must ensure appropriate guidance is available to assist RPs in the discharge of their duties under Arts 8 to 22. This was intended to be *"... clear and authoritative... [to tell the RP] how he ought to implement fire safety..."*[179]. The SS is treated as having discharged that duty if the guidance was available before Art 50 came into force, and the SS considers the guidance appropriate. The guidance may be revised from time to time. In 2006, DCLG produced the Sleeping Guide[180] and four more guides were added in 2007[181] but the Government's website also referred to

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173 LGA Guide Type 1 *Common parts only non-destructive... includes examination of at least a sample of entrance doors* {**CTAR00000033_0048**} but cf. para 29.2{**_0043**}.

174 {**RBK00036722**} which proposes *any* fire resisting compartment doors are checked every 6 months and *all* self-closing fire doors be checked annually **{ _0121};** note also *daily* checks that doors on escape routes "*close fully*" and are in a "*good state of repair*" and *monthly* checks that fire doors are in "*good working order*" and "*closing correctly*" (para 3.4.6 {**_0033**}). Likewise the LGA Guide suggests inspection of flat entrance doors every 6 months para 82.3 & 82.4{**CTAR00000033_0128**}**.** There was in any event no purported restriction on Stokes' inspection at GT: *See* High risk brief Part 2 par 1.3, which states FRAs are to focus on "*i...Compartmentation...ii The operation and adequacy of fire doors including their fire resistance rating and smoke/fire seals etc*" **{TMO10037438_0055}** and medium risk brief Part 2 par 1.1 provided: "*The FRA... will include an individual examination of each communal fire door including whether it operates correctly...*" and at 1.4 an example of defect reporting: "*the front entrance door of flat 7 was inspected and found not to have self-closers or intumescent strips*"**{TMO00842371_0006}.** Lane suggests that clarification should have been sought by Stokes and recorded in the FRA regarding any agreement to either omit the flat entrance doors, inspect a sample or inspect all of them. *See* para 13.3.22 **{BLARP20000027_0302**}

175 Lane considers it does: 1/6.1.5 **{BLARP20000023_0076}.** Todd considers it does not Todd First para 9.1.13- 9.1.14 **{CTAR00000001_0096}** Todd Second para. 3.13 {**CTA00000011_0021}**

176 Elaborated on by CLG *Guidance Note No 1 Enforcement as "...e.g stairs, corridors, shared kitchens, bathrooms and lounges etc" para 19* **{CTAR00000031_0010}**

177 Contra Lanc1/6.1.5 **{BLARP20000023_0076}** and 6.4.1 **{_0082**} to 6.4.16 **{_0084}**

178 RRO Sch 1 part 3 **{INQ00011327_0034}** and approved guidance :PAS79 S5 ix b**{CTA00000003_0019}**

179 Para 233 (p52) House of Commons Regulatory Reform Committee Proposal for the [RRO] 2004 eleventh Report of session https://publications.parliament.uk/pa/cm200304/cmselect/cmdereg/684/684.pdf

180 **{RBK00036722}** It identified a simple five stage plan for FRAs**{ _0013}**including the identification of people at risk, removal/reduction of risk and the preparation of an emergency plan. Critically the guide expressly made clear *"you must carry out a fire risk assessment which must focus on the safety in case of fire of all 'relevant persons'. It should pay particular attention to those at special risk such as disabled people, those who you know have special needs and children..."* **{RBK00036722_0008}**

181 Lane 1/5.1.8 and table 5.1 **{BLARP20000023_0065}**

the LACORS guidance (2008)[182], and the LGA Guide. The LGA Guide was commissioned under Art 50 RRO[183] by DCLG in December 2010 following an agreement between the housing sector and enforcing authorities in January 2010 that additional guidance to assist landlords in how to fulfil their statutory duties would be beneficial. This appears also to have been hastily commissioned, and motivated by a desire to be seen to be doing something following Lakanal[184]. It was subsequently expressly endorsed by the SS[185]. DCLG funded this sector led guidance, saying it no longer had the expertise or resource to produce such guidance,[186] but whilst LGA instructed Colin Todd to draft the guidance, the final product was ultimately agreed in conjunction with all the stakeholders including DCLG[187] and it appears their input was significant[188]. Art. 50 provides no order of precedence for the guidance and so on the face of it, all approved guidance pertinent to purpose built blocks is to be read together. The Inquiry's experts disagree with each other on this: Dr Lane considers there is no hierarchy[189] whereas Todd considers that the LGA guide has superseded the Sleeping Guide[190]. Although the Sleeping Guide has not been withdrawn and remains on the Government's website,[191] the LGA Guide, which was commissioned in the wake of Lakanal, advertised by Government as *"... specifically addressing fire safety in purpose built blocks of flats"* [192] (and holds itself as "*more appropriate*" than the Sleeping Guide or LACORS[193]) the LGA Guide has gained some increased significance over the Sleeping Guide, beyond the purely chronological. Given the LGA guide is flawed and detracts from duties owed under RRO, its prominence is regrettable, but must be recognised. Dr Lane's view is that given the LGA Guide is in conflict with all other guidance, the RP and risk assessor come under a duty to consider why this lower standard is appropriate before solely following it[194]. Whilst PAS 79, which provides a methodology for

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182 (Local Authority Coordinators of Regulatory Services). Approved by the Under-Secretaries of State for Housing and Fire to assist in managing the interface between the Housing Act 2004 and the RRO by giving advice which would ensure fire safety, regardless of which of those pieces of legislation it derived from. It introduced the concept of the protocol between local housing authorities and FRS stipulating which body would be the lead enforcer depending on type of housing. In relation however to self-contained flats (purpose built or converted) the protocol stipulated both LFEPA and RBKC would share responsibility for enforcement thereby leaving the situation unclear **{RBK00003076_0066}.** The bespoke protocol between RBKC and LFB did the same **{LFB00031977_0069}**

183 **{CLG00001825_0009}**

184 Email Bob Neill (Fire minister) to SS CLG (Eric Pickles MP) 1.12.10 *"... questions raised about what Government is doing ... it would be good if we could say the fire safety guidance for purpose built flats has been commissioned"* **{CLG00001824}**

185 Letter SS to Lakanal coroner **{HOM00001413_0001- 0002]}**

186 DCLG funding letter 11.11.10 **{CLG00001808_0002}.** The guidance was forwarded by RBKC's Executive Director J Dainith to Wray on 29.7.11**{CST00004390}**

187 Letter DCLG (Brookes-Duncan/Upton) to Bob Neill MP & Grant Shapps MP 21.1.11 par 7 **{CLG00001842_00001-00002}**

188 Louise Upton congratulatory email 28.7.11 to LGA , Todd and ors *"... Delivering a pretty complex guidance document that the fire and housing stakeholders are happy with is a great achievement not least because of the relatively short timeframe of Jan to July in which we had to work"* (emphasis added) **{CLG00001843}.** See also LGA par 1.1 **{CTAR00000033_0014}**

189 Lanc 1/5.1.20 and 5.1.23 **{BLARP20000023_0068}**

190 First report para 9.2.29 to 9.2.34 **{CTAR00000001_0109}.** It is unclear (para 9.2.31) to what letter (he says dated 19.11.13)from DCLG stating there is no statutory provision under which guidance is approved Todd is referring to. It seems flawed since DCLG do accept that guidance is approved pursuant to Art 50 see {**HOM00001413}**

191 Albeit now with the caveat that it is *"no longer comprehensive, in particular given recent planned amendments to [ADB]* https://www.gov.uk/government/publications/fire-safety-risk-assessment-sleeping-accommodation

192 Letter Grant Shapps MP and Bob Neill MP to Cllr Gary Porter 28.7.11email at **{CLG00001843}** letter at **{CLG00001844}**

193 Para 5.1 and 5.2**{CTAR00000033_0017}**

194 Lane 9/2.2.69-2.2.70 and 5.4.9**{BLARP20000028_0020}{_0065}**

how to carry out an FRA is not separately listed as approved guidance on the Government's website, nevertheless it is incorporated by reference at Appendix 2 of LGA Guide and as such forms part of the Art 50 Guidance[195].

4.7.2 ***Effect of overlapping guidance.*** The plethora of guidance, the most prominent of which (the LGA Guide) positively undermines the duties imposed on RPs by the RRO as explained below, is undesirable. The fact of numerous guides allows the fire risk assessor to cherry pick as between guidance to suit their purpose[196]. Many small and medium sized businesses took that view and users also considered the guidance *"complex and confusing"*[197]. LFEPA also considered the guidance to lack clarity[198]. On certain points, such as the need for appropriately fire resisting doors with smoke seals and self-closing devices the guidance is almost unanimous[199], however the volume of differing guidance on the same building type is unhelpful. This fundamental problem is evidenced by both Mr Todd's approach[200] and Dr Lane's[201] in which they benchmark Stokes' performance against different pieces of guidance: this should not be necessary or possible for buildings of a similar type: the standard required by the RRO is a suitable and sufficient risk assessment which is reasonably reflective of the risks posed.

4.7.3 ***The LGA Guide.*** This sector-led guidance[202] was produced in the wake of Lakanal in response to questions from landlords as to how to fulfil their obligations. TMO's Janice Wray had been amongst those seeking guidance: she inputted into the brief to LGA querying what the position was when the LFB requirements differed from those of Building Control and asking what the requirements on a landlord were in the event of a disabled resident living above ground floor without an evacuation lift[203]. Sadly, that is one of the key respects in which the LGA Guide is profoundly unsatisfactory and its guidance contradicts guidance contained in the earlier 2006 Sleeping Guide[204]. The LGA Guide further suggested that in general needs blocks it was unrealistic to expect landlords to produce Personal Emergency Evacuation Plans ("**PEEPs**") or keep that

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195 Appendix 2 para A2.2 at 2012 Ed. (described as amplifying the but not conflicting with the five steps in the Sleeping Guide) **{CTAR00000033_0149}** }See contra Lane 1/5.2.6 **{BLARP20000023_0069}**

196 As LFB considered Stokes did: 13.10.15 Burton to Wray thread **{LFB00003439}**and see his view on signage : letter to Wray 27.9.10 **{CST00001162}**

197 Dept for Business Innovation and skills Focus on Enforcement Regulatory Review of RRO August 2013 para 8, 2nd bullet and 5th bullet par 23. See also internal DCLG letter Larking to Lewis 4.2.14 ***"User views"*** **{HOM00048285_0003} to {0004}**https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226938/bis-13-1080-focus-on-enforcement-reviews-of-regulatory-reform-fire-safety-order-2005.pdf

198 Lakanal Hosue working Group 31.3.14 **{LFB00000207_0073}**

199 Albeit LGA Guide does not advocate the fitting of smoke seals /intumescent strips as a generic recommendation (para 62.16 {**CTAR00000033_0101**})

200 Todd second s9 **{CTA00000011_0098}**

201 Lane compares Stokes' 11 step methodology with both the 5 step approach in the Sleeping Guide and the 9 step approach in PAS 79.Lane 8 /9.4.4 **{BLARP20000027_0192}**

202 Now said to be *"no longer comprehensive"* and should be read alongside various guidance including NFCC guidance on simultaneous evacuation https://www.local.gov.uk/fire-safety-purpose-built-flats

203 Wray email 31.5.10 **{CST00004256}**

204 In that the LGA 2012 Guide states *"In 'general needs' blocks of flats, it can equally be expected that a resident's physical and mental ability will vary. It is usually unrealistic to expect landlords and other responsible persons to plan for this or to have in place special arrangements, such as ['PEEPs']. Such plans rely on the presence of staff or others to assist the person to escape in a fire."*. para 79.9**{CTAR00000033 _0123}**

data in a premises information box and that, even in sheltered homes, reliance on the fire and rescue services was inevitable[205].That statement also contradicted the methodology to be adopted towards the provision for PEEPs contained in PAS 79 see below. It is unclear why the LGA Guide in this respect contradicts the requirements of the RRO, the Sleeping Guide and also PAS 79. Social housing providers apparently did not feel they had had significant input into the LGA Guide, although TMO was a founder member of the National Federation of ALMOs who are listed as stakeholders in the LGA *Acknowledgements*[206]. In 2011 some social housing providers sought to lobby government and others by forming groups such as the National Social Housing Fire Safety Group ("**NSHFSG**")[207] with a view to influencing fire safety guidance within purpose-built blocks and including new guidance for sheltered housing. They recorded as at October 2012 that they had "*hitherto…had no meaningful input into guidance which directly affected them (e.g. Fire Safety in Purpose Built blocks of Flats)*"[208]. It seems housing associations/ALMOs in general sought to make a clear distinction between care homes on the one hand and sheltered or general needs housing on the other and objected to the additional burdens they saw the LFB requirement to prepare PEEPs in sheltered/general needs blocks as imposing on them[209]. The Westminster ALMO obtained guidance for itself and NSHFSG members on liability for gross negligence manslaughter arising out of Lakanal, so was clearly at pains to understand the implications of a future similar incident[210]. In these circumstances, it is of concern that NSHFSG appear to have sought to lobby LFB through organisations such as the Chief Fire Officers Association ("**CFOA**") and others to minimise the need for PEEPs in both sheltered and general needs housing.

Further major flaws in the LGA Guide include overlooking the requirement for an evacuation strategy in the event of serious and imminent danger as required by Art 15 RRO. The LGA Guide gives a nod, by noting a simultaneous evacuation policy has sometimes been adopted even where the block had been designed to support a stay put policy, but characterised this as "*unduly pessimistic*"[211].The guidance, which runs counter to the need for an evacuation plan, is that in purpose-built blocks it would only rarely be necessary to have an emergency

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205 Paras 79.9 to 79.11 **{CTAR00000033_0123}**

206 **{CTAR00000033_0013}.** TMO Board meeting 25.3.10 Item 8 confirms TMO founder member of NFA with seat on board **{TMO10037436_0007}**

207 https://www.shfsg.info/about-us/

208 Minutes of National Social Housing Fire Strategy Group 5.10.12 (Wray in attendance) Item 3 **{CST00004324_0001}**

209 See LFB *Guidance on FRA's in care homes and 'Specialised Housing'* : Definition of specialised includes *"independent self contained flats in a purpose built building"* which required PEEPs in such cases **{CST00008156}** email Claire Wise RBKC to Nicholas Coombe LFB 15.8.12 in which he noted vulnerable people in general needs housing was prevalent **{CST00006033}** and see Wise attached Briefing Note at **{RBK00053707}** and J Davies (another ALMO) to RBKC 24.2.12 **{RBK00026091}** email; thread October 2016 indicating Todd working with the National Social Housing Fire Strategy Group : identifies risk that if it's a requirement of specialised housing that each flat have a warden call, then all flats will be designated General needs **{CST00028252_0004}.**

210 City West Housing (the Westminster ALMO and NSHFSG member) had asked David Crowder to prepare a presentation which differed from his normal one (i.e. that given to NSHFSG in London 30.4.13 D Crowder statement para 13 **{BRE00032332_0005} and slides at {BRE00032336}**).The presentation given on 11.6.13 to the Westminster ALMO, and on 17.7.13 included, at s6, a section on corporate/gross negligence manslaughter **{BRE00032273_0040} to {_0044}** not contained in the standard presentation

211 Paras 19.6 & 19.7 **{CTAR00000033_0031}**

plan; that instead only *"a simple fire action notice"* (which the LGA Guide suggested need not be displayed) would suffice, but Lane disagrees strongly[212].The LGA Guide also alluded to a presumption that if a stay put strategy pertains to the building, then there is no requirement to have an evacuation strategy[213] and in such blocks with a stay put strategy it was *"undesirable to have a fire alarm"*[214]. The LGA guide is also flawed in its treatment of doors in two key respects. First, it introduced the notion that the residents might be regarded an RP in relation to demised doors and be prosecuted under RRO[215]. This was essentially advocating the irresponsible position which TMO/RBKC and some other housing providers later took.

Second, it suggested *"It will not be practicable to test existing doors to confirm their actual fire resistance"* and allowed an assumed *"notional FD30 door"*, i.e. one with 30 minutes fire resistance, admittedly only if the door satisfied standards at the time of construction[216]. The LGA Guide should have made clear, as other contemporaneous guidance prepared in response to Lakanal did,[217] that without certification, the only way to check if the door provided minimum fire resistance was to carry out a destructive test. The LGA Guide concept ofi *"upgrading"* so as to become an *"FD30S"* door is also flawed (absent certification to show that the door originally complied) because it overlooks the fact a class of doors ("fire check doors") which are known to be in existence but which could never have provided the 30 minutes integrity to the applicable test at the time of construction, and even with an intumescent seal fitted cannot achieve the 30 minutes resistance required by subsequent revisions of the standard[218]. Dr Lane considers that the LGA Guide should highlight that such doors exist and cannot be upgraded. Those were the stair doors at Grenfell[219].

4.7.4 ***PAS 79 2007 & 2012: Proposed Methodology for carrying out FRA.*** The critical exercise prescribed by PAS 79 is to ascertain the likelihood ofioccurrence ofia fire, its consequences in human terms to combine both in order to determine the level of fire risk, and to ascertain the measures required to reduce the risk level to tolerable. Serious consequences include a high likelihood of harm to even a small group of persons[220]. Accordingly, without PEEPs, there would be a high likelihood of harm to those with disabilities seeking to attempt to escape from the building. Both versions of PAS 79 made clear that the MOE must be assessed for adequacy and that PEEPs are required for those with disabilities. A troublesome development is that Mr Todd,

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212 Lane 9/14.4.21**{BLARP20000028_0182}**

213 Para 19 LGA Guide **{CTAR00000033_0031}**

214 Para 20.4 **{CTAR00000033_0032}**

215 LGA Guide para 29.2 **{CTAR00000033_0043}**. Lane considers that TMO had the *"dominant responsibility for all fire doors"*, because they were primarily a collective protective measure 4/3.8.18 {**BLARP20000030_0032**}and also that TMO had primary responsibility to take all reasonable steps to cooperate and coordinate with leaseholders to protect all relevant persons in the building, since demised doors *"did not just protect the leaseholders in that flat"* (4/2.4.21 at {**_0020**}).

216 Para 62.17 **{CTAR00000033_0101}**.

217 Leasehold Excellence Network *"Positive Practice: fire safety"* **{TMO10037479_0001}** forwarded to Wray by Daniel Wood by email 1.8.11 **{TMO10037480}**.

218 Lane's investigations indicate that such doors would achieve as low as 12 minutes integrity, increasing to 20 minutes with an intumescent strip: Lane Phase 1, Section 19 at 19.6.14 {**BLAS0000019_0030**}

219 Fire check doors applicable standard was BS459 3:1951: Lane Phase 1 Report M8.1.8-M8.1.13**{BLAS0000034_0067}** and M5.2.9 to M5.2.13**{BLAS0000034_0056}**

220 S17 par (ii) **{CTA00000003_0055}**

the author of PAS 79 and the Inquiry's expert on the history of fire legislation[221] and (together with Dr Lane) on FRAs and Stokes' FRAs (see Todd's second report[222]) has drafted a further version of PAS 79 namely Part 2 covering housing which PAS 79-2 records was requested of Todd by the housing sector[223]. This version proceeds on the basis that PEEPs are not required in general needs housing[224]. The premise of this PAS is entirely at odds with the Inquiry's recommendations expressed in the Inquiry's Phase One recommendation that PEEPs should expressly be required[225]. Furthermore, insofar as Todd's views of Stokes' FRAs are concerned, are also *"diametrically opposed"* to those expressed by Dr Lane, particularly on legislative requirements for the evacuation of people with disabilities[226]. The divergence of views of these important experts will doubtless be the subject of extensive exploration.

4.8 Stokes approach to FRAs under PAS79

Todd's conclusion on Stokes' FRAs is that *"with the possible exception of the information on the external cladding"* he does not consider "*any of the... negative features were such that it could be said the FRA was not suitable and sufficient"*[227] .This conclusion is at odds with those of Dr Lane, who concludes, on careful analysis of the TMO's maintenance plans and FRA actions outstanding, that the risk was *intolerable*[228] as opposed to Stokes' *tolerable* rating. Todd's analysis is unlikely to bear scrutiny for the reasons explained below. Lane's analysis of the most fundamental failings is Stokes' failure: (1) to identify the occupancy of the building which is both a failure to identify the *relevant persons* as well as a failure to evaluate the risk to those persons and what was required to mitigate it[229];(2) to link the importance of shortcomings in passive/active measures and/or his FRA actions to risk they posed if not cured[230]; (3) failure to probe TMO's fire safety management in order to evaluate the risks to relevant persons[231]; and (4) failure to ask for/review the emergency plan for evacuation. Stokes' obsession with form over content (in some respects cutting and pasting either from earlier versions of the document, or from other documents entirely[232]) is wholly inconsistent with a careful assessment of the risks

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221 First Report dated March 2018 *Legislation Guidance and enforcing Authorities relevant to fire safety measures at Grenfell Tower* **{CTAR00000001}**

222 Second Report dated August 2020 *Fire Risk Assessments of Carl Stokes* **{CTA00000011}**

223 Not on Relativity and withdrawn following publication

224 Page 44

225 Phase One Report Part V Chapter 33 S12. ***Evacuation*** para 33.22e Page 777

226 Todd second para 8.69 **{CTA00000011_0086}** Lane 9/5.4.1-5.4.9 **{BLARP20000028_0064}**

227 Para 8.92 **{CTA00000011_0094}**

228 Lane 8/20.4.50 **{BLARP20000027_0499}**

229 Lane para 11.1.16 **{BLARP20000027_0247}**

230 This was an all-pervasive problem but see e.g. Stokes' failure to ascertain the operation of the smoke extract system and the likely consequences to the relevant persons if it failed to function s12.2.35 to 12.3.54 **{BLARP20000027_0272}**, his discovery of a recurring defect with the door closers, which he failed to record in any of his FRAs s16.6.10 **{_0397}** and the dry riser being overdue for service Lane 12.6.13-12.6.14 **{_0285}**. Note also Stokes' knowledge that ESAs had been disconnecting door closers and whilst he raised this with TMO, he did *not* mention the hazard in his subsequent FRAs nor whether it had been remedied: *See* Lane at 13.12.3-13.12.5 {**BLARP20000027_0320**}.

231 Lane 8/15.1.9 **{BLARP20000027_0342}**and TMOs management of FRA's of other occupiers of GT 8/15.4.48 **{_0363}**

232 For example, the reference to balconies in the context of pest control, whereas there were no balconies at Grenfell see e.g. June 2016 FRA **{CST00000070_0020}** but in all Stokes' FRAs from 2014 onwards. The basic template Stokes used from 2010 onwards appears to have been that which he prepared for YWCA Clarendon House Oxford **{CST00011394}** which is in turn broadly based on PAS79

posed by the building which requires careful review and re-assessment each time the FRA is reviewed to reflect changes. Cutting and pasting from previous versions also inhibits identification of those at risk and the measures necessary to protect them (both of which change over time) and assessment of risk in terms of the harm caused to the individuals most at risk. It is striking that Stokes' assessment ofi risk never changed even when he appreciated the ventilation was not working[233].He identified neither the increase in hazard posed by the refurbishment, nor the lack ofiavailability ofithe lift during that period[234].

4.8.1 ***Failure to understand the strategyifor Grenfell and Grenfell's key weaknessesifrom the outset.*** Stokes prepared certainly his first and second FRAs (and possibly also his third, in November 2012) without the benefit of any existing fire safety strategy ("**E**FSS") for GT. The EFSS was first produced on 16.**8**.12 and Stokes does not appear to have received it before 10.1.13[235]. Dr Lane's opinion that it was not possible for the RP to discharge their fire safety duties properly without an EFSS, and that Exova's findings in the EFSS ought also to have been recorded as Significant Findings in the FRA[236]. Stokes also does not appear to have himself measured the travel distances from flat doors to the stair doors at GT[237]. This remained so even once he had received Exova's EFSS, which also did not contain the travel distances[238]. Although his FRAs from 2010 onwards tick the boxes: *"Are travel distances in dead ends suitably limited?"* and *"Are the travel distances suitable for disabledipeople?"*, [239] in fact the travel distances on levels **4**-23 from the number **4** flats were non-compliant at the time Grenfell was constructed, and both the 5 and 6 flats exceeded the maximum permissible under current guidance[240].Stokes therefore either did not measure at all, or measured incorrectly, as he should have noted these excessive distances in his Significant Findings[241].By the same token, it appears Stokes was never satisfied as to the adequacy ofithe ventilation[242].The significance ofithis is that is that ifihe did not know

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233 Stokes also failed to advise the TMO of *"their duty to provide a suitable system of maintenance"* and *"the mitigation measures they should take to reduce the risks to persons due to the inoperability of the smoke control system between 2009-2015"*: Lane 8/12.3.38 **{BLARP20000027_0272}**. Post-upgrade, Stokes appears to have regarded maintenance as irrelevant to his FRAs (in his April and June 2016 FRAs, he marked the box for testing/maintenance as *"N/A"*) and as such failed to address the LFEPA's concern (in the 2014 Deficiency Notice) that effective monitoring of the system should be implemented (Lane 8/ 19.7.67**{_0464}**) and simply relied upon the fact that the system was new to address this point (Lane 8/ 12.3.70 **{_0277}**).

234 Lane 8/17.3.10 {**BLARP20000027_0405}** and Table 17-2 at**{_0410}**

235 Email Dunkerton to Stokes attaching Exova's initial Design Note (JW13703DN) and existing Fire Strategy **{CST00003104}**

236 **T/61/22:1-6** and the first Fire Safety Engineer Report par 5.4.19 **{BLARP20000003_0117}** removed in error from second version but Lane wishes to reinstate it: **T/61/40:3-18**

237 2009 FRA Item 6.5 **{CST00000631_0012}**. Plans emailed by Stokes to Wray on 15.1.11 **{CST00002344}** and **{CST00002104}** appear to have been *"altered"* by him on 20.10.10 **{CST00002345}** to **{CST00002352}{CST00001256}** to **{CST000001258}** but there is no initial drawing date and no dimensions of any kind including travel distances. In his 2016 FRA in the *"definitions"* **{CST00000070_0035}** travel distance includes the following *"....If the building has been constructed in accordance with The Building Regulations and no unauthorised alterations have then place[sic]then the travel distances will be satisfactory"*. That is tantamount to a statement that he had not measured them.

238 Dr Lane **T/61/113:9 to 114:11**

239 See e.g. November 2012 FRA s12 **{CST00000471__0018}**

240 Dr Lane 2.21.43 **{BLAS0000002_0057}**and **{BLAS0000037_0025**} Figure 15.5 and **Phase One T/15:7 to 16:17**

241 **Phase Two T/61/22:1-6** and the first Fire Safety Engineer Report par 5.4.19 **{BLARP20000003_0117}** removed in error from second version but Dr Lane wishes to reinstate it: **T/61/40:3-18**

242 Significant Findings items 19a)-e) Aril 2016 **{TMO10017691_0007}** and June 2016 item 19a) to f) **{CST00003098_0005}.** Although June 2016 FRA s 17 addresses some deficiencies **{LFB00000066_0027}** neither the April nor June FRAs (at s19) make clear that Stokes has not been able to check the system.

whether or how it functioned, he could not consider its impact on the means of escape. The potential lack of adequate ventilation and the fact that the distances from three flats on each floor from the fourth upwards exceeded the current permissible distance were clearly issues that should have been recorded as Significant Findings, and should have influenced the selection of the general fire precautions required by the RRO as being necessary to ensure the safety of the premises for its *relevant persons.*

4.8.2 Stokes' treatment of the Façade

(1) ***Obligation to risk assess the external wall.*** As stated above, if the external wall is combustible this is an unavoidable risk which must be evaluated under Sch 1 part 3 RRO. Stokes had, during the Refurbishment, recommended in his 2014 Record of Significant Findings that TMO obtain information from Rydon on the fire rating of the cladding[243], presumably with the intention that it should be risk assessed. Neither TMO nor Stokes ever established the nature of the cladding so as to risk assess the external wall. The FRA of the whole building, including the external wall should have been carried out after Practical Completion of the Refurbishment[244].Stokes did not provide a new FRA of the altered building but instead only a summary update by way of his June 2016 FRA. Lane considers that FRA deficient in that it characterised the cladding as *"fire rated"* as explained below and omitted significant components of the external wall namely insulation and infill panels. As a result TMO did not have a suitable and sufficient FRA, not least because it preceded receipt of the Reg 38 fire safety information provided by Rydon, albeit that information was inadequate[245].

(2) ***Stokes' implicit suggestion he had assessed the cladding.*** Even if, as Todd and others (FIA 2020 guidance[246]) assert, Stokes was not required to risk assess the cladding under the RRO[247], he suggested he had in fact done so. As Todd concedes, *"if at his own prerogative, a fire risk assessor includes in his FRA information beyond the minimum required by legislation, the Responsible Person is entitled to rely on that information"*[248]. Todd does not mention PAS 79 requires that Stokes should have included in his Significant Findings the combustibility or otherwise of the construction of the premises as *"given factors"* affecting the risk posed by the premises[249]. Stokes referred in his FRA to the Coroner's Lakanal recommendations as *"Important Relevant Information"*[250].Given that these recommendations included that ADB should be reviewed with *"... particular regard to the spread of fire over the external envelope... and ...whether proposed work might reduce existing fire protection"*[251], Stokes implicitly suggested that he had in fact risk assessed the

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243 **{CST00000002_ 0009}** Final item
244 Lane 8/17.8.2 **{BLARP20000027_0425}**
245 Lane 10/9.7.15- 9.7.17 **{BLARP20000032_0097}**
246 https://www.fia.uk.com/static/1af956eb-7630-4ae7-b04d0a82d475438b/FIA-Guidance-on-the-Issue-of-Cladding-and-External-Wall-Construction-in-Fire-Risk-Assessments-for-Multi-Occupied-Residential-Premises.pdf
247 See Todd's argument cladding does not form part of the common parts: Todd first report para 9.1.13- 9.1.14 **{CTAR00000001_0096}** and second report 11.9 first bullet **{CTA00000011_0105}**
248 Todd second report para 8.93 **{_0095}**
249 S5ix b **{CTAR00000003_0019}**
250 **{CST00000070_0008}**
251 **{CST00001802_0009}**

cladding. He described the cladding as *"new fire-rated cladding ...and the whole process has been overseen by ..RBKC Building Control... They have approved and accepted the fixing system and cladding used"*, thereby giving the impression that it was compliant[252]. TMO (Wray) was aware of the NSHFSG suggestion in a presentation of 30.4.13 that the *"Fire Risk Assessment should address potential for external fire spread*[253]. It is unclear whether Stokes was aware of this suggestion, but it is clear he failed to consider the impact of the cladding in the event of a fire at GT since he did not know the nature of the cladding panels or insulation at the time of his June 2016 FRA[254]. As such, he should not have described it as *"fire-rated"*, which is in any event a meaningless term[255], but also represented a misdescription of the hazard posed[256]. His failure to assess the risk posed by the cladding resulted in his overall assessment of risk and harm being flawed[257]: as Lane concludes in her Phase One report *"The building envelope created an intolerable risk ....resulting in extreme harm"*[258]. Todd's defence of Stokes' misdescription of the cladding is wholly unsatisfactory. Despite acknowledging that Stokes' treatment of the cladding might be a *"possible exception"* to Stokes' FRAs being suitable and sufficient, and including Stokes' description of the cladding as *"fire rated"* inclusion within his list of *"negative findings"* and *"minor criticisms"*[259] .Todd defends Stokes by suggesting that the fault may lie with the information provided to Stokes. Todd relies on the fact of Stokes' inadequate email in which he suggested he had asked for the compliance of cladding and wall dowsing[260]. Had Stokes reflected on this he would have realised there was no wall dowsing at Grenfell, but in any event this suggests awareness that the cladding was combustible and might need dowsing. There is no written evidence that Stokes obtained any detail of what the cladding was, beyond his own two manuscript notes on his 2014 Significant Findings[261], and he candidly admits now that he did not know the composition of the cladding system. Todd's defence of Stokes' treatment of the cladding raises questions both as to the quality of Todd's evidence, and as to the competency of fire risk assessors generally. Todd overlooks the fact that Stokes wholly failed to assess the cladding despite giving the impression he had done so.

4.**8.3** ***The Lifts.*** Stokes was obliged to consider whether the lifts could be used as part of the MOE and was aware that the evacuation of the disabled could not rely on the fire service[262]. In his first (2009) FRA, Stokes

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252 June 2016 FRA **{CST00000070_0004}**
253 **{TMO10002638 012}**
254 Stokes 1/177 **{CST00003063_0057}**
255 *Don't be a Flaming liability* **{RBK00059351}**
256 Lane 10/ 9.7.14 **{BLARP20000032_0097}**
257 Lane 10/6.18 & 10.6.19 **{BLARP20000032_0113}**
258 Para 2.25.50 **{BLAS0000002_0077}**
259 Todd 2nd paras 8.90 and 8.91, 6th bullet **{CTA00000011_0093}**
260 Email to Wray 19.4.17 **{CST00001100}**
261 **{CST00000002_0009}** and **{_0014}**
262 PAS 79 S15xxviii **{CTA00000003_0044}** " *consideration needs to be given to arrangements for [the evacuation of the disabled] in the event of fire... specially designated evacuation lifts or firefighting lifts (which can be used to evacuate disabled people in the premises...* " and xxix "*Disabled evacuation strategy should not rely on the rescue of disabled people by fire and rescue service...* "See also LGA Guide para 70.11 : consideration should be given to evacuation for disabled /elderly **{CTAR00000033_0112}**

recorded that he could not determine whether the lifts were firefighter ("FF") or evacuation lifts, but recommended that they be either FF or evacuation lifts[263]. By the time of his next FRA in December 2010 he described both lifts as evacuation/FF lifts which *"could be used in the evacuation of any disabled residents from the building"*[264]. This statement was repeated in all subsequent FRAs, but Stokes was aware in March 2010 that Wray and TMO's lift engineers had compiled a list of nine points relating to TMO's lifts servicing blocks over 18m, and Dr Lane considers that from this list it should have been obvious to him that the lifts did not have an additional power supply and did not have an escape hatch and therefore were not FF lifts[265]. Given lifts are a critical life safety feature, risk assessors should understand the different types, in order to evaluate the risk to relevant persons[266]. Although he did not in fact conclude that they were FF lifts at that point, in June 2010 he concluded that they could be used for the evacuation of the disabled, which Todd also accepts was an incorrect assumption[267]. From his 2012 FRA onwards, Stokes noted that there was no escape hatch in the lifts[268]. But in 2013 Stokes had highlighted in bold on TMO's fire safety strategy those lifts he considered to be FF lifts[269] and advised Wray of TMO that the lifts at Grenfell were FF lifts in March 2014[270]. Stokes' continued description of the lifts as FF lifts gave a false impression of fire risk control by referring to an active fire protection measure which did not exist[271].Both these occasions were after Stokes had been advised in February 2011 that Cahalam, TMO's lift engineer, did not consider the lifts FF lifts,[272] so Stokes had no basis for doing so[273]. His failure to ascertain whether the lifts were FF lifts meant a vital opportunity to identify necessary mitigating measures was lost[274]. Todd considers Stokes lacked knowledge of lift standards, but claims this does not detract from his competence as a fire risk assessor[275]. Even though Todd rejects Stokes' reasons for assuming the lifts were FF lifts,[276] he nevertheless seeks to justify Stokes' behaviour by assuming that his misunderstanding that the lifts were FF lifts originated from his time at Salvus, but this assumption is

263 Item 9.3 **{CST00000631_0014}** and **{_0018}**

264 **{CST00000703_0016}**

265 Lane 8/12.2.49-12.2.53**{BLARP20000027_0258}**

266 Wray email to Salvus 3.3.10 defining lift characteristics **{CST00010200}**As Todd says it is obvious from Wray/Calaham's description that the lifts were not FF lifts, as they had no duplicate power supply: Todd 2nd para 4.40 **{CTA00000011_0035}** and yet considers (para 8.74) *"... other than with respect to the lack of an emergency trap door.... there was nothing obvious to cause him to reconsider whether the lifts were compliant [FF]lifts"***{CTA00000011_0088}** Lane 8/12.2.20 **{BLARP20000027_0254}** and 12.2.26 **{_0255}** and see BS5588-5 1991 **{BSI00001721_0007}** which stated at clause 2.10 that only lifts which complied with that code could be designated FF lifts

267 Letter to Wray 23.6.10 **{CST00001822_0003}**and Todd 2nd para 8.68 **{CTA00000011_0086}**

268 S 19 **{CST00000471_0025}**

269 Highlighted amendments on TMO Fire safety strategy are Stokes' (see covering email Stokes to Wray 1.12.13 at **{CST00001159}.** Those in green are his inserts **{CST00001160 _0021}. S**ee Appendix 7 a**t {_0027}**

270 Email to Wray 12.3.14 **{CST00003073}**

271 Lane 8/12.2.67 **{BLARP20000027_0260}**

272 Wray email to Stokes forwarding Cahalam email **{CST00003080}**

273 Stokes' defence is that he relied on the March 2010 spreadsheet he had been sent characterising the lifts as FF lifts (row 33-34) but the list was initialled by Cahalarn on 5.2.10 **{CST00003185_0002}** -predating his 2011 statement that they were not FF lifts.

274 Lane 8/12.49-12.50 **{BLARP20000027_0258}**

275 Todd second para 8.60 **{CTA00000011_0084}**and para 8.71**{_0087}**

276 Todd second para 8.73 **{CTA00000011_0087}**

flawed[277]. On the important requirement to test the fireman's lift switch, Lane considers Stokes both failed to check the operation of the lifts himself and failed to advise TMO to check it[278]. She emphasises the importance not merely of turning the key but seeing whether it gave control to firefighters[279]. Both Lane[280] and Todd consider Stokes erred in his adaptation of the PAS 79 2007 template to suggest monthly not weekly testing of the switch. Todd bizarrely concludes that Stokes did not in fact intend monthly testing, but says that, in any event, monthly testing is what the most recent Scottish guidance requires[281]. This explanation is both self-contradictory and creates the impression Todd is at pains to exonerate Stokes. Had the switch been tested weekly, it might have become apparent that there was a risk of an incorrect key being used, and/or that the key design was not code compliant and that a different type of fireman's switch altogether should have been used[282]. More alarmingly still, Todd's view (contradicted by Lane) is that the *"**design of the lift [did not] significantly affect....the risk to relevant persons from fire**"*[283]. This is unknowable; had the lifts been FF lifts, either no key at all would have been required[284], or an emergency unlocking triangle key would have been required[285]. In either case, at least one and possibly more deaths could have been avoided[286], the lifts could have been used in a more effective way than they were, and many more lives could have been saved. As it was, Stokes' FRAs misleadingly recited that both lifts could be used for evacuation of disabled people. Coupled with the statement that PEEPs would be prepared[287], this led to a false impression as to the ability of disabled people to evacuate. Had it been recognised the lifts were not FF lifts, other precautions, especially for disabled people, might have been judged necessary.Suggestions that Stokes' misstatements concerning the lifts are not highly significant to the validity of the resultant FRAs raises cause for concern that the whole competency level for fire risk assessors is too low. Lane considers the competency and qualifications of assessors should be reviewed[288].

4.8.4 ***Failure to consider adequately the need for an emergency plan and the evacuation of disabled people.***

It should have been clear to Stokes that he needed to address Art 15 RRO and s i 5 and 16 of PAS 79 (MOE and Fire Safety Management). That included ensuring an emergency plan was in place, which would address

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277 Todd second paras 8.59 and 8.61, 3rd bullet **{CTA00000011_0084}** relying (by reference to 4.39 of his report) on a meeting dated 23.2.10 between Salvus, Cahalarn and Wray but at which Stokes was not present **{SAL00000042}.** There is no evidence that Stokes received this document, but even if he had, it would not support Todd's assumption since the meeting minutes record that *"...the group concluded that most of the Borough's lifts meet the majority (but not all) of the criteria which define a [FF] lift"*(emphasis added).

278 Lane has seen no evidence that it was checked: 8/12.2.39 **{BLARP20000027_0256}**

279 Lane 8/12.2.75 and 12.2.38 **{BLARP20000027_0261}{_0256}**

280 Lane 8/9.3.15 to 9.3.17 **{BLARP20000027_190}**

281 Todd second paras 8.77 to 8.87 **{CTA00000011_0090}**

282 Namely an *"emergency unlocking triangle"* type

283 Todd second para 8.73. **{CTA00000011_0087}**

284 but instead a lift switch behind a lockable door but with a glass front which could be broken in the event of fire: BS5588-5:1991 14.1 commentary**{BSI00001721_0029}** and Howkins para 64**{RHO00000003_0064}**

285 Howkins paras 281-283 **{RHO00000003_0131}**

286 Ali Yawar Jafari fell out of the lift with fatal consequences when it became packed with residents and the doors opened other than under firefighter control and more likely than not that Khadija Khaloufi met the same fate and likely M Tuccu. Phase 1 Report [33.13] [10.221] .

287 June 2016 FRA par 13 **{CST00000070_0024}**

288 Lane 8/6.5.43 **{BLARP20000027_0091}**

evacuation (including for the disabled) for those who either wished, or inevitably needed, to evacuate. Lane considers there was no up to date plan: the various iterations in existence were aimed at assigning roles/responsibilities within TMO and did not adequately record a current plan listing the actions required in the event of a fire at GT; only partial and often incorrect information was available in the FRAs and partial information in other policy documents, but even that information was not used[289].Stokes neither ensured there was a documented emergency plan as part of his FRA, nor raised the lack of such a plan with TMO[290]. Although Lane suggests that Stokes' reference to the LGA Guide in the context of the use of the lifts for the evacuation of the disabled was sufficient to alert TMO of the need for staff to be involved in evacuation, this was far from pellucid and was not understood by TMO as indicating they needed staff in the event of fire[291]. Lane concludes it was Stokes' obligation to obtain information about the vulnerable, as opposed to waiting to be asked, yet he *"substantially failed to adequately assess"* the arrangements needed for their evacuation[292]. Stokes should have appreciated the need for PEEPs in general needs housing like Grenfell (not solely sheltered housing)[293] and had drafted them at TMO sheltered housing, Gilray and Markland Houses[294]. At a meeting with Wray in June 2010 he was shown the appendices from the Government's *"[MOE]...for disabled people"* guide [295]. It is unclear whether Stokes considered, then or subsequently, the entirety of the guide but it made clear that *"there is a vast range of people"* including those with heart conditions/asthma, who fall into the category mobility impaired[296].TMO and Stokes knew it was increasingly common to have vulnerable residents in general needs housing. Despite Stokes recording (uncorrected by anyone at TMO) in his FRAs from 2010 to 2016 inclusive that PEEPs would be prepared based on data from the TP tracker, he did not use such data and nor did TMO monitor the effectiveness of occupancy profiling[297].Stokes clearly understood as at June 2016 that PEEPs had not been prepared for GT residents, and indeed for a large number of TMO's properties[298]. This is a good illustration of Stokes' failure to be in any way proactive: he should have pressed for the information, without which he could not assess the risk posed by GT to those with disabilities. He failed, contrary to the PAS 79

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289 Lane 9 9/8.2.15 **{BLARP20000028__0086}** Table 8-1 for list of emergency plans 2001-2016 **{BLARP0000028_0083}** and 8.7.2-8.7.6 **{_0111}**

290 Lane 9/8.4.11 to 8.4.17**{_ 0101}**

291 2014 FRA onwards **{CST00000092_0021}**and Lane 8/15.3.11- 15.3.17**{BLARP0000027_0353}**

292 Lane 6/ 13.3.9.3 to 13.9.7 **{BLARP20000034_0234}** 8/16.5.33 **{BLARP20000027_0396}**

293 Copied on email thread 30.9.10 re Claire Wise research article and Black confirming PEEPs required for general needs as well as sheltered/specialised housing see Black email to Dainith acknowledging *"... as and when people's disabilities are brought to our attention there is a need to produce a PEEP... in truth we have only done this is a small number of cases..."* **{CST00003989_0002}** Also Wray forwarded to Stokes a copy of Wise's email to herself and others confirming a meeting with LFB and their stance on the need for PEEPs, which was clearly applicable to general needs as well as sheltered housing and suggesting list of residents with special needs be kept in PIB **{CST00002275}.**

294 Gilray PEEP at **{CST00006149}** Markland at **{CST00021295}**

295 See Wray PEEPs statement para 2 **{TMO00862589}** and appendices JW1-JW10 and Stokes' letter 23.6.10 to her confirming discussion **{CST00001822}**

296 S4.2 **{RBK00045205_0022}**

297 Lane 6/10.7.36 **{BLARP2000034_0183}**

298 *"a comprehensive programme to gathering (sic) information about tenants including any disabilities....This information will be imputed (sic) on a "TP Tracker system"*(emphasis added) **{CST00000070_0024}.** Wray asserts PEEPs only prepared for sheltered housing PEEPs statement para 10 **{TMO00862589_0003}.**

template[299], either to state the approximate number of residents or identify the occupants especially at risk from fire. Similarly, he failed to record in his Significant Findings those with disabilities and the nature of their disabilities, thereby failing to advise TMO of the protection needed for the vulnerable. At the very least he should have alerted TMO to his failure to consider the occupancy profile[300]. It is unclear how he felt able to say there was no Grenfell resident with a hearing impairment[301]: there is no evidence that he was aware of specific conditions of any residents although he was aware of e.g. mobility scooters[302] and therefore knew there were residents with disabilities. In any event PAS 79 directed him to assume a certain number of residents would be elderly and/or have disabilities[303]. He failed to identify such residents and therefore failed to consider the effect fire would have on those persons in terms of time they would need to evacuate[304] or at all. Given PAS 79 expressly directs the risk assessor to assess the likely consequences of a fire and gives as a possible means of calculating these[305] the time likely to be taken to evacuate as opposed to the available time, it is reasonable to expect an assessor to have some knowledge of that subject. Insofar as the evacuation of the disabled is concerned, it had been established in the World Trade Centre evacuation that that the rate of evacuation of the 1,000 occupants with disabilities was half as fast as those experienced in drills[306]. As a result of Stokes' failure to consider at all the disabled population/the rate at which disabled people could evacuate if the need arose, he failed to consider the consequences of a fire and therefore failed to assess the degree of harm to be caused by a fire. Stokes was clearly cognisant of his and TMO's failure to prepare PEEPs at GT and elsewhere and was at pains to protect himself and TMO from the immediate consequences by advising TMO not to participate in LFB's sprinkler pilot for vulnerable people, since participation would draw LFB's attention to the lack of PEEPs and raise the question *"why they were not included in the FRA"*. He went so far as to suggest wording to put LFB off the scent by suggesting no vulnerable persons had as yet been identified[307].

4.9 RBKC's failings in relation to the FRAs/fire safety measures required by RRO.

4.9.1 ***Non-compliant leaseholder doors.*** Despite leaseholder doors being a standing item at scrutiny[308], RBKC sought over a prolonged period (from 2011 and still ongoing in May 2017) to avoid ensuring leaseholders'

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299 (2012)Paras 2 and 3 **{CTA00000003_0079}**

300 Lane 8/16.5.13-16.5.15 and 16.5.18**{BLARP20000027_0394}**

301 June 2016 FRA S13 ***"DISABLED PEOPLE"*** **{CST00000070_0023}**

302 **{CST00030186_0038}**

303 S15 para xxviii **{CTA00000003_0044}**

304 This is to be contrasted with his approach on other buildings where he appears to have understood the need to address the necessary time to escape by a person with disability: para 13 {**CST00011394_0021}**

305 Lane considers this guidance referred to in PAS 79 is not pertinent, but proffers no explanation as to how the consequences of a fire are to be assessed using PAS 79; Lane 8/9.6.4 and footnote 30 **{BLARP20000027_0199}** but this begs the question why PAS 79 refers in detail to to the BS 7974 guidance and its timelines if it is of no relevance

306 Crowder and Charters BRE Guide *Evacuating Vulnerable and Dependent people from buildings in an emergency* p1 Section 1 first para citing Galea & ors 2001 World Trade Centre Evacuation Springer 2007 p 225-238 https://www.gloucestershire.gov.uk/media/2088362/evac_vuln_people_from_bldgs_in_emer.pdf and some sources suggested the rate might be up to four times as slow**{RBK00026864_0006}**

307 *"A good response I believe would be thank you for this information if we find anyone in the future we will let you know"* (emphasis added) **{CST00016416}**. Pilot at **{CST00003191}** and covering email at **{CST00003190}**

308 Caliskan 1/62**{RBK00035166_0014}**

doors met minimum required fire safety standards using powers under the HA to risk assess using the HHSRS. It instead sought to persuade LFB to enforce directly against leaseholders under RRO notwithstanding LFB's clear advice to enforce under the HA[309]. RBKC may not have been alone in adopting this stance, although it knew other boroughs were using the HA[310]. RBKC clearly appreciated that it was failing to comply with the RRO in this respect, hence its submission to the SS[311] which albeit not so characterised was effectively a submission under Art 36, namely where the RP has failed to comply with the RRO, and in any event RBKC admitted it had identified 68 potentially non-compliant leaseholder doors[312]. By its submission, RBKC asserted LFEPA was acting in breach of both the protocol agreed between them[313]and the protocol approved by SS[314]. RBKC and TMO had sought counsel's advice pending the SS determination and this apparently *"largely supported RBKC's position"* but it also suggested that TMO's actions to identify non-compliant doors and inform the lessee represented *"due diligence"*[315] (a defence to breach of RRO). RBKC noted that counsel's advice was that TMO's writing to leaseholders constituted due diligence but noted also that it had identified the worst offending doors so that "... *in the event of one of the statutory authorities undertaking an enforcement pilot these can be targeted"*(emphasis added)[316].In adopting this approach of awaiting prosecution and calculating risks caused by non-compliant doors both on the micro[317] and macro level, RBKC demonstrated a cavalier attitude to safety. Despite being aware of the risks to safety posed by poor compartmentation including doors, it appears it made a cynical calculation of potential loss/risk versus cost of seeking to replace doors and recoup costs: *"The issue would be that if something did happen at one of our properties, we are still likely to be the organisation that faces prosecution. We therefore have to weigh up the potential cost of dealing with this issue, against the situation we would face if something happened and we were found liable"* (emphasis added). This was within an internal email in which the writer had noted that there was no realistic prospect of criminal prosecution of Southwark LBC in relation to Lakanal and that the prosecution had just been

309 See eg email Andy Jack LFB to RBKC/TMO **{CST00001085}** and A Jacks email to RBKC 16.8.13 recording meeting on 8.11.12 and Jack email to Stokes Wray and RBKC recording meeting 8.11.12 **{LFB00032145}**

310 See email 14.9.13 N Comery to P Brace and ors at LFB *"If this crops up with other housing providers could you please let me know"***{LFB00032145}**. Also RBKC Environmental Health meeting with TMO re doors in which it is recorded H&F were using the HA**{RBK00013240}.** Brent Housing Partnership offered replacement front doors free of charge **{TMO10039954_0003}** But note High Rise Forum subgroup minutes **{LFB00000251_0002}** para 2 at 6th & 7th bullets Andy Jack comments *"-the fact that many local authorities and housing associations have spent substantial sums ..on legal advice on the issue of who has responsibility for flat front doors - The importance of putting money to the best use"*

311 Submission dated 30.1.13 at **{RBK00013757}**

312 Para 5 **{_0003}**

313 Dated 1.10.11 **{LFB00031977_0069}**

314 Incorporated into LACORS guide Appendix 2 **{RBK00003076_0065}**

315 Para 7 TMO H&S Com meeting 16.4.13**{TMO10002637_0003}.** Despite RBKC's signature of the Hillsborough Charter and its expression of willingness to cooperate with GTI (Phase 1 opening para 2**{RBK00026858_0001}**) RBKC has claimed privilege in respect of this advice and a large number of emails produced by Vachino, RBKC's in-house solicitor e.g. **{TMO00869658}.** It should waive any claim to privilege over these documents: selective disclosure of correspondence can create a emisleading impression.

316 Para 8.2 L Johnson Report for HSPC 16.7.13 **{RBK00032449_0011}**

317 L. Johnson wondering about the impact of non-compliant doors on insurance on the same date as her HSPC report **{RBK00059579_0015}**

dropped[318]. There can be no room for any form of cost benefit analysis when RBKC was under a statutory obligation to keep the protected route safe, and lives were at stake. Even as late as May 2017, when two councillors were suggesting RBKC should replace leaseholder doors at Trellick Tower, regardless of whether they would be reimbursed as this would be safer for the block in the event of fire, they were overruled by L Johnson who described it as a *"non-issue"*[319].This demonstrates a staggering lack of respect for safety which could only have been tolerated with a culture and leadership with scant regard for safety. Given RBKC's awareness of the crucial importance of doors (see below) it is extraordinary that RBKC/TMO took any comfort from the suggestion that they were acting with due diligence. The SS declined to determine the dispute, noting it had no role in directing public authorities on their use of enforcement powers, but expressing the view that the powers available under HA were sufficient to enable LAs to address fire hazards[320]. Having "*tried valiantly to deflect responsibility for this to the LFB*", Johnson decided RBKC was "*not going to win the argument*"[321]. But even then, RBKC continued to allow the situation of non-compliant doors to remain. It had been warned in August 2014 in the context of the requirements of the RRO concerning flat entrance doors that "*...flat entrance doors in blocks are critical to safety of the common parts in the event of a fire within a flat"* and that LFB would usually seek to enforce that requirement by action against the freeholder[322]. RBKC's Building Control Department's Paul Hanson was also warned in September 2014 by LABC's email[323] "*Fire doors are an important part in every building and they are often the first line of defence in a fire. Their correct specification, maintenance and management can be the difference between life and death for building occupants. However, they remain a significant area of neglect"*. Against this backdrop, it is extraordinary that RBKC adopted the stance it did on leaseholder doors, over such a prolonged period. It was a failure to preserve a safe MOE as required by the RRO[324] in circumstances where RBKC was clearly aware as from June 2012 that it could enforce under the HA, and that Hammersmith & Fulham ("H&F") and also the Westminster ALMO were doing so[325]. RBKC's objections to using the method prescribed by the HA namely the HHSRS appear unsound[326]. RBKC knew HHSRS could be used and that LFB and DCLG expected such use.

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318 Keane email 13.6.12 to L Johnson, A Johnson and Cahskan **{RBK00045661_0005}**

319 *We've been through this before and I refuse to open this up again as a subject for Cllr Pascal to dwell on,....*
I wouldn't contact Cllr Pascall or Mackover on this, it's a non-issue that they are trying to turn into something because we've reported on it before.." **{RBK00023400_0002}**

320 DCLG letters 29.4.13 **{LFB00054647}** and 3.7.13 **{RBK00001475}**

321 Email L. Johnson to Keane, A Johnson, Wray and ors cc Black 21.8.13 **{TMO00869658_0005}**

322 Email N Austin Director for Environmental Health of Hammersmith and Fulham and to Cllr Borwick RBKC "*The flat entrance doors are critical to the safety of the common parts in the event of a fire within a flat"* **{RBK00029909}**

323 **{RBK00030489}**

324 Art 14(2)(b) and Art 17

325 RBKC Environmental Health and TMO meeting re Leaseholder Fire Doors 8.6.12 item 2 **{RBK00013240_0001}** and email thread 14.6.12 Wray, City West Homes and Stokes **{CST00002988}**

326 *"In brief it is not a case of assessing just the fire door in isolation. The assessment needs to have consideration of the individual flat, common parts, other substandard doors in the building, access to those flats and any anomalies re escape route. The fire safety of the whole building would need to be considered"*. Item 3 **{RBK00013240_0002}.** If RBKC did not wish to do this it could simply replace the doors free of charge as other boroughs had done.

4.9.2 ***Door closers.*** RBKC adopted a similarly irresponsible attitude in relation to the absence of door closers: cost management/savings took priority over safety. RBKC did not take a decision to fit door closers until March 2017[327] despite the fact that from as early as 2009 it had been aware of the criticality of door closers to the stay put policy[328]. On 31.10.15[329], a serious fire occurred at Adair Tower, in which the flat of origin's door failed to close due to a lack of door closer, filling the lobby with hot gases and heavy smoke[330] and 24 fire survival calls were received[331](in that respect resonant of Lakanal). A Deficiency Notice had been issued prior to the fire, identifying a failure to address the absence of self-closing devices, which absence had, extraordinarily, been noted in the Adair FRA[332].The LFB Post Fire Review Report noted: *"[FRA]Questions raised about failure to give weight to identified lack of self closing devices to front doors despite original design requiring self closing flat entry doors..."*[333].Thereafter Enforcement Notices were issued on Adair and Hazelwood Towers, including for failure to fit door closers in December 2015 and January 2016 respectively[334] and a Deficiency Notice was issued in November 2016 on GT also including a failure to fit door closers[335]. Exova had advised in March 2016 in relation to Adair and Hazelwood that all flat entrance doors required self-closing devices[336]. RBKC therefore had full knowledge of the extensive issues and fire risks to which lack of door closers was giving rise, and yet failed to act decisively by committing to install closers until nearly two years after they had seen the serious consequences of this omission. Even then, at the March 2017 meeting at which Laura Johnson gave approval for a door closer installation programme,[337] she pushed the installation of door closers from a 3 to a 5 year programme: *"...it will make funding the programme more manageable."* At that meeting she also decided not to instigate a programme of annual inspection, not being convinced of the need for an inspection programme, and aware it *"...would have to be ongoing and therefore an additional expense to the HRA indefinitely, without any identifiable evidence that it impacted positively on the fire safety of residents"*. This was a misguided and perverse perspective, given that 2 years earlier Johnson/RBKC had already had the best evidence of the devastation which ensued in fire if a door fails to close (Adair). The Sleeping Guide recommended 6 monthly checks for fire door closers[338]. Johnson clearly understood the need to check doors regularly and had incorrectly told a councillor that there was an *"annual programme"*[339]. Whilst Stokes noted obviously defective doors in his Significant Findings, that was only every 2 years. Similarly, asked in 2016

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327 At a Joint Management Team Meeting **{RBK00046603}**

328 TMO FRA meeting with LFB and RBKC 6.8.09 Item 9 ***Evacuation Strategies*** **{LFB00001529_0003}**

329 As recorded in LFB Post Fire Review Report **{LFB00001627}**

330 M. Terry email 2.11.15 to Burton and ors **{LFB00001614_0002}**

331 LFB *Senior Fire Safety Officer's Report* 31.10.15**{LFB00001626_0001}**

332 See under Art17(1) first column **{LFB00084110_0004}**

333 Dated 31.10.15 under ***"FSR Follow up Actions"*** **{LFB00001627_0004}**

334 Dated 23.12.15 {**CST00007046_0005}** and dated 18.1.16 **{TMO10011891_0005}**

335 Dated 17.11.16 **{TMO00832135_0006}**

336 Exova's fire safety engineering risk assessment Report for TMO ***Adair & Hazlewood Towers*** par 3.3 **{TMO00860203_0008}**

337 Recorded in her email 6.3.17 **{RBK00046603}**

338 Appendix A**{RBK00036722 _0120}** and annual checks for the fit of self-closing fire doors on the protected route **{_0121}**

339 Minutes of the HPSC 13.5.15 Item A5 *".. TMO tenant doors were checked for fire safety compliance as part of an annual programme and replaced if non compliant* **{RBK00014448_0002}**

about whether RBKC complied with requirements for self-closers at blocks other than Adair, Johnson confirmed this saying "*door closers were uniformly fitted*". There was no basis for this assertion. Taken together with her belligerent attitude towards any LFB action brought in respect of Adair based on a belief that RBKC had "*done all it could*"[340], it suggests a deep-seated disregard for safety. The fact that Johnson felt able to mislead councillors as to safety is a clear manifestation of poor culture. This in turn appears to have infected TMO who appear to have agreed with Johnson that the installation programme should be 5 years not 3 and agreed not to have an inspection programme[341]. Moreover, it put RBKC in breach of duties as RP under Art 17(1) to maintain a safe MOE via a protected route[342].

4.9.3 ***MOE for disabled.*** RBKC was originally a trailblazer for accessible housing; having procured an access audit for the purposes of making reasonable adjustments in accordance with the Disability Discrimination Act 1995[343]. Such an audit ought to have taken account of the adequacy of MOE and ease of use of door opening /closing devices[344]. RBKC was also the first London Borough to complete a stock survey using the London Accessible Housing Register[345], and was aware from June 2009 that PEEPs were required for residents of sheltered housing because it was told it would receive an enforcement notice due to Gilray House not having any PEEPs[346]. RBKC's Claire Wise's response to TMO's notification of this fact suggests she did not at that time understand that RRO applied to common parts of domestic premises, but in noting an "*...opportunity for collaborative working with... [LFB] to develop a model that can be applied across the remaining TMO buildings*"[347].It was clear she was referring to all housing, not merely sheltered housing. Wise advised RBKC in her September 2010 research paper that although MOE for people with disabilities in high rise buildings was not specifically addressed in legislation, the RRO "*requires all users of a building to be considered in a risk assessment...an understanding of disability is critical in ensuring that disabled residents are accounted for in an appropriate and respectful way...Specifying that disabled people should not live above ground -floor level acknowledges that existing fire safety features of many buildings are not inclusive. Resolving this should be a*

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340 At HPSC 13.7.16 item A9 **{RBK00048170_0005}**

341 e.g. paper by Wray entitled "*Review of Fire Strategy – update on self-closers*" dated 16.3.17 which states at paragraph 3 that "*it has been agreed that, at this stage, we will not be instigating a dedicated inspection/maintenance programme for these [self closing] devices*" it was further noted that if the LFB sought to enforce this the TMO "*would take legal advice and make representations to the GLA in advance of instigating an inspection programme*" **{TMO10016192}**.Also Lane's criticisms of this approach at 4/13.13.29 of **{BLARP20000030_0244}**

342 See Deficiency Notice at Grenfell **{TMO00832135_0005}.** Also Lane 4/11.7.13 **{BLARP20000030_0190}**.

343 Albeit noting a lack of clarity as to whether RBKC/TMO was under any obligation in relation to the common parts **{RBK00059464_0004}**

344 RIBA "*Access Audit Handbook*" 2013 in RBKC's possession **{RBK00045171_0014}** s.3.1 ***"Audit methodology…*** *importantly the auditor should also consider how easy a building is to exit...*" and ***"Means of escape-*** *The means and route of escape from a site or building in an emergency is equally important as the route of entry and should be fully considered in any audit*" **{_0031}**. See also s 12 ***"Doors – opening and closing systems"*** **{0117- 0119}**

345 Homes and Housing Group Meeting RBKC 30.1.12 para 7 **{RBK00030113_0004}**

346 Email 17.6.09 Wray to Black forwarded by Wray to RBKC (Daimith/L Johnson) **{RBK00052528_0003}**

347 **{RBK00052528_0002}**

priority as opposed to placing restrictions on those who cannot meet current evacuation processes"[348]. In a briefing note to LFB in 2012, Wise expressly acknowledged that RBKC was not entitled to exclude people from buildings based on disability/age[349].This awareness, together with RBKC Building Control's awareness of the revisions introduced by ADB 2006 requiring MOE for the disabled[350] may explain why RBKC had, in December 2010, adopted a Supplementary Planning Document as part of its Local Development Framework ("**LDF Guide**") requiring the highest standards for inclusive (accessible) design[351]. Though the LDF guide was expressed to apply to new builds, it also noted that *"...extra consideration will often be required when improving the accessibility of many of its existing buildings ...the guidance ..should be applied where practical and feasible"*[352]. RBKC seems to have become aware of a presentation by the *Fire Evacuation and Inclusive Design Group* dated 2.3.11 which noted that disabled persons made up 18% of the population and could take up to four times longer to evacuate[353]. Accessibility of design for disabled people was therefore at the forefront of RBKC's mind when it came to consider developing GT. LFB had repeatedly made clear to RBKC the need for it to be made aware of residents with vulnerabilities and of the need for this to be recorded in FRAs and in Premises Information Boxes[354]. Despite this, RBKC fell woefully short of its own requirements: instead of resolving the MOE issues for people with disabled, it sometimes sought through TMO (contrary to Wise's Paper), to re-home the disabled rather than cater for them[355]. In June 2015, RBKC was reminded that in buildings over four storeys with a sleeping risk, a single stair, and only one exit, sprinklers would be needed[356].Though this relates to the conversion of a single dwelling house, it was a timely, but unheeded, reminder of the difficulties posed by single stair escapes in buildings with a sleeping risk. As RBKC stated in its own LDF Guide, the requirements of inclusive design demanded that MOE be accessible[357], and this issue

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348 Claire Wise paper in FRM journal *"Inclusive Needs"* **{RBK00030073_0003}** sent by J Dainith RBKC to R Black 28.9.10 **{CST00003989}**

349 Wise's briefing note to LFB (sent by her email to Coombe 15.8.12 **{CST00006033**}) referring to 16.13 LGA Guide (re purpose built blocks) **{RBK00053707_0003}** and covering email at **{RBK00053706}**. Wise's statement followed RBKC embarking in July/August 2012 on a 6 month pilot scheme to ensure those on the Common Housing Register but needing high cost adaptations were prioritised for Accessible Housing instead**{RBK00059451}** and **{RBK00059461}.** In her original draft of jointly produced guidance in October 2012 (RBKC/LFB) for sheltered housing providers**{RBK00026107}** see covering email at **{RBK00026106}** she was still proposing that as an alternative to sprinklers etc, the *"... resident could be encouraged to move to more accessible housing"* This was deleted in the LFB/RBKC final draft **{RBK00000777}.**

350 Instructions to MOE surveyors ***"Disabled Escape"*{RBK00045044__0002}** referring to 0.19 of ADB **{CLG00000224_0013}**

351 Para 1.1 **{RBK00050645_0005}** and Annex 1 para 1.0.1 **{_0043}.** Note that this version is not identical to that adopted in December 2010: see cover sheet for date of adoption https://www.rbkc.gov.uk/wamdocs/Access Desing Guide SPD - December 2010.pdf

352 Para 1.1.2 **{RBK00050645_0005}**

353 **{RBK00026864_0006}**

354 Wise to A Johnson cc Wray 26.9.12 **{TMO00863422}**.This was in the context of sheltered housing but as RBKC had been informed 15.8.12 was an issue also in general needs housing: Wise/N Coombe LFB email exchange **{CST00006033 }.** In any event Black had already accepted PEEPs were required for all disabled residents (regardless of how accommodated) in his email 30.9.10 to Dainith L Johnson and Wray **{CST00003989}**

355 Statement of Millicent Williams paras 78-87 **{{TMO00879804_0011}**Runs counter to ADB 0.19: *"..not appropriate... to presume certain groups ... will be excluded from a building because of its use"* **{CLG00000224_0013}**

356 Head of Building Control John Allen **{RBK00051048}** LABC *Means of Escape from Dwelling Houses with Four or More Storeys* **{RBK00051049}** and **{RBK00051050_0004}**

357 **{RBK00050645_0033}**

together with its associated fire safety strategy *"...should be treated as an integral part of the design process and not as a separate issue"*[358].It was also known to RBKC that altering existing buildings could increase the fire risk profile (as had been the case at Lakanal). The refurbishment offered an opportunity to rethink MOE for people with disabilities,and RBKC had originally intended wheelchair friendly flats in the new accommodation at GT, but this did not materialise[359]. RBKC was aware that the problem of ensuring adequate MOE for the disabled was not a problem confined to specialised housing but was increasingly relevant to general needs blocks. In these circumstances, it is an extraordinary failing by RBKC not to have followed through its original suggestion that there be a KPI for improving accessibility and thereby MOE (para 2.2.2 above) and not to have recognised the need for it to ensure that the TMO sought and obtained data on vulnerable people for the purpose of preparing PEEPs.

4.10 TMO's failings in relation to the FRAs/ fire safety measures required by RRO

4.10.1 ***Leaseholder Doors.*** TMO knew that they were not complying with the RRO. Salvus' 2009 FRA had recommended that *"a sytem of formal checks on tenant fire doors and all other fire compartment doors is introduced... to ensure fire compartments remain fit for purpose"*[360]. Counsel's advice had been obtained jointly by RBKC and TMO to advise on the issue and apparently as at April 2013 Counsel considered TMO were exercising due diligence[361]. This defence to breach of RRO was obviously only being considered because it was accepted the requirements of RRO were not being met. It is hard to see how TMO can have thought they were exercising due diligence in relation to non-compliant leaseholder doors especially given Maddison in September that year did not seem to be aware of what action was being taken and was aware of 68 potentially defective doors[362]. In July 2012 Stokes had warned TMO of non-compliant doors: *"If it is that dangerous must be sorted out immediately"*,[363] though he also encouraged TMO's focus upon "*evidence to show due diligence*" even if this was limited to an email saying "*whilst having the required survey from Banham's, I was assured the front door was fire rated*"[364]. In 2015, Stokes expressly drew Wray's attention to the fact that landlords were being prosecuted for non-compliant doors which were on the protected route[365]. It is plain that TMO and Stokes' focus was on avoiding liability rather than on fire safety for its own sake.

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358 Para 4.6 BS9991:2015 **{RBK00036238_0031}.**The predecessor BS9991:2011 para 4.6 was to like effect **{CTAR00000040_0035}**

359 See emails 29.11.12 Trethewey and Wise {**RBK00045717**} 13.8.13 Sounes to DBA **{SEA00008055}** who had been instructed to carry out an accessibility check for Grenfell

360 Item 3.4 {**CST00000631_0016**}

361 TMO H&S Committee 16.4.13 **{TMO10002637_0003}**

362 PM notebook entry 4.9.13: "*LH Firedoors: RBKC → TMO. Whats happening and who? 68 potentially defective fire doors* **{TMO00879773_0049}**

363 Stokes'comments highlighted in yellow on H&F letter to leaseholders **{CST00002710_0002}** and covering email at **{CST00002709}**

364 {**CST00003615**} at {**0001**} (Email from Stokes 17.1.13) and {**0002**} (email from TMO resident).

365 Stokes email to Wray 7.5.15 **{CST00023173}**

4.10.2 ***Door Closers.*** TMO was aware that door closers had been required since 2009 and were essential to any evacuation strategy, including stay put[366]. In 2011 Stokes told TMO in terms that the removal of door closers on the protected route was *"...placing relevant persons at risk of death or serious injury in the case of a fire"*[367]. If a firm reminder were needed, the Deficiency Notice requiring self-closers on all doors at Adair[368] and the subsequent serious fire there should have sufficed, together with Exova's subsequent report advising all flat entrance doors must be self-closing[369]. Instead, faced with possible prosecutions relating to the Adair fire, TMO sought to resist installing self-closing doors at all properties, seeking instead to instruct counsel to consider whether they were only required where it was a *"fundamental part of the fire strategy for the building"* and wondering *"How can we best transfer responsibility [for maintenance of closers] onto the tenant?"*[370]. Stokes, to whom this question was forwarded,[371] made clear all new flat entrance doors must be fitted with closers, but that it wasn't retrospective[372]. TMO clearly knew prior to the Adair fire that LFB required all doors to have closers and be inspected regularly. It considered LFB's interpretation of RRO to require urgent replacement/repair of self-closers more quickly than TMO planned. TMO (Wray) knew L Johnson was resistant to a borough wide programme of fitting self-closers[373] and even after the Adair fire appear initially to have agreed with her decision, in March 2017, not to institutean inspection programme [374]. RBKC's suggestion not to inspect does not excuse TMO's failings in this regard: they had had clear warnings from both LFB and Exova as to the need for door closers and regular inspections and should have advised RBKC accordingly in strong terms. TMO exhibits the same tendency shown by RBKC in relation to leaseholder doors: to acknowledge the risk of prosecution if the self-closers were not installed, but to address this in the context of *"feasibility"* (meaning cost) seeking to explore *"other options"* with RBKC[375].

4.10.3 ***Failure to implement findings of LFB Audits under Art. 27 RRO.*** TMO showed an inexcusably lax attitude to the rectification of deficiencies notified by LFB audits. At GT this was so since at least November

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366 TMO (Keith Holloway) meeting with LFB and RBKC re FRAs item 9 "Discussion re stay put/defend in place *"if people were more aware of the importance of door closures ... they may be less likely to remove them"* **{LFB00001529_0003}**

367 Stokes' letter to Wray 4.8.11 **{TMO00867927}** which followed Webster/Acosta/Stokes email thread 4.8.11 **{TMO00867924}**

368 **{LFB00084110}**

369 ***"Adair & Hazlewood Towers KCTMO"*** para 3.3**{TMO00860203_008};** LFB also explicitly advised TMO that its policy of only checking that self-closers were fitted/operational when properties became void was not a sufficient level of checking: *See* Bi-Monthly Meeting between LFB and TMO on 5.1.16 {**LFB00000061_0003**}. Also Wray email to Black and Matthews on 5.1.16 confirming LFB's advice that "*ALL flat entrance doors throughout our stock are required to be self-closing"* and the advice that TMO's policy of checking when properties are void did not go "*far enough"* and that TMO required a "*procedure in place for regular checking of these and this would need to be documented"* {**TMO00840453**}

370 Maddison email 14.10.16 to Wray and others **{TMO00840728_0001}**

371 Email 27.10.16 **{TMO00843871}**

372 This view was incorrect: Lane 4/4.4.3 and 4.4.12 **{BLARP20000030_0050}**: the guidance is unanimous that self-closers are essential in all cases. This was not the first time that Stokes had expressed this view, which appears to have heavily influenced TMO's policy on door closers at Adair Tower e.g. Maddison's view on 20.11.15 that it was not necessary for the installation of door closers in Adair Tower to be categorised as *"High"* in part because "*It is not a statutory requirement to install self closers retrospectively..."* {**TMO00866489**} and the response of B Matthews that "*I agree with Peter... that this finding should be low ... there is no regulation requiring the retro fit of self closers..."* {**CST00008885**}.

373 Wray to Ian Lines 6.10.16 **{TMO00840701}**

374 TMO H&S Committee 16.3.17 par 3 **{TMO10016247}**

375 TMO H&S Committee meeting 19.1.17 tem 6**{TMO00840763_0006}**

2009 when four non-compliances were identified including GT lobby doors not fitting into the frames and lack of self-closers on flat entrance doors[376]. Stokes' first FRA 13 months later noted self-closing doors on staircases not closing [377] which provided TMO with evidence that it had not completed the four items the LFB notified as deficient. As set out above, prior to the Adair fire, LFB had issued a Deficiency Notice requiring self-closers on Adair[378] but this had not been actioned by the time of the fire[379]. TMO received two Deficiency Notices in relation to GT (on 24.3.14[380] and on 17.11.16[381]) but did not act upon either by the LFB deadline, and it seems that the last Notice which required action by 18.5.17 had only one out of five non-compliances resolved by the fire (the installation of fire action notices which had not been present during the period 2010-2016[382]). An installation programme for flat door closers had not started and fire stopping had not been remedied[383].

4.10.4 ***TMO health and safety governance failings.***

(1)*Lack of effective FRMS* Salvus had in 2009 *"strongly advised"* that a fire safety policy setting out the objectives *"including ...achieving full compliance with ...[RRO]"* be introduced[384]. Almost half the items in Salvus' review constituted a *"statutory breach"* Despite this the first TMO Fire Safety Strategy did not materialise until September 2012, was then commented on by Stokes[385] and seemingly adopted by the end of 2013[386]. An audit for Robert Black in July 2013 **"Hodgson's Audit"** (commissioned pursuant to the RBKC led April 2013 Audit[387]) established that there were fundamental problems with TMO's approach to health and safety, which *"...could potentially expose the business and those in H&S management positions to corporate and personal liabilities"*. Among the problems identified was a lack of data available to the Executive Team [388].The TMO policy arrangements also did not reflect the risks to the business as had been found in the properties inspected, which included Trellick Tower and GT. *"The governance of H&S requires a serious review as the responsibility for different risk areas sit within different departments and not because the decision was made at committee but more through default"*. The audit also identified at recommendation 2 *"the significant volume [of] outstanding actions unresolved in statutory reports especially in relation to fire risk assessments"*. This was reiterated more starkly in recommendation 28 which read "*Clear the outstanding FRA*

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376 Notification of *"compliance level 1 with "verbal action only"* **{LFB00000144_0005}**
377 Significant Findings and Action plan 29.12.10 item 12 a **{CST00000448}**
378 Adair NOD 12.10.15 **{LFB00084110}**
379 Matt Ramsey – Wray email 18.7.17 **{LFB00001617}**
380 24.3.14 **{LFB00000068}**
381 **{TMO00832135}**
382 Lane 8/19.8.18 **{BLARP20000027_0470}**
383 Lane 8/19.8.34 **{_0477}**
384 Salvus "*Fire Risk Assessment for Fire Safety Policy and Procedures*" item 1.1 **{SAL00000013_0005}**
385 Stokes' email to Wray 1.12.13 **{CST00001159}** and policy with comments at **{CST00001160}**
386 Version of Strategy dated 22.11.13 {**TMO10004486}**
387 Para 11 **{RBK00000313_0004}**
388 *"Without meaningful data on statutory/mandatory risk assessments and best practice inspections the H&S committees and Executive Board are unable to demand and review information to assess compliance with ...[TMO] H&S policy"*. S. 2.1 **{TMO10003124__0008}**

actions from previous years". RBKC was aware of the fact of the audit[389] but received an edited version of the report. This changed the priority of recommendation 3 (to establish procedures for management of all property risks) from priority 1 to priority 2. It also flagged as a priority 1 recommendation the need for maintenance of the lifts in accordance with regulation[390]. Recommendation 28 was removed in the final version of the report[391]. Lane has analysed the respects in which Hodgson's Audit reiterated the deficiencies in TMO's systems identified in Salvus' 2009 review, concludes they are broadly similar and demonstrates TMO did not have an effective system of fire safety management[392]. Despite noting the need to strengthen its H&S department and implement the Hodgson recommendations[393], TMO failed to recognise its management deficiencies and indeed lauded itself as having been given a clean bill of health by both internal and external audits[394]. From 2013 onward, as had been recommended in the 2013 Audit, a health and safety section featured in TMO's Performance Review Reports[395]. The high volume of FRA items outstanding over prolonged periods appears to have persisted, and with it, TMO's desire to conceal this fact from RBKC *"[Maddison]... added the age profile [of the data] needs to be carefully monitored going forward... PM confirmed that the data would be cleansed in a meeting tomorrow"* (emphasis added) [396]. TMO suffered from a lack of transparency generally which extended to it seeking to avoid adverse findings by its fire risk or assessors, or auditors, especially egregious when said in the context of a complaint which triggered internal recognition within TMO that its systems were poor[397].The result of this behaviour is that the FRA's are not a reliable review of TMO's maintenance system[398]. It is also clear that there was no system in place to inform Stokes of records or certificates of inspection , and neither did he ask for them, with the result that his assessment of risk was necessarily flawed[399].

(2) ***Failure to effect change/learn*** Although Wray reported to the TMO H& S committee concerning fire safety/LFB by way of *High Level Exception Report*, these do not appear to have been shared with TMO's Board and it is unclear how if at all these reports were used to inform any critical changes to the FRMS[400]. TMO failed to consider other external wall fires or near misses as learning opportunities. Despite receiving a Deficiency

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389 Discussed at RBKC board 25.7.13 **{TMO10010082_0248}**

390 September draft **{TMO10039507_0010}.**

391 **{TMO10039529_011}**

392 Lane 3 /7.4.20 to 7.4.255 **{BLARP20000029_0140}**

393 TMO H&S Com par 3 **{TMO10004260}**

394 Para 3.1 TMO H&S Com 28.8.13 **{TMO10004255_0002}** 7.11.13 item A6 *"External audit had given the highest level of assurance that the board was operating effectively"* **{RBK00030337_0007}** CE's Objective 2013/14 final bullet **{TMO10004176_0010}** *"no management points received from external auditors"*.Lane 3/7.5.29 **{BLARP20000029_0148}**TMO H&S Com 9.1.14 Parkes *"advised we had been given a clean bill of health from the recent RBKC follow up audit"* **{TMO10005009_0005}**

395 See e.g.s3.9 of TMO Annual Review 2013-14 **{RBK00032466_0015}**

396 29.9.15 TMO H&S Committee meeting minutes **{TMO10011214_0001}** to **{_0003}**

397 Maddison email to Jevans 27.2.13 **{TMO10002223 _0001}**

398 Lane 7/12.3.42 to 12.3.44 **{BLARP20000033_0245}**

399 Lane 7 / 11.2.61- 11.2.66 {**BLARP20000033_02221}**

400 Lane 3/ 6.4.8-6.4.9 **{BLARP20000029_0113}**

Notice for Trellick Tower in September 2012 which noted the FRA required review under Art 9(3) due to *"storage of combustibles on the balconies together with the suitability of the exterior timber cladding"*[401] this did not trigger a review of external wall cladding generally, nor did TMO appear to notice that those of Salvus' FRA's carried out by Mr Wain as opposed to Stokes contained a specific row in the *"fire hazard"* column for consideration of the external wall construction[402]. RBKC forwarded the Lakanal House Corner's recommendations to Wray in April 2013 seemingly attaching all the coroner's letters including that to Southwark, as it is summarised in her email [403]. Yet when Wray summarised the coroner's recommendations in her *"Briefing Note"* June 2013[404], she focussed solely on the DCLG letter and ignored the recommendations in the Southwark letter regarding guidance to residents and FRA's, critically ensuring risk assessors have access to relevant information concerning the design of the building to enable assessment of whether compartmentation had been breached[405].When discussing this note at the H&S committee meeting 20.6.13[406], it was noted that the coroner's recommendations included extension of FRAs to within dwellings in high rise blocks and retro-fitting sprinklers, but in each case TMO noted *"Early indications from D[C]LG that this will not be taken up"* and yet there is no evidence that TMO reviewed the Coroner's recommendations to assess the adequacy of TMO's FRMS[407].TMO's approach was clearly default to the minimum legal requirement, rather than properly considering the safety needs their blocks demanded in view of the relevant recommendations . TMO was prompted again by receipt in 2015 of the LFB's *Audit tool* designed in the wake of Lakanal to assist authorities in fire safety management of refurbishment[408].Despite this containing specific questions: *"When the project was complete was a (new) fire risk assessment undertaken? Can officers confirm that the completion of the project resulted in a building that is equally or more fire safety compliant than they were before the works?"*[409].TMO, despite Gibson accepting it was relevant to the GT refurbishment did not consider using it to risk assess GT[410]. The final prompt to TMO to consider the risk posed by the external wall was the notification from LFEPA regarding Shepherd's Court (para 2.1 above). That letter was passed to TMO (Black) in April 2017, but despite LFEPA's letter having alerted them to specific hazards in external walls and making clear that facades should be risk assessed with this in mind, wholly unsatisfactory answers were received back

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401 {CST00005434_0003}
402 These are extracted by Lane at 10/7.4.2- 7.4.4 **{BLARP20000032_0057}**
403 Wray's email 17.4.13 forwarding to Stokes Vacino's email (see para 2 for ref to Soutwark letter) **{CST00001800_0002}** and Vacino email 17.4.13 10.48 *"Lakanal Fire- Coroner's Inquest , Ltrs recommendation, NarrativeVerdicts"* attaching a PDF, but unclear what precisely was attached **{CST00001801}**
404 **{TMO10003056}** covering email at **{TMO10003054}**
405 http://moderngov.southwark.gov.uk/documents/s37765/Appendix 1 Coroners Rule 43 Letter.pdf
406 Item 6 ***Lakanal House*** **{TMO00841428_0004}**
407 Item 6.1 **{TMO10002929_0005}** and Lane 10/2.26 **{BLARP20000032_0103}**
408 J Allen RBKC building control email to Liza de Jesus who in turn forwards to Wray at {**TMO10042949}**
409 Items 3.13 and 3.14 **{TMO10042976_0005}**
410 David Gibson T/53/ 201:15 to 211:16 at 210:2-7 *" accept with hindsight it would possibly have assisted [at GT]"*

from Stokes[411].TMO's internal response was flawed from the outset. Matthews' initial email to Wray *assumed* the cladding at GT was compliant and Wray in reply did the same in reliance on the vague assurances from Stokes, and Matthews' final shot was *"..we need to provide a response to Laura from Robert that confirms we do not have this on our buildings"*[412].Lane considers this reliance solely on Stokes, rather than on TMO's own FRMS flawed, but there is no evidence that Matthews or Black challenged such reliance[413]. What should have been done following Practical Completion was a risk assessment of the entirety of GT to include the cladding and by reference to the Building Manual for GT. Despite the Manual being deficient in not providing the fire performance of the window and façade, it could nevertheless have been gleaned that the Celotex insulation was merely class 0, namely not limited combustibility as it should have been[414].

4.10.5 ***Process for control of hazards created by works*** Various works and alterations were carried out between 2011 and the night of the fire and as a result the risk to relevant persons increased and yet TMO had no formal arrangements in place to control the hazard and risk to life thereby created[415]. This was equally true of the 2012-16 refurbishment in respect of which there was no true assessment of the risk to life, merely some ad hoc inspections. These failures lead Lane to conclude Wray's management of the Refurbishment works resulted in TMO failing to discharge its duties under arts 9,11, and 22[416] . This pattern repeated itself in the 2016-17 gas replacement works, which Wray failed to appreciate required an FRA, and albeit she asked Stokes' advice, it did not constitute an FRA[417]. Wray compounded this error by failing to recognise, as she should have as a *competent person* that the works would create penetrations thorough fire rated walls protecting the single MOE and that such penetrations would remain exposed for 4.5 weeks, thereby exposing relevant persons to substantial risk[418]. This risk was in the event somewhat mitigated by residents' complaints prompting the expedition of the fire protection works, albeit TMO top management failed to seek assurance that the risk to relevant persons was being adequately controlled/obtain an FRA of such risk, and yet despite this Black communicated to Cllr Blakeman that a risk assessment had been done[419]. Throughout these works, neither TMO nor tRIIO considered GT's emergency plan even though it depended on the single stair MOE[420].

4.10.6 ***Emergency Plan/PEEPs.*** TMO failed to produce an emergency plan specific to GT, as required by RRO. Lane considers Stokes and Wray should have advised this was required. As a core part of her role, Wray should have reviewed the communication and effectiveness of such a plan[421].The guidance, with the exception

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[411] LFEPA letter **{CST00001567}** forwarded to Black/Wray by email *"fyi"* from L Johnson **{CST00001284_0003}.**Stokes replies at **{_0001}** and **{CST00001169}**
[412] Matthews initial reply to Wray 19.4.17 @10.09 **{TMO00861972_0002}**
[413] Lane 10/ 10.6.3 **{BLARP20000032_0112}**
[414] See Lane 10.6.8 -10.6.18 **{BLARP20000032_00112}**Building Manual Celotex datasheet at **{TMOM00001972}**
[415] Lane5/8.10.13-8.10.16 **{BLARP20000031_0099}**
[416] Lane 3/11.3.90-11.3.101 **{BLARP20000031_0134}**
[417] Lane 5/12.2.29 **{BLARP20000031_0140}** 12.3.42 **{_0144}**
[418] Lane 5/12.3.53 to 12.3.54 **{0145}**
[419] Lane 5/12.4.33 **{0151}**, 12 4.23**{_0149}** 12.6.14- 12.6.17**{_0153}**
[420] Lane 5/12.5.4 **{_0152}**
[421] Lane 9/10.5.21-10.5.23**{BLARP20000028_0131}** and 11.7.25**{_0153}**

of the LGA Guide, is consistent on the need to provide PEEPs[422]. TMO had been aware of the vulnerable people in its blocks since 1999[423] and aware its failure to produce PEEPs was considered a statutory breach since 2009[424], and had intended to create them since September 2010[425]. It had known since October 2012 that the issue of increasing numbers of vulnerable people in general needs blocks was inevitable by reason of the Government's *"care in the community"* imperative[426].By February 2016 at the latest, it was clear to TMO that there was no mechanism for its staff to report back data on residents with vulnerabilities[427]and act on such information; accordingly, at this stage TMO took steps to update its *"Supporting People Policy"*[428]which appears to have existed in draft since 2014/2015[429], but had still not been implemented by the time of the fire. Lane is critical of Wray's statement that the H&S team *"..were not routinely advised of the location of vulnerable residents..."* given her responsibility for the risk assessment process, *"one of the most fundamental outcomes"* of which is identifying vulnerable residents[430].Despite an *"organisational assumption"* within TMO that the FRAs incorporated the vulnerable, Lane finds no evidence they did[431]. TMO lacked a policy describing the procedures to be followed in the event of a fire[432].

Various means were available to log vulnerable people but data was not comprehensively collected or made available to Stokes for the purpose of his risk assessments. The final FRA for GT in June 2016[433] referred to the TP tracker, which had been obsolete since 2013.[434] TMO knew no PEEPs had been created, save for at sheltered housing. Few had been created for sheltered housing, as Stokes advised Wray in December 2012[435]. TMO's systems for ensuring its neighbourhood team and customer services staff communicated effectively with her concerning data collection were deficient, such that Wray was not able to discharge her responsibilities in relation to vulnerable people. Critically there was no policy explaining how PEEPs would be carried out[436]. Although TMO claimed to have a system in place to identify the occupancy profile across their portfolio of buildings, it is not clear how this information was shared between teams/departments within TMO, nor how this information would be updated for the purpose of ensuring accurate FRAs[437].

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422 TMO/Stokes should have considered the entirety of the guidance Lane 6/5.7.14**{BLARP20000034_0081}**
423 Wray to London Fire and Civil Defence Authority 17.8.99 {**TMO00854034}**
424 Salvus' 22.9.09 FRA for Fire Safety Policy and procedures Para 9.3 **{SAL00000013_0018}**
425 Black to Dainith and Johnson re Wise's fire safety research article acknowledging the need for PEEPs for residents as well as employees noting that FRAs have sometimes identified individual residents for whom TMO should produce PEEPs **{CST00003989}**
426 Minutes of National Social Housing Fire Strategy Group 5.10.12 (Wray in attendance) Item 4.1 first para **{CST00004324_0004}**
427 Minutes of TMO Senior Management Team meeting 18.2.16 item 8 **{TMO00866011_0004}**
428 Noble second [12] **{TMO00866003_003}** and latest version of policy at **{TMO00866013}**
429 *Supporting People Policy* Version1 dated October 2015 (Relativity Date 31.12.14) **{TMO00880477}**
430 Lane **8**/11.1.17 to 11.1.23**{BLARP20000027_0249}**
431 Lane 6/1.1.54 **{BLARP20000034_0010}**
432 Lane 6/8.1.13 **{BLARP20000034_0010}**
433 **{CST00000070_0024}**
434 Cancellation at **{RBK00057527}**
435 Stokes'email 3.12.12 **{CST00016416}**
436 Lane 6/9.4.55-9.4.58 **{BLARP200000034_0134}**
437 Lane 6/9.4.76 **{_0137}**

4.10.6 ***MOE for those residents with disabilities.*** TMO was on notice of, but failed to act on, design issues impacting upon MOE for the disabled at GT. In August 2013, TMO retained David Bonnett Associates ("DBA") for a desktop review of access for the disabled at GT[438].Contrary to the RIBA Access Audit Handbook[439], the audit did not expressly address ease of exit as well as entry.The survey made recommendations including door widths for wheelchair accessibility and door closers for use by those with limited upper body strength[440]. It is not clear whether this was ever shown to RBKC, but it is clear TMO were aware that ordinary door closers would not suffice for those with limited body strength and that there might be difficulty evacuating for those requiring wheelchairs. TMO also knew that some of the doors were too heavy to open, even by an able-bodied person and despite mechanical options being at one time considered[441]. But instead of welcoming this report and addressing the issues raised by it, TMO (Williams) stated she had told them to omit a report[442] sought to limit various of the recommendations, and failed to adopt those concerning door widths for wheelchairs and door closers fit for use by the elderly/those with limited upper body strength were fitted. TMO should have addressed the entirety of the Art 50 Guidance directing it to provide adequate MOE for those with disabilities[443].This made the need to protect vulnerable people clear.Despite this, TMO had no policy identifying the need or process for achieving the necessary protective measures[444]. As a result there were none.

5. TOPIC 3: ACTIVE AND PASSIVE FIRE SAFETY MEASURES INSIDE GRENFELL TOWER

5.1 **Management of maintenance of GT.** It was vital to define clearly the requirements and to express them as a management policy[445]. This certainly did not happen in 3 out of the 4 systems subject to specialist planned maintenance investigated by Lane: lift, smoke control and emergency lighting. Only the maintenance of the dry fire main met the required standards[446]. Of the 7 Deficiency Notices issued for GT between 2009 to 2017, 6 highlighted breach of Art 17 maintenance as an *"area of concern"*evidencing a failure in TMO's management system[447]. Some inspections of various systems in the form of weekly and monthly checks[448] was carried out by Estate Services Assistants ("ESAs") employed directly by TMO, and reactive maintenance by

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438 **{SEA00008055} {SEA00008056}**and record of DBA being on board at DTM 22.10.13 **{TMO00834979}.**

439 Para 3.1 **{RBK00045171_0014}**

440 Survey at **{SEA00009496_0008 }** and **{_022}**

441 Email thread Wray Rydon and Stokes 20.2.17**{CST00001648}** acknowledging doors at GT too heavy and that the door closers have been *"detuned"* such that they don't fully close. See also Cunningham to Brown at Masterdor cc Acosta 2.8.11 **{TMO0086757}.** It was a common problem: see email Cunningham to Acosta and ors *"Re Door installation- Elderly"* acknowledging elderly residents at Cremoorne *"they have to lean on the door, to keep it open and of course because of the self closer the door pushes closed consequently pushing the frail person"* **{TMO00873633}**

442 Thread C Williams and Sounes 26.11.13 **{TMO00850151}**

443 Not solely LGA :Lane 6/ 5.7.3 to 5.7.14**{BLARP20000034_0080}**

444 Lane 6/8.7.1 to 8.7.2 {**BLARP20000034_0119}**

445 CIBSE Guide M s 3.1.1. quoted by Lane 7/5.3.6 **{BLARP20000033_0034}**

446 Lane 7/ 19.9 **{BLARP20000033_0477}**

447 Lane 7/13.2.6 -13.4.3 **{BLARP20000033_0290}**

448 These were lised as *"daily routine checks"* in the TMO *Estate Staff Quick Reference Hnadbook* dated June 2013 **{TMO10028449_0083}** but Lane finds no evidence that daily checks were carried out 7/18.2.4 **{BLARP20000033_0427}.** Lane lists at table 18-1 the checks which appear to have been carried out weekly and monthly **{ _0427}**

Repairs Direct ("**RDL**"), a wholly owned subsidiary of TMO[449].ESAs claim to have carried out weekly health and safety inspections, including checks to the lifts and smoke ventilation system, but Lane finds no written or digital records of this for the period prior to April 2015 albeit this may be referable to a switch from manuscript to digital record keeping by the introduction of Personal digital assistants in June 2014[450]. Thereafter in the period April 2015 to the fire there are 36 weekly and 10 monthly inspection records missing which suggests TMO staff did not understand the weekly and monthly inspection regime[451] If ESAs discovered repairs were required during these inspections, they were allegedly reported to RDL, but Lane finds that generally fault reporting did not occur on inspections and the majority of the reporting of faults occurred following Practical Completion of the Refurbishment[452].Residents' repairs jobs were also allocated to RDL via TMO Call Centre[453].From at least 2013 a significant and continuous backlog of maintenance issues persisted, including critical FRA actions[454]. In January 2016, some 4000 RDL jobs were outstanding[455].As a result, relations between RDL/TMO and residents were, by March 2016, "*dire*"[456]. The volume of unresolved items led TMO to conceal the extent of the problem, by marking down items as complete when they were not[457] or data being "*cleansed*" in advance of health and safety audits[458].

5.2 Lifts.

5.2.1 ***Lift Refurbishments*** The lifts are an exemplar of TMO's missed opportunities to ensure resident safety. Installed in 1972-1974, the lifts were extensively refurbished in a project spanning 2002-2006 ("**2002 Project**") and subject to further works during the refurbishment in 2015. Despite the 2002 Project presenting an ideal opportunity to upgrade the lifts to modern standards of FF lifts[459] and/or evacuation lifts[460] (at least to the extent reasonably practicable) TMO failed abjectly. TMO's Project Brief to Butler & Young ("**B&Y**") for the 2002 Project sought a Feasibility Study specifically addressing the requirements of FF and evacuation lifts[461].B&Y's Feasibility Study[462] was essentially silent[463] on this, and the Specification produced was at best ambiguous as

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449 Second Witness Statement of Graham Webb at [4] {**TMO00840366**}; this had previously been out-sourced to an external contractor, *see* Witness Statement of Sacha Jevans at [27] {**TMO00000893**}

450 First Witness Statement of Paul Steadman at [7]-[9] and [22] {**TMO10049875**}Lane 7/18.2.14-18.2.16 **{BLARP20000033_0429}**

451 Lane 18.2.21-18.2.25**{BLARP20000033_0429}**

452 First Witness Statement of Paul Steadman at [10] {**TMO10049875**}Lane 7/18.3.3- 18.3.12**{BLARP20000033_0431}**

453 Witness Statement of Sacha Jevans at [28] {**TMO00000893**}

454 *See* for example Health & Safety Group Meetings in 2013 **{TMO00862608_0003}**, 2014 {**TMO00844024**} **{TMO00844024}** and 2015 **{TMO10010033}.**

455 Second Witness Statement of Graham Webb at [9] {**TMO00840366**}

456 Email Andrew Newton to Jevans {**TMO00839652**} at {**0005**}: "*When I say relations are dire I am not exaggerating... We have vulnerable residents that are resigned to beling left and bad conditions rather than approach TMO staff.*"

457 E.g. TMO Health & Safety Committee *Fire Safety Update* dated 16.3.17, Item 3 **{TMO00841366_0001}**

458 TMO Health & Safety Committee meeting minutes dated 29.9.15 **{TMO10011214_0001}** to **{_0003}.**

459 BS 5588-5:1991**{BSI00001721}**.

460 BS 5588-8:1999**{BSI00000018}.**

461 Project Brief [4.10(c)] **{TMO00853783_0023}**.

462 **{BUT00000038}**.

463 There is reference to the Disability Discrimination Act 1998 at e.g. [1.2], [3.6] and [3.10] and generic reference *to "Heath and Safety requirements"* and "*current lift standards"* at e.g. [3.7] but not to the provisions of BS 5588-5:1991 or BS 5588-8:1999.

to applicable standards[464]. TMO failed to ask why feasibility of upgrade had not been addressed. TMO sought a lift which was accessible to those with disabilities[465] and B&Y expressly probed TMO for *"Leaseholders and Tenants needs – It may help to know if these [sic] are vulnerabilities associated with these [sic] categories of residents"*[466]. Yet TMO ultimately did not seek to procure a lift suitable for evacuation in fire. Despite this, during 2010, TMO was nonetheless contemplating using the lifts for evacuation in PEEPs[467]. As for FF lifts, TMO now claims disingenuously that the concept did not come into force fully until 2015[468] despite its Project Brief acknowledging their requirements[469] and numerous TMO documents dating from 2010 referring to FF lifts[470].Rather than highlighting the lifts' deficiencies, TMO's fire safety strategies sowed confusion by creating its own bespoke definition of a FF lift which was liable to mislead[471].TMO's failings were compounded by the indifference of the relevant contractors, each now disavowing any responsibility to consider regulatory compliance. B&Y failed to address with TMO the relevant British Standards for FF and evacuation lifts, their applicability and the feasibility of compliance. Significantly, B&Y's Specification included provision for a fire control switch in the form of an express drop release key[472] which, even at 2004, had become *"out of date and obsolete"*[473]. B&Y should instead have specified the required emergency unlocking triangle fire control switch[474]which has standardised dimensions and avoids the risk of what appears likely to have occurred at GT, namely the wrong key being used [475]. Although Howkins cannot reach a firm conclusion[476] he appears to favour LFB using a key of incorrect size for the aperture, given the lifts/switch itself was not damaged by fire at the early stage at which Secrett sought to operate the switch[477]. It may be the Inquiry will never reach a firm conclusion on the cause of the lift switch failure, as it seems TMO never established whether the fire lift switch functioned either during the refurbishment (level 2) or afterwards (ground floor)[478].

B&Y's failings were exacerbated by the passivity of the lift contractor, Apex, who failed to inform B&Y that the Specification did not comply with the relevant standards[479] or to recommend in 2015 that TMO should carry out an audit assessing the existing levels of safety and whether changes were necessary, as recommended by section 4.1 of BS 5655-11:2005[480].Neither Calfordseaden, which undertook a pre-condition survey of the

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464 **{APX00005521}**.
465 Project Brief [4.10(c)] **{TMO00853783_0023}**.
466 **{MET00070573}**.
467 **{CST00003102}**.
468 Robin Cahalarn [36] **(TMO00866023_0004}**.
469 Para 4.10(c)**{TMO00853783_0023}**.
470 **{RBK00053579} {CST00001269} {RBK00052522} {CST00001781} {TMO10001582} {TMO10001578}. {TMO10001577}.**
471 **{TMO10001582_0013} {TMO10001578_0011} {TMO10001577_0010}**.
472 Specification [2A.70] **{APX00005521_0058}**.
473 Phase 2 Expert Report of Mr Roger Howkins [280] **{RHO00000003_0130}**.
474 Howkins [337-338] **{RHO00000003_0144}**.
475 Howkins [283] **{RHO00000003_0131}**.
476 Howkins [598] **{RHO00000003_0222}**.
477 Howkins [597.2, 5.988-601 ine] **{RHO00000003_0222}**
478 Lane 7/14.3..48-14.3.51**{BLARP20000033_0322}**
479 Howkins [333] **{RHO00000003_0143}**.
480 **{BSI00001724_0008}**.

lifts prior to the 2015 works[481] nor PDERS,TMO's lift maintenance contractor, reported the lifts' non-compliance with relevant standards. Each maintained it was not a matter for them[482]. Every party involved in the 2002 Project and 2015 works, missed multiple opportunities to ensure the lifts were compliant with modem standards of fire safety and accessibility. Even following the GT 2016 Refurbishment, Wray, Williams and Stokes had still failed to establish whether an automatic recall function on the lifts was connected to the detection system associated with the smoke control system. Absent such function there would be no way to prevent relevant persons operating the lift until after the fire brigade have used their lift key correctly[483].

5.2.2 ***Maintenance of lifts*** Correct identification of the category of lift (ie Fire or FF) is critical to selection of appropriate maintenance regime[484].The mischaracterisation by TMO of the lifts as FF lifts in its fire strategy[485] was a significant failure to coordinate its policy and procedure documents[486] Lane considers the lift switch required weekly testing to ensure the lift returns to the fire access floor etc and annual full testing [487],but that the requirement in version 11 (June 2012) of TMO's lift safety procedure[488] for monthly testing of the switch by TMO's senior lift engineer (Calaharn; 2004-2012) was removed by Wray in version 12(2014). However Calaharn was responsible under version 11 until he retired, yet he failed to check the operation of the lift switch[489]. No TMO staff checked the lift switch either as ESA checks did not require it. Lane considers this a *"significant failing"*[490].Given that despite being obliged to carry out monthly checks, the lift maintenance contractors, PDERS, over a seven year period, never documented checks to the switch there is reason to question their evidence. Furthermore none of PDERS 27 inspection records nor Bureau Veritas mention the presence of two lift switches, suggesting a lack of care in inspection[491].

5.3 Fire doors

5.3.1 ***Flat entrance doors:2011 Door Replacement Programme.*** In 2009, Salvus advised that as part of the FRA programme checks should be carried out to ensure that each flat door was *"FR30"* and had self-closers[492].Stock-wide surveys of flat entrance doors in June 2010, identified significant numbers of non-compliant flat entrance doors that required replacement[493]. In early 2011, the door replacement programme was

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481 Michael Burke [5] **{CAL00000048_0001}**.
482 Mark Wallis [18] **{PDR00000036_0004}** Michael Burke [14] **{CAL00000048_0002}**.
483 Lane 7/14.3.34-14.3.35 **{BLARP20000033_0320}**
484 See Annex A1 of LEIA *Maintenance for lifts, lifting Platforms escalators and moving walks* p 24 of 29 and Lane 7/5.8.87-5.8.90 **{BLARP20000033_0083}**
485 Par 18.2 **{TMO00830598_0012}** and App 8 **{_0034}**
486 Lane 7/ 14.2.30 **{BLARP20000033_0299}**
487 Lane 7/5.8.78**{_0082}**
488 Appendix E *Checks* para 2 **{TMO00849330_0030}**
489 Lane 7/ 14.2.33 **{BLARP20000033_0299}** and 8/12.2.62 **{BLARP20000027_0260}**
490 Lane 7/19.5.21 **{BLARP20000033_0459}**
491 Lane 7 /19.5.19-19.5.24 **{BLARP20000033_0459}**8/12.2.40**{BLARP20000027_0256}**7/19.5.6 **{BLARP20000033_0464}**
492 **{SAL00000011_0015}**
493 TMO email dated 21.10.10 **{TMO00866662}** and attached spreadsheet **{TMO00866665}**; *See* also minutes from 20.7.11 RBKC/TMO meeting with LFB **{RBK00053638_0002}**

put out to tender[494].The contract was awarded to Manse Masterdor ("MM"). By its tender, MM offered what it claimed to be *"FD30S"* doors[495](the required rating for GT[496]).That claim was false. MM's *"Suredor"* literature only offered FD30 doors (not FD30S)[497].In order to carry the suffix *"S"*, a door must be tested for smoke leakage[498]; there is no evidence that MM conducted such a test. Further, in order to be FD30, a door must pass a BS 476-22 test. Though MM appears to have conducted two such tests, both are invalid because the doors were tested from *one side only* contrary to the requirements of ADB[499]. Finally, ADB makes clear that for fire doors *"... it is only the complete assembly as described in the relevant fire test report, that can be deemed to provide the required performance"*. Therefore, at most, MM could only offer *two* FD30 fire door variations (the two variations tested). However, MM offered 28 variations[500], all said to be available as *"30 minute rated'* fire doors[501].These issues would have become apparent on careful consideration of ADB, the Suredor literature and MM test reports. Despite being asked by TMO on two separate occasions to review the doors to be installed for compliance[502],Stokes failed to identify these critical issues, and incorrectly advised that the doors were FD30S and compliant with the BRs[503]. He did not even request sight of the MM test reports.[504] It is clear however that TMO failed to administer an effective monitoring arrangement for this programme, which resulted in wholly non-compliant fire doors being installed[505].

5.3.2 ***Flat entrance doors: self-closers.*** The self-closing devices used were concealed door jamb closers [506].Despite these being a standard option offered by MM[507], neither of MM's BS476-22 tests used such devices, rendering the test evidence inapplicable to those doors. At GT these devices suffered from a multitude of issues, which resulted in them being removed in numerous instances both during and after the door replacement programme[508]. The risk of removal as a result of poorly specified closers is one that ought to have been considered by MM, since it is highlighted in BS 9991:2011, clause 35.1.6.1[509].The poor specification of closers

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494 Email dated 05.01.11 issuing Invitation to Tender {**MAS00000015**}

495 Masterdor tender documents dated 13.1.11{**MAS00000035_0007**}

496 ADB, Appendix B, Table B1 and Lane Phase 1 report, Appendix 1, 14.3.57 {**BLAS0000030_0033**}

497 Suredor brochure {**TMO00868639_0007**}

498 Under BS 476-31.1 ADB, Appendix B, Table B1, Footnote 2; Note also Lane's view that a door set cannot achieve this *"S"* rating unless subjected to the appropriate tests, even if fitted with a smoke seal (4/9.8.29 {**BLARP20000030_0135}**)

499 First test {**MAS00000001_0028**} and second test {**MAS00000002_0003**} at 2.1. Lane Phase 1 Report ,Appendix 1, 14.5.26-27 {**BLAS0000030_0041**}

500 14 different styles of doors, each with two alternative skins.

501 Suredor available style sheet {**CST00001329**}

502 Stokes' letter dated 7.3.11 to Wray {**CST00013074**}; A. Acosta email to Stokes dated 15.6.11 {**CST00001607}**

503 Stokes' letter to Acosta dated 24.6.11{**CST00001388**}.Lane agrees his advice was incorrect:4/9.8.36 {**BLARP20000030_0137}**

504 Stokes' First Statement [88] **{CST00003063_0029}** and Second Statement [59] **{CST00030186_0015}**

505 Lane **4/**9.9.5 {**BLARP20000030_0146}.** TMO's Project Manager (Acosta), initially did not understand the fact that LHC only had a very limited scope to inspect newly installed flat doors, and seemingly chose to ignore that fact after being explicitly informed of it **:**Lane 4/9.8.71 and 9.8.74, {**BLARP20000030_0143}** and {**_0144**}.

506 *"Astra 3003 Concealed Door Closers V1 PL3"* {**MAS00000003**}

507 Steven Mocklow [6] {**MAS00000342}**

508 E.g email concerning Flat 82 dated 27.9.11{**TMO00868337}.**RDL Witness Statements[15]{**TMO00879729**}[16] {**TMO00870942}** [18] {**TMO00879687}**

509 {**LFB00034829_0112**}

and the subsequent mismanagement of their repair/replacement, led to a great number of flat entrance doors without functioning door closers on the night of the fire[510].

5.3.3 ***Stair doors.*** The stairwell doors at GT were not included in the 2011 door replacement programme and are likely to be the ones originally installed at GT[511],being "*No.3 Class A door from Table G of Schedule VI of the London Building Constructional Amending Bylaws*"[512]. These were non-compliant at the time of construction, since Type 2 doors were required, and Type 3 doors did not achieve the required 30 minutes stability and integrity[513]. According to the LGA Guide, the required standard at GT was an *"upgraded or replacement FD30S"?*[514].In order to be an "*upgraded*" FD30S door, the LGA Guide requires the door to be a "*notional*" FD30 door fitted with intumescent strips and smoke seals[515].Though this concept is flawed as identified by Dr Lane (see 4.7.3 above) a "*notional*" FD30 door is one that satisfied the current specification or fire resistance test for 30 minutes at the time of construction of the building or manufacture of the door[516]. Since the doors were non-compliant at the time of construction and would not achieve 30 minutes stability and integrity, they could not be "*notional*" FD30 doors and therefore cannot be "*upgraded*" FD30S doors. As such, despite being upgraded in around March 2015 by the addition of smoke seals and intumescent strips[517], the stair doors remained non-compliant. Though Stokes raised concerns about the status of these doors as fire doors, this was for different reasons[518], and he failed to advise that since the doors themselves were originally non-compliant, they could not even be classed as notional FD30 doors. Stokes even argued *against* the retrofitting of smoke seals and intumescent strips[519].

5.3.4 ***Maintenance of doors.*** There should have been a system of planned maintenance, routine inspections and reactive repairs for all fire doors[520]. In fact, there was *no* planned maintenance regime for fire doors at all[521].The only evidence of fire door maintenance was reactive repairs, following ESA inspections and defects

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510 According to a BRE post-fire survey, 43 doors had no door closers at all and 34 doors had non-functioning closers:[113] {**MET00039807_0076**}; Lane 4/ 11.7.3 {**BLARP20000030_0189**}.

511 Phase 1 Report, Appendix I, 15.4.6 {**BLAS0000030_0075**}

512 Phase 1 Report, Appendix I, I5.5.3 {**BLAS0000030_0076**}

513 Phase 1 Report, Appendix M, M6.1.9 {**BLAS0000034_0062**} and Appendix I, I5.6.9 {BLAS0000030_**0077**}

514 LGA Guide second box down {**CTAR00000033_0103**} and Lane Phase 1 Report, Appendix I, I5.2.30 {**BLAS0000030_0070**}

515 LGA Guide {**CTAR00000033_0182**}

516 LGA Guide {**CTAR00000033_0182**}

517 Claire Williams' email to Wray dated 20.3.15 {**TMO00858191**}, John Tatham email dated 24.3.15 {**TMO00858217**}

518 Stokes' letter to Wray dated 10.4.15 {**ART00003868**}; he was concerned about workmanship.

519 This was on the basis of his opinion that the stair doors were the inflow route for the air supply needed for the AOV system, (Page 15 of 2012 FRA **{CST00000090}).** However, Lane has confirmed that this belief of his was incorrect: Lane 4/13.6.11 **{BLARP20000027_0312}**. It appears that Stokes was specifically informed that this was incorrect (See advice from Ramsey (LFB) in March 2014 that the dedicated vents at GT "*should not need to rely on leakage around the staircase doors to make up air*" {**CST00003115**}), however Stokes still did not correct this mistake in his 2014 FRA {**CST00000092**}.

520 Lane 4/2.6.2 {**BLARP20000030_0022**}

521 Lane 4/5.1.6 {**BLARP20000030_0052**}

reported in FRAs[522].However, those inspections related purely to communal doors, thus there was *no* procedure in place for the routine inspection of flat entrance doors[523].

5.4 Gas Works at the Tower

5.4.1 ***The installation of the gas pipe into the protected stair.*** Following Cadent's inspection on 30.09.16[524], it commissioned tRIIO to design and build a new gas riser[525]. The design agreed by the TMO on 30.11.16[526] placed the new riser in the stairwell. The design for the riser was non-compliant in numerous respects. In particular, the design intent involved changing the configuration of fire compartmentation, by making the boxed in pipework in the lobbies part of the stairwell fire compartment. The consequent unsealing of the entry between the protected stairwell and common landing within the boxing was non-compliant with section 6 of IGEM/G/5[527]. In certain instances the available evidence shows that smoke could have entered the body of the stairwell via the oversized penetrations of the compartment wall through which the gas pipes passed[528]. Further, Hancox found no evidence of any interim fire stopping of any of the penetrations of the stairwell/lobby wall by the pipeline[529], which when considered in conjunction with evidence of smoke staining, renders it highly likely that smoke would have travelled from one lobby to another via the oversized penetrations and boxing within the stairwell[530].Further, the design process for the ventilation of the riser and laterals lacked rigour and the design was not and would not on completion have been compliant with IGEM/G/5 Edition 2, BS 8313 and Approved Document B[531]. Once the option of running the replacement riser and laterals up the outside wall had been discounted, Cadent should have refused to replace the pipeline on the basis that it was unable to comply with current legislation and standards and to compensate the residents accordingly[532]. RBKC Building Control should have considered the new gas riser installation controllable under the BRs; as venting the lobby boxing into the stairwell was not only detrimental to escape, but also affected the integrity of the stairwell as a firefighting stair. The installation of the new riser resulted in GT *"**not complying with** a relevant requirement **where previously it did**"*, so was a material alteration[533].Had the new riser been adequately fire separated from the stair by 120 FR construction and ventilated independently of the stair and lift lobby, it would have been reasonable to consider the proposal as compliant and not seek an application for BR approval. Absent that, an application should have been required[534].

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522 Lane 4/6.1.5 {**BLARP20000030_0055**}.
523 Lane 4/7.6.25 {**BLARP20000030_0097**}
524 {**CAD00000031**}.
525 Hancox [312] {**RHX00000012_0135**}.
526 {**TRI000000791**} and later updated in March 2017{**TRI000001223**}.
527 Hancox [367-368] {**RHX00000012_0162**}.
528 Hancox [371] {**RHX00000012_0186**}.
529 Hancox [373] {**RHX00000012_0187**}.
530 Hancox [374] {**RHX00000012_0187**}.
531 Hancox [446] {**RHX00000012_0210**}.
532 Hancox [446] {**RHX00000012_0210**}.
533 Menzies [560] {**BMER0000004_0158**}.
534 Menzies [570] {**BMER0000004_0159**}.

5.4.2 ***The works to isolate the gas supply on and around 14.6.17.*** As to the night of the fire, the *"key principle"* from a gas perspective would have been stopping the flow of gas into the building as soon as practicable, so as to make the situation safe[535]. Whilst acknowledging the Chairman's tribute to Cadent's actions in isolating the gas supply[536], Cadent's difficulties in identifying the diameter, depth and location of the Station Walk main strongly suggest a breach of Cadent's obligations under the Gas Act 1986 and Pipeline Safety Regulations 1996. These require that gas transporters have accurate graphical records of services of 2" diameter and above, readily available to its emergency personnel and others requiring access[537]. This was not complied with: the records were accessible, but not accurate.

6. CONCLUSIONS

The failure of controls at every level begs many questions: the Inquiry will wish to consider the ambit of the RRO/its interface with other legislation; the adequacy and extent of Art 50 guidance; the qualification and training necessary for fire risk assessors. Considerable focus will be on the types of FRMS which LA's/ their ALMO's might adopt to comply with the RRO, including the format of an adequate emergency plan for all residents including the vulnerable[538]. Given that such plans, including evacuation strategies, are necessarily person and building specific, the Inquiry's primary focus must be on managerial systems, formats and governance. The RP is obliged under the RRO to provide MOE which are safe for all, including the disabled (regardless of the age of a building or its compliance with modern standards). Nevertheless, the adequacy of the Building Regulations and ADs must be considered, as albeit premised on inclusive design, and requiring that a building must be capable of being managed, they offer little guidance[539]. The multiple tiers of failure at GT speak in favour of a safety case for each building, of the kind recommended by the Piper Alpha Disaster Inquiry, extending to all aspects of building safety including the gas valve isolation, which could be audited by those with the relevant specialist knowledge and available to the emergency services.

Stephanie Barwise QC
Omar Eljadi
Marie Claire O'Kane
Dalton Hale

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535 Hancox [27] **{RHX00000012_0095}**.
536 Phase 1 Report, [31.14].
537 Hancox [98] **{RHX000012_0045}** Note: Hancox identifies the obligations but does confirm breach by Cadent. A clarificatory question to Hancox on this issue has been submitted by Hancox pro forma.
538 Lane 9/s14 and see 14.4.21 **{BLARP20000028_0182}** and table 5-2**{BLARP20000028_0063}**
539 Para 0.19 ADB {**CLG00000224_0013}** Lane **T62/93:7-17** Lane 6/4.7.104. to 4.7.22 **{BLARP20000034_0035}** NB the ability to require reasonable adjustments (under s36(1)(d) & Sch 4 par 5 Equality Act 2010) is not in force. SI2010/2317 brought S36(1)(a)-(c) only into force.