
MODULE 3 OPENING ON BEHALF OF THE BSRs

REPRESENTED BY TEAM 2.

INTRODUCTION AND OVERVIEW

1. The Inquiry has now heard, in Modules 1 and 2, extensive evidence over many months. That evidence is shocking. The hallmark of the Module 1 evidence was incompetence on a massive scale, and a complete failure on the part of any of the key parties to take responsibility for their actions and inactions. During the course of the evidence, and at the time of the events which characterised the refurbishment, we have seen the “merry-go-round of buck-passing” which Counsel to the Inquiry complained of on the very first day of Phase 1.¹
2. If anything, Module 2 has even been more shocking. The materials suppliers, Arconic, Celotex and Kingspan have been shown to be consistently fraudulent, with a reckless disregard for human safety. The guardians of the public interest, the BRE and the BBA, were, at best, asleep at the wheel.
3. In Module 3 the Inquiry will once again need to penetrate the wall of obfuscation set up by the corporate CPs and hold to account the many individuals, firms, companies and organisations who have contributed to this tragedy.
4. The BSRs featured little in the Module 1 evidence and hardly at all in Module 2. At times, the complex technical evidence has appeared remote from the lives and deaths of those who lived in the Tower. Module 3, however, brings those lives and deaths back to center stage.
5. As the Phase 1 Report made clear, it is central to this Inquiry that “the external walls of the building did not resist, and indeed actively promoted, the spread of fire...principally due to the presence of ACM panels with a polyethylene core”.² However, this disastrous situation was allowed to occur in a building which had suffered neglect for many years and was unsafe. The key issues to be examined by the Inquiry in Module 3 will focus upon critical failings by the TMO and RBKC which were ultimately causative of the deaths. The Inquiry should also focus upon the fact that this fire was foreseeable.
6. Just as Modules 1 and 2 contained a litany of failures, so too does Module 3, failures which on analysis a reasonably competent technician should have foreseen: lifts that were not firefighters lifts with no communication system, duplex power and inadequate control; failure to record or make accessible

¹ [Day 1, 18/16-19].

² Volume 4, Chapter 26.

emergency gas control valves or which were built over; doors incapable of closing, thus incapable of maintaining compartmentation, manufacturers prioritising finances over safety, installing doors of a lesser build quality than those they replaced; smoke ventilation systems based on fragmented designs, not properly commissioned or maintained and which did not function on the night of the fire; and a failure to risk-assess the building and to put in place any evacuation procedure.

7. There was a litany of failures, and each failure requires its own careful investigation and analysis. However, at the heart of this story lies the systematic failure of RBKC and the TMO. Their conduct is a story of sustained institutional neglect of the residents. A significant number of residents were from black, brown and other minority communities, and social housing tenants. All this calls for an inquiry as to the role of race and social class as a causative or contributing factor to the fire, as well as the causative or contributing role of RBKC and the TMO more generally.³
8. The Grenfell Tower fire was not just fueled by the flames from a commonplace domestic fire, but by an incendiary mix of forces that had been intensifying over the previous decade. The mix is by no means new but is both insidious and pervasive - power and profit above people. Every time anyone passes nearby, the Tower stands stark against the sky as a chilling reminder of these forces and represents how a whole community, a vertical village, was ill-served by a raft of individuals, corporate bodies, and governance. The fire was not an isolated event but the inevitable culmination of this mix. The circumstances surrounding the fire, which the panel has been enjoined to examine, are therefore intimately linked to how the families and their safety were ignored constituting a culture of institutional neglect which must be examined by the Inquiry as a causative factor of the fire and the deaths of the 72.
9. Wherever you look, if a corner could be cut, it was; if a regulation could be bent or broken it was; if the truth could be hidden or manipulated it was; as we have seen in Modules 1 and 2 and so the causative impact of deregulation and cuts must too be examined as causative factors in Module 3.
10. This is the story that must be told by the families, who experienced first-hand the impact of flagrant breaches of duty, the violation of rights and the basic disregard for fundamental values. The Inquiry is therefore invited to examine the actions of RBKC, the TMO and their agents and consequential breaches of the **Defective Premises Act (1972) s1(1) and 4**; **Tenant Involvement and Empowerment Standard (2012)**; **Landlord and Tenant Act (1985) s11**; **Health & Safety at Work Act etc. (1974)**; **Regulatory Reform (Fire Safety) Order (2005)**; **Construction (Design and Management) Regulations (2007) and (2015)**; **Occupiers Liability Act (1957) s2(2)**; **ECHR Article 2 read with Article 14**; **Equality Act (2010)** and the KCTMO Modular Management Agreement. Last but by no means least liability for individual gross negligence manslaughter and corporate manslaughter.
11. These families are not being wise after the event. They were wise before the fire, but were ignored. After the April 2010 fire, the GTLA wrote to Mr Black (CEO of the TMO) requesting an independent full

³ We refer to and rely on the written and oral submissions on Equality made by Birnberg Peirce, Saunders Law, Duncan Lewis, Deighton Pierce Glynn, Russell Cooke and Saunders Solicitors.

health and safety investigation and at the same time identifying numerous risk factors (fire alarms, vents, lighting, evacuation procedure, smoke inhalation, staircase, lifts) all of which were still prevailing at the time of the 2017 fire and in particular predicting an INFERNO AND LOSS OF LIFE. This letter is one of the most telling documents in this module.⁴

12. Two weeks before the fire, a petition was delivered to the Town Hall calling for a full independent safety review of the building,⁵ the culmination of the GTLA's persistent approaches throughout April and May.
13. Even at the very last, these complaints might have produced changes and these changes could have saved lives. However, the complacency and neglect which characterised the organisations' responsibilities for the Tower continued until the eve of the disaster. On 10th June 2017, there were cursory, 5-minute fire safety visits to 25 flats.⁶ 32 people from 15 of the 25 flats died in the fire – 7 were children and 5 residents with mental and/or physical vulnerabilities⁷.

TOPIC 1: COMPLAINTS AND COMMUNICATION WITH RESIDENTS

14. This inquiry opened with the moving testimonies of the BSRs. We welcome the newly appointed panel members and assessor and invite them to view the pen portraits and visit the Tower, which we believe will provide powerful insights into the lives lost and those surviving.
15. Module 3 will mark an important moment to refocus and recognise that ultimately the people at the center of the Grenfell Tower Inquiry all represent the singular voice which rings true.
16. The bereaved, survivors and relatives are best-placed to give evidence about the nature of that culture and how it impacted their lives. That description necessarily extends beyond the confines of the fire causative complaint. In a sense they are the experts.
17. There can be no better opportunity to take stock of the Grenfell community, to accord them the regard they are due, and to confront the question posed by the global audience that watched events unfold on that fatal night: How could such a disaster have been allowed to occur in one of the UK's richest local authorities, and in one of the world's richest cities? We therefore invite the Inquiry to widen the number of residents being called to give live evidence.
18. For these reasons the oral opening for Topic 1 will begin with a brief retrospective of events on the fateful night set against quite remarkable and poignant precursors touched on in paras 11/12/13 supra, which in turn provide a compelling perspective on why, as opposed to how, this death trap was a disaster waiting to happen.

⁴ TMO00846312, Letter from GTLA to Robert Black, 03/09/2010. TMO10037439_0001-8 and in SA second witness statement 23 Jan 2010 para 21 IWS00001335_0008-9

⁵ RBK00000181, 30/05/2017.

⁶ LFB00060956, Home Fire Safety Visits to Grenfell Tower, 10/06/2017.

⁷ Children in Flats 153, 155, 175, 182, 193. Vulnerable residents in Flats 111, 122, 132, 142 and 191.

SECTION 1. POLITICAL/COMMERCIAL CULTURE

19. On 7th February 1497 the religious authorities in Florence instituted a ‘bonfire of the vanities’ to rid the city of impediments to the established faith. Celebrated, latterly, in a novel and film adaptation.
20. More recently however (January 2014), this allegory was employed obliquely by then PM David Cameron in an address to the Federation of Small Businesses, (coincident with the early stages of the Grenfell Tower refurbishment project) when he announced 100 standards and building regulations were ‘facing the bonfire’, an allusion he also applied to EU regulations and ‘red tape’ in his bid to ‘kill off the safety culture’ for the benefit of a more profitable business arena.
21. The insidious nature of this ideology can be readily detected in the serial negligence of successive Government Ministers responsible for Housing, Planning and Local Government between 2014 and the time of the fire in 2017.
22. Starting with Eric Pickles through to Gavin Barwell there was a startling failure to embrace recommendations and warnings about safety in high-rise residential buildings (HRRBs); the Coroner’s recommendations following Lakanal House fire Inquests in 2013 following the fire in 2009 is one example. Absent a satisfactory response from Government, the All Party Parliamentary Fire Safety and Rescue Group pursued these matters and sent a total of 21 letters to relevant ministers during this period. These were ignored, lost, or rejected as non-urgent or delayed because of the ‘desire to reduce red tape’.
23. Meanwhile in the wings, Mayor of London, Boris Johnson was endorsing draconian cuts to London fire stations, fire engines (18 including aerial first response), the longstanding Southwark training facility and 520 jobs. When challenged about this by Andrew Dismore in the London Assembly in 2013, the same year as the Lakanal Inquests, his clarion riposte was ‘get stuffed’.
24. This agenda was facilitated by the Conservative/ Liberal Democrat coalition’s 2010 platform of austerity coupled with the dismantling of regulatory frameworks and a move from accountability and oversight to privatisation and outsourcing. These austerity measures heralded funding cuts and spending freezes of £610 million with the slashing of capital funding from £8.4 billion to £4.5 billion, having greatest impact on the housing and fire and rescue sectors⁸. The Audit Commission,⁹ which had oversight over the performance of councils, fire and rescue services and housing organisations was abolished with its function outsourced to the private and not-for-profit sectors.
25. Against this background, it is hardly surprising to find a pandemic of lies, manipulation, misrepresentation, fabrication and ultimately a downright ‘fraud upon the market’, an apt description used by Counsel to the Inquiry. This shocking and disgraceful ‘race to the bottom’ by elements of the construction industry exposed by this Inquiry was essentially given the green light over several years.
26. The magnitude of this malaise beggars belief and was nurtured with blatant disregard for the right to

⁸ <https://www.insidehousing.co.uk/insight/insight/the-year-that-changed-social-housing-forever-24764> last accessed 18.2.2021

⁹ Established under the Local Government Finance Act 1982.

human life and safety. It is marked by unrepentant witnesses bereft of any remorse let alone a scintilla of responsibility – instead the victims of this catastrophe have been subjected to a parade of arrogance born of impunity, wherein not a single one of these witnesses was prepared to give evidence without an undertaking; or even at all where they could hide behind the tattered veil of a blocking statute.

27. At the hub of this web of deceit and central to its impact are the Tower's owners - RBKC/TMO - exemplified by their collusive relationship with main contractor Rydon and the architects and blatant breaches of EU procurement rules. Councillor Feilding Mellen, though having no experience in high rise refurbishment, was involved in discussions with Studio E, signed the planning application as the "decision maker"¹⁰ and discussed the cladding¹¹ selection.
28. The regeneration project was not about improving residents' lives but instead about providing a cheap facial postscript to the more prestigious KALC development nearby with a focus on gentrification. This climate of collusion was fostered and enabled by the manner in which residents were regarded and treated as 2nd class citizens. Cllr Feilding-Mellen's response to residents' concerns about delay in the Tower's planned refurbishment focused solely on the resulting "improvement of the appearance to the residents in the surrounding area"¹² rather than refurbishment to attain the decent homes standard.
29. At the same time the title TMO is both a misnomer and an accurate reflection of reality. The letters TMO did not signify, even remotely, tenants managing anything. Perversely, it had become nothing less than an organisational front for managing tenants.
30. An environment of deregulation and profiteering entailed social housing tenants being marginalised, disrespected, and excluded, perceived at best as a hindrance and at worst as a rebel hostile force. Some of this has been touched on in earlier modules, lamentable efforts to gather tenants, lip service to consultation and involvement, image over substance. No residents gave evidence about these matters during these modules, but as they constitute major areas of complaint, they come within topic 1.
31. The curtain has been raised and remains up, ready for the return of Claire Williams who has displayed extraordinary indifference towards residents and has conveniently disposed of contemporary notebooks/diaries despite being aware of both this Inquiry and the police investigation.
32. Her evidence about tenant involvement in the tender process is in stark contrast to the evidence of the BSRs you are about to hear. It is as though she is working in a parallel universe¹³.
33. Although she had no experience of HR residential refurbishment schemes, she was described as project manager. In fact, she did not project manage, only monitored and reported on the programme and budget.

¹⁰ RBK00003309; RBK00019249.

¹¹ RBK00028392.

¹² Minutes of the HPSC 16th July 2013 TMO00849507_0003 [*the Deputy Leader and Cabinet Member...said he understood residents' impatience with the progress on regenerating the Tower but it was a significant investment and it was vital a high quality design resulted to improve the block and its appearance to residents in the surrounding area...*]

¹³ [Thurs 15th October 2020 12.20 onwards to Monday 19th]

34. Instead, her role was fronting the scheme for residents as their TMO point of contact.¹⁴ Given this purported role, her answers to questions on this are totally inexplicable, especially in relation to Shah Ahmed, highlighted in section 4.
35. Having commenced her job in September 2013 it was incumbent upon Claire Williams to ensure that during the ensuing months she rapidly familiarise herself with her constituency, particularly where a major impending project is destined to affect daily lives for a substantial period. A matter largely of common sense, there should be no need for protocols and rule books.
36. In this role she was obliged to know where those with ‘protected characteristics’ lived, to ensure safety, access, evacuation in an emergency and adequate communication on a range of disparate needs. Yet by March 2014, the start of the tendering process, she had barely scratched the surface. A detailed knowledge of each resident, and how or who to contact was non-existent. This incredible approach demonstrates beyond measure just how marginalised the residents had become.
37. The most obvious starting point for this haphazard last-minute tender exercise with less than 2 weeks to go, should have been resident groups.¹⁵ In the event only 1, possibly 2, individuals took part, it being claimed no one else was interested. When a list was finally compiled on 4th March 2014 it conspicuously shows that Flat 156 was not contacted, the home of longstanding GTLA chair Shah Ahmed.¹⁶ Claire Williams could not explain this, still less her unawareness that he was chair. And no one told her! Prime responsibility, however, lies with RBKC and those who had oversight like Laura Johnson.
38. The underlying theme of this and subsequent sections is to distil what potential categorical imperatives are essential preconditions for change:
 - (a) A paradigm shift in culture, attitude and policy toward social housing;
 - (b) An enforceable regulatory housing regime in which;
 - i. health and safety are paramount and non-negotiable;
 - ii. there is provision for effective management by tenants.

SECTION 2. LOCAL BACKGROUND

39. The Government has already embarked upon a programme which attempts falteringly, to address these objectives and how best to accommodate Tenants’ rights. Its proposals are contained in 2 bills and the Social Housing White paper, all published between July and November 2020. A range of mechanisms are floated – and the social housing agenda or Charter is claimed to provide a much-needed voice for tenants. It is prefaced by new powers for the Social Housing Regulator and the Ombudsman, a

¹⁴ TMO 00840364/4 para 19] *‘My role was to keep residents informed, to liaise with them and to report to others within TMO and RBKC. My role was very specifically in relation to monitoring liaison and facilitation*

¹⁵ *Q.did you not think to contact the groups.....the Leaseholders Association (and the EMB) and find out from them whether any of their members would be willing to assist in the tender A. No I didn’t.....but I don’t remember anybody even mooted either of these groups.* [Day 56 – 20th October 2020 – Page 161-162]

¹⁶ TMO00879781

commitment to transparency and accountability and a code for handling complaints, customer satisfaction measures and empowerment programme including webinars and panels.

40. Whether any of this yields a paradigm shift in ideology and real tenant participation in policy at a national level or management at a local level is yet to be assessed.
41. Any assessment requires some understanding of the forces which led to an environment in which an inferno predicted by tenants took place.
42. The borough embraces one of the wealthiest urban districts in the UK in the southern two thirds, and one of the poorest in the northern third. This imbalance has important repercussions for governance, social housing, maintenance of safety standards and tenant involvement. Since the borough's creation in 1965, the governing Conservative Party has retained a substantial majority, often more than double that of Labour. The Council's political leadership reflects this dominance with only 5 different leaders since 1968 compared to 14 in neighbouring Hammersmith & Fulham.
43. There are inherent dangers in a monopoly of power. Those who hold the reins believe they and their policies are unassailable. This breeds a culture of complacency in which challenges to authority are readily denied or dismissed. Vested interest becomes the order of the day supplanting the voices of the disempowered. This facilitated the progress of gentrification and "social cleansing" of the borough with a blueprint decant strategy aimed at closing down existing Council housing and transferring the residents to new homes to facilitate "regeneration"¹⁷.
44. The Conservative Manifesto for the 2014 Council elections pledged building new homes to further the then London Mayor's Plan with a target of 750 new homes for the Borough¹⁸. The 2014 London Housing Strategy Report signed off by Boris Johnson targeted the construction of 42,000 new homes a year for the next 20 years built in "attractive neighbourhoods"¹⁹. This was and has been at the heart of the Conservative plan for economic expansion and job creation through the construction industry with a focus on own ownership at the expense of social housing.
45. This was buttressed by Cabinet style governance and a number of Scrutiny committees. Considerable power accrues to the Leader and Cabinet in these circumstances. The Scrutiny committee has no power to make decisions, only recommendations.
46. Key Performance indicators (KPI's) presented to the Housing and Property Scrutiny Committee by the TMO failed to reflect shortcomings and dissatisfaction and instead regularly suggested high compliance.
47. The inherent dangers in this coalescence and concentration of power can be demonstrated by the fate of groups and individuals in the social housing estate. Prior to the 1996 establishment of KCTMO was an Estate Management Board (EMB) for Lancaster West. In 1993 a management agreement was signed

¹⁷ Housing Property Scrutiny Committee meeting 13 July 2011 [RBK00050445]

¹⁸ Nicholas Paget Brown s.9 MCA statement [MET00072274]

¹⁹https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Housing%20Strategy%202014%20report_lowresFA.pdf (last accessed 18.2.2021)

recognising their right to manage. It was not honoured and 3 years later was overtaken by the KCTMO. In 2013 the Council closed down the EMB.

48. Therefore, the principal point of contact for tenants became the TMO which, almost from inception, was not intended to empower tenants. It fast became characterised as a 'fake' TMO by those tenants who discovered how little their voices mattered. The impetus for its creation was a device to circumvent legislative obligations with regard to Compulsory Competitive Tendering (CTT). By 1999 all councils would have had to contract out the management of their housing stock which could entail a transfer of the stock itself. This was a valuable asset for RBKC which it did not wish to risk.
49. To retain control, it adopted the TMO model and adapted it to take in all its housing stock of around 9000 homes. It was the first of its kind because usually a tenant-led organisation would be locally focused on 1 block or at most 1 estate. A borough-wide responsibility is plainly dependent on officials not tenants even though they had a theoretical majority vote on the board.
50. In 2002 this majority was reduced and the TMO became an arms-length ALMO. The essential rationale was once more economic, to facilitate access to the Government Decent Homes fund.
51. The litmus test for tenant status in RBKC is found in the treatment of the Tenant Consultative Committee (TCC) established at the start. Its terms of reference involved a key role in the KPI annual review and the annual setting of KPI targets. To accomplish this they would receive reports, make recommendations and comments, consider proposals, from TMO, the Council, HP&R and tenant associations.
52. Whilst this looks promising from a tenant's point of view, in practice, the amount of tenant influence was limited. Firstly, its composition was dominated by councillors. Secondly, its meetings gradually reduced from 4 p.a. to 2 and then under Rock Feilding-Mellen (Deputy Leader and Cabinet member for HP&R 2013-2017) to once a year until it was abandoned altogether during refurbishment.
53. For a brief time, this marginalisation of tenants' voices became a general issue attracting national attention. In 2007 the Cave Review of Social Housing Regulation found 'inadequate concern for tenant interests' and a 'strong case for regulation to protect tenants. From this review, 2 important innovations were established. The TSA (Tenant Services Authority) in December 2008 and the National Tenant Voice. The TSA took a particular interest in the July 2009 Lakanal House fire and lessons to be learned.
54. Both initiatives were short-lived. They were axed and described as 'toast' by the incoming Coalition Government led by the same PM who set light to the bonfires mentioned at the start. Part of the 'one in two out' regulation mantra.
55. In the lead up to the Tower refurbishment project therefore, the landscape for tenants was indeed bleak. No EMB, no TSA, no NTV, no TCC and no effective voice on the implacably authoritarian RBKCTMO.

SECTION 3. LEGAL FRAMEWORK

56. RBKC and the TMO systematically failed to comply with fundamental housing law duties. As the refurbishment works involved creating new flats, the **Defective Premises Act** (1972) s 1(1), obliged all

those involved in refurbishment works to ensure that dwellings, together with the common parts of the block were all fit for habitation upon completion. The duty fell not only on Rydon, Studio E and all subcontractors but also on RBKC. It was plainly breached. The failings of RBKC, and the TMO as its managing agents however, are not limited to the refurbishment. At their core is a failure to engage with Tower residents in a manner which did not result in them feeling disregarded and treated with contempt.

57. As a registered Provider of social housing, RBKC was obliged to comply with consumer standards published (at that time) by the regulatory wing of the Homes and Communities Agency, including the Tenant Involvement and Empowerment Standard 2012. This required RBKC to ensure that tenants are given a wide range of opportunities to influence and be involved in:
- (a) the formulation of their landlords housing-related policies and strategic priorities.
 - (b) the making of decisions about how housing-related services are delivered including the setting of service standards.
 - (c) the scrutiny of their landlord's performance and the making of recommendations to their landlord about how performance might be improved.
 - (d) the management of their homes where applicable.
 - (e) the management of repair and maintenance services, such as commissioning and undertaking a range of repair tasks, as agreed with landlords, and the sharing in savings made, and
 - (f) agreeing local offers for service delivery.
58. Further, RBKC was required to support its tenants to develop and implement opportunities for involvement and empowerment including by:
- (a) supporting tenants to exercise their right to manage or otherwise exercise housing management functions, where appropriate.
 - (b) supporting the formation and activities of tenant panels or equivalent groups and responding in a constructive and timely manner to them.
59. The experience of GT tenants, of which a prime example follows in the next section, demonstrates a striking failure by RBKC to fulfil those obligations and provides the basis for earlier comments on the nature of the TMO as a 'fake' vis-a-vis the community.
60. In contrast a genuine TMO was referenced in the last section. The Lancaster West Estate Management Board (LWEMB). It could have provided effective management and autonomy for the tenants by the tenants had it been properly resourced, supported and supervised. This was an anathema to the Council which went to the lengths of installing a management consultant to the board of EWB to wind it up.
61. The template for tenant involvement and empowerment outlined above, like the groups themselves (GTLA and GAG) was blatantly ignored and, even where recognition was accorded, it was merely tolerated – GTLA (Shah Ahmed). For others it was denied (Grenfell Community Unite) and yet others grudging (Grenfell Compact).
62. The standard for tenant involvement and empowerment required RBKC to have an approach to

complaints that is ‘clear, simple, and accessible’ and that ‘ensures complaints are resolved promptly, politely and fairly’. The narrative of GTLA and Shah Ahmed in the next section reveals that none of these features were present. The 3-stage process was intimidating and complex. It had to be exhausted before a resident had any opportunity to argue their complaint before someone independent, *i.e.*, the Housing Ombudsman. As we shall see Mr Ahmed and other tenants were forced to resort to a myriad of other channels including individual councillors, MPs, Ministers, and petitions.

63. Prior to and after the refurbishment, RBKC and the TMO had a wholly inadequate system for dealing with repairs, under the stewardship of Graham Webb, a former employee of Morrison Facilities Service, the previous contractor for repairs, a failing service described by Robert Black as “terrible” [TMO00000888] paragraph 78.
64. Analysis of the BSR statements reveal over 70 complaints about recurrent problems with windows (e.g., draughty and ill-fitting) and over 20 complaints about flat entrance doors (e.g., draughty or having broken or faulty closers). Failure to carry out these repairs was a breach of both RBKC’s repairing obligations under the **Landlord and Tenant Act** (1985) s11, and its duty under the **Defective Premises Act** (1972) s4 to ensure anyone who might be affected by defects in the property was reasonably safe.
65. As ever, costs and the financial bottom line were driving forces. [TMO00840541] At a meeting of the Exec Team (19 April 2016), a decision not to join a Chartered Institute of Housing learning group to “rethink repairs” was seemingly made on the basis of the cost (£10,000) and Mr Webb’s view that he could recommend a better (cheaper) alternative provided by Housemark. Further, minutes from a KCTMO Board Meeting on **26 May 2016** [TMO00853185] show Repairs Direct was seeking new sources of income from other markets (minor repairs and services to leaseholders) because of a threat to its income from RBKC.
66. In relation to fire doors, failing to comply with basic routine repairing obligations directly contributed to the deaths and injury caused by the fire. LFB FSO Team Leader Rebecca Burton, identified that there may be a systemic problem with KCTMO’s approach to self-closer doors (**LFB00084098_0008**) and KCTMO handman Seamus Dunlea expressed that they were “*not interested*” in fixing fire doors once they had been replaced despite there being known issues with the self-closing devices. [MET00019959]
67. The failings of both RBKC and the TMO under the **Regulatory Reform (Fire Safety) Order** 2005 are considered in more detail in topic 2, but their failings also constitute a breach of the duty under the **Occupiers Liability Act** (1957) s2 (2) to take such care as is reasonable to see that anyone in the common parts of the Tower would be reasonably safe.
68. **Article 2 of the ECHR** places a positive obligation upon the state to protect life. Article 14 of the ECHR prohibits discrimination within the ambit of rights protected by the ECHR. The Article 2 procedural duty, read with **Article 14**, places a duty on the Inquiry to investigate whether discrimination played a role in the deaths, and this duty includes questioning witnesses on matters which raise discrimination and discriminatory practices and to make findings of discrimination where the evidence exists.

69. RBKC and KCTMO's management and maintenance of Grenfell Tower exposed residents and occupants to the risk of fire. This failing, coupled with inadequate mechanisms for residents' complaints and receipt of information particularly concerning fire safety and fire risk, violated their Article 2 rights.
70. Additionally, RBKC and KCTMO were required to comply with the **Equality Act 2010**, specifically the public sector equality duty (PSED) pursuant to s149 and the duty to make reasonable adjustments pursuant to s20. They were also required not to discriminate directly or indirectly in relation to any of the characteristics protected under the Equality Act (here, race, age and disability).
71. The PSED places a legal duty on public authorities in the exercise of their functions to have due regard to the need to eliminate discrimination and advance equal opportunity between persons who share relevant protected characteristics and persons who do not share it. The duty includes: removing or minimising disadvantage suffered by persons who share a relevant protected characteristic that are connected with that characteristic; to take steps to meet the needs of people who share a relevant protected characteristic that are different to the needs of persons who do not share it; meeting the needs of disabled persons that are different from the needs of persons who are not disabled; in particular taking account of disabled persons disabilities. Relevant protected characteristics include: age, disability, pregnancy and race.
72. Equality duties are an integral and important part of the mechanisms for ensuring anti-discrimination legislation aims are fulfilled; per Arden LJ in *R (Elias) v Secretary of State for Defence* 1 WLR 3212
73. The relevant legal principles are set out in *R (Bracking) v Secretary of State for Work and Pensions* [2013] ECWA (Civ) 1345 §26 and *R (on the application of Daniels) v May* 2018 EWCA 1090 (Admin) §43:
"An important evidential element in demonstrating the discharge of the duty is the recording of the steps taken by the decision-maker in seeking to meet the statutory requirements. The relevant duty is of the decision-maker personally."
74. In *R (Brown) v Secretary of State for Work and Pensions* (2008) EWHC 31158 (Admin) the Court noted:
i) The public authority decision maker must be aware of the duty to have "due regard" to the relevant matters; ii) The duty must be fulfilled before and at the time when a particular policy is being considered; iii) The duty must be "exercised in substance, with rigour, and with an open mind". It is not a question of "ticking boxes"; while there is no duty to make express reference to the regard paid to the relevant duty, reference to it and to the relevant criteria reduces the scope for argument; iv) The duty is non-delegable; and v) Is a continuing one; vi) It is good practice for a decision maker to keep records demonstrating consideration of the duty.
75. Officials reporting to or advising Ministers/other public authority decision makers, on matters material to the discharge of the duty, must not merely tell the Minister/decision maker what he/she wants to hear but they have to be "rigorous in both enquiring and reporting to them": *R (Domb) v Hammersmith & Fulham LBC* [2009] EWCA Civ 941 at [79] per Sedley LJ.

76. RBKC and KCTMO in discharging their human rights and equality obligations had duties to the residents of Grenfell Tower as regards i) housing allocation; ii) the maintenance of fire safety measures in accordance with current requirements; iii) complaints; iv) consultation including re the refurbishment; v) appropriate plans for PEEPs and such other measures as required for the escape of all residents in the event of fire. RBKC and KCTMO's allocation of residents on higher floors in a high rise, with a single staircase as the only exit in the event of a fire, placed elderly residents, those with physical and mental disability and families with young children at a disadvantage in the event of a fire. Likewise, residents with visual impairment, or other physical disability which affected their mobility were placed at a disadvantage in the event of a fire as they were unable to self-evacuate. The complicated complaints procedure was such that most residents, particularly, those whose first language was not English would have difficulty navigating and be therefore placed at a disadvantage because of their race.
77. In relation to PEEPs, it is clear from the conduct of RBKC/ KCTMO and residents' accounts that this was not the case. Elderly residents, those with physical disabilities affecting their mobility, those with mental ill health and families with children were located on higher floors in a building with a single staircase, which was the only means of escape during a fire. 41 residents had physical disability including mobility impairment; 9 mental illness; 16 over age 65 and 63 were children²⁰. A sample of 8 of our clients, 6 of whom sadly died, is illustrative of this.: Raymond Bernard – flat 201 (floor 23) had arthritis and walked with a cane; Anthony Disson – flat 194 (floor 22), whose disability affected his mobility and impacted on his ability to escape the fire – he mentioned this in his 999 call; Sirra Choucair – flat 191 (floor 22) – had severe arthritis, suffered from back pain and used a walking stick, she was unable to use the stairs to escape the fire; Mehdi El Wahabi, child aged 8, epileptic – flat 182 (floor 21) Emma O'Connor – flat 171 (floor 20) – her physical disability affected her mobility and she was unable to walk up and down the stairs, Jessica Urbano Ramirez, child aged 12 – flat 176 (floor 20) died on floor 23; Joseph Daniels – flat 135 (floor 16) – suffered from dementia and had mobility difficulties – he was unable to self-evacuate; Elpidio Bonifacio – flat 83 (floor 11) – was visually impaired, unable to self-evacuate and was the last person rescued at 08:07am.
78. As regards whether inadequacies of for example the complaints system were causative, in an Article 2-compliant Inquiry, it is not necessary to prove that failings are causative in order to investigate them. Where it is not fanciful that failings occurred which more than minimally contributed to a death, the failings should be investigated²¹. Further, if shortcomings are admitted and are possibly causative, then findings should be made in relation to them²². Finally, just as in an inquest, where non-causative failures are present that could cause deaths in other cases, the permissive power to make a Report to Prevent Future Deaths 'can only properly be exercised in one way if the purposes of Article 2 were to be

²⁰ See schedule of vulnerable residents of Grenfell Tower: attached to submissions

²¹ R (AP) v HM Coroner for Worcestershire [2011] EWHC 1453 (Admin)

²² R (Tainton) v Senior Coroner for Preston and West Lancashire [2016] EWHC 1396 (Admin) 16 June 2016

respected'²³, so in this Inquiry, failures that are found to be non-causative in this case after appropriate investigation, but that could cause deaths in other cases, should result in appropriate recommendations in accordance with paragraph ii) of the Terms of Reference. Where there is prima facie evidence of discrimination in relation to such failures, Article 2 read with Article 14 requires appropriate findings.²⁴

79. Criminal liability – currently the subject of Police investigation – also has a bearing on the Article 2 Inquest function of this Inquiry. A finding of ‘unlawful killing’, for example on the basis of gross negligence manslaughter or corporate manslaughter, is in principle available to this Inquiry on the civil standard of proof, and would not infringe the prohibition in s10(2) Coroners Act 2009 on any finding appearing to determine any question of criminal liability.²⁵ This has been manifested in modules 1 and 2 and equally applies to module 3 in relation to individuals as well as corporate bodies. There are 2 main pathways. The first relates to the commission, design, installation and provision of combustible materials which caused death. The second, to the design, installation and maintenance of systems, which failed to suppress the effects of fire, fumes and smoke, to enable evacuation, exacerbated by the absence of a fire safety plan, and thereby caused or contributed to death.
80. We will in due course invite the Inquiry to make findings of unlawful killing of the 72 in the discharge of the Inquest function.

SECTION 4. THE CHRONICLE OF SHAH AHMED²⁶

81. The GT community is one of remarkable diversity and collectivity. It is as potentially invidious to select one story as it is complicated to try and encompass all and we have highlighted Mr Ahmed’s experience which can be said to reflect that of the many and especially the imprint of points contained in the previous 3 sections and common experiences of the residents of Grenfell Tower.
82. Mr Ahmed, with his wife Sayeda moved into flat 156 on the 15th floor (post refurbishment renumbered 18th) as RBKC tenants on 13th April 1992. Their son Zaki was born the same year. They remained as social tenants until 11th October 1999 when they signed a leasehold agreement with RBKC under the right to buy scheme. This means the Ahmed family had 25 years of experience by the time of the fire, 21 of which is with the TMO.
83. What needs to be appreciated is that well before the ‘regeneration’ project KCTMO had a pattern of behaviour highly relevant to the fundamental shortcomings underlying the causes of the fire. Whatever the Council proclaims, in practice nothing changed. Warnings and suggestions were not taken seriously. This was reflected in the Memoli report commissioned in 2009 into the longstanding complaints.

²³ R (Lewis) v HM Coroner for the Mid and North Division of Shropshire [2009] EWCA Civ 1403; [2010] 1 WLR 1836

²⁴ See submissions on behalf of BSRs represented by Birnberg Peirce, Deighton Pierce Glynn, Duncan Lewis and Saunders Law dated 2 July 2020

²⁵ R (on the application of Maughan) v Her Majesty’s Senior Coroner for Oxfordshire (2020) UKSC 46; Chief Coroner’s Law Sheet No 6

²⁶ Mr Ahmed’s witness statement can be found at IWS00001335_0001-0138 hereafter all references will merely employ the last 4 digits.

84. The report's 34 recommendations make necessary reading as a precursor to the period of the refurbishment and fire. The top recommendation was both prescient and crucial – to establish an independent process of mediation/conciliation to build relationships between aggrieved residents and the TMO especially where they have broken down irretrievably.²⁷
85. The Council's conditioned response to the report was one to which residents had become accustomed – an unwillingness to accept the majority of criticisms, indicative of a culture of institutional indifference.
86. On 30th April 2010 a fire at Grenfell Tower raised serious questions about fire safety. Although starting on the 6th floor landing, smoke spread up rapidly and Mr Ahmed's wife suffered injury. Numerous residents were affected and complained to the TMO. Their pleas for an investigation into the fire's cause and compensation was sidelined. In response to the Council and TMO's culture of indifference, Shah Ahmed founded the Grenfell Tower Leaseholders Association (GTLA) to help challenge this culture and neglect with a collective voice. Of the 120 flats, 15 were leasehold, of which 3 were Housing Association. (Shah Ahmed is concerned that the Housing Association is not a CP).
87. Once established, the GTLA wasted no time in articulating the numerous unresolved shortcomings which included the heating system, fire doors, 4-year delay in windows replacement posing a risk to health and safety and, on 28th July 2010 in a letter to Geoff Payne (KCTMO Head of Housing Leasehold Services) the list was extended to malfunctioning lifts, ineffective concierge services and fire safety concerns arising out of the fire in the block on 30th April 2010.
88. Despite being officially recognised, KCTMO ignored and deliberately sidelined GTLA and the opportunity for a productive relationship with them was missed. It was quite clear that KCTMO did not like organised groups such as GTLA which might challenge and hold them to account. *"We asked the TMO to treat us as an asset and work positively with us but, this did not happen."*²⁸ The Council's obdurate intransigence provoked a direct approach to the TMO's CEO (appointed in spring 2009).
89. An unforeseen accident is bad enough, but a foreseeable disaster is unforgivable.
90. Between 2010 and 2017 GT residents²⁹ regularly raised a catalogue of significant issues including: Repeated requests for an independent health and fire safety review, proper consultation from planning stage onwards, an effective complaints process, prompt action to rectify deficiencies relating to fire/smoke alarms, smoke vents and extraction; emergency lighting, signage for floor numbers and fire safety, fire drill, evacuation, tenants booklet, lifts, staircase, fire doors, windows, heating, security-concierge, LFB inspections, testing (condemned fire extinguishers) and maintenance, electrical power surges, gas pipes into flats and communal areas.
91. All of these have a bearing on fire safety and demonstrate RBKC and TMO's culture of indifference towards and neglect of the Grenfell residents and Lancaster West Estate. The discernible pattern of

²⁷ IWS00001462_0043.

²⁸ IWS00001335_0008 para17

²⁹ IWS00001335_0045-0075 paras 134-216

response tends to be an initial denial of fault, followed by delay, then a minimising of fault ending with either delayed or deficient rectification. These are all matters to be investigated by the Inquiry.

92. Power surges: It has been contended that they are not relevant because they play no part in the fire on 14th June 2017. However, the power surges demonstrate RBKC's attitude to health and fire safety and the residents' complaints which are undoubtedly relevant to causation.
93. The power surges in spring 2013 resulted in damage to several residents', including Shah Ahmed's, electrical appliances. Items such as white goods, computers and lighting exploded, literally went up in smoke, an alarming and fearful experience, naturally invoking the risk of fire. Repeated requests for an emergency meeting were ignored, liability was denied initially and then minimised as it was claimed only 7 resident complaints were received. Numerous representations were made to the TMO, through councillors (principally Judith Blakeman), to MPs and a petition gathering 94 signatures.³⁰
94. What the residents did not know was the contents of a report by RGE Services on 29 May 2013 stating: *"The tenants above floor ten were reporting smoke issues, lights, and power failing intermittently. General condition of these sub-mains Pasolini bus bar covers have been damaged or were missing and live parts exposed on all Ryfield boards to floors 11 – 20. Remedial works are urgently required."*³¹
95. Such a deplorable state of affairs cannot have appeared overnight and suggests inadequate fire safety inspections in the first place. The whole situation for residents was compounded by a formal complaints system not fit for any purpose other than diffusing and delaying. GTLA found the complaint system was just a mechanism for closing complaints off. It was byzantine, cumbersome and long-winded. Very few succeeded, let alone were resolved. For these reasons GTLA decided to ensure its points were circulated as widely as possible. Not only to the Council, councillors, individual officers, but also to MPs and others. If, however, a point was raised by a councillor, it would not be registered as a complaint but as a member's request. That is one reason why the complaints system itself does not reflect the true state of dissatisfaction, compounded by some complaints being registered as service requests.
96. There were 3 stages, a Scrutiny Committee and panels. It was not uncommon for a complaint to be broken down into segments requiring separate consideration. Additionally, the threshold for KPI was set so that a fault or service would have to be seriously defective before it was registered. The TMO would therefore write reports commending themselves on their achievements.
97. Matters came to a head once more for GTLA and others in the weeks before the fire itself, with works for the introduction of exposed gas pipes in the communal parts especially the staircase and thence into individual flats. This was done without consultation with residents and gave rise to legitimate fire safety concerns. Residents wanted reconsideration, an independent fire safety review and reassurance. Was there a fire safety certificate? Would pipes be boxed in? The risk of leakage? Was compartmentation

³⁰ paras 106 - 133...0037 -0045.

³¹ ZUR00000025.

breached particularly in relation to entry into flats? Were the seals round pipes adequate? Would effective residents escape and fire brigade access on the staircase be impeded?³²

98. Once more, like the surge saga above, this is about the Council's attitude to potential risk in spring 2017.
99. Throughout March and April, the GTLA contacted the TMO, local housing officer Millicent Williams, Cllrs Blakeman and Mason, Housing Ombudsman, local MP, Minister for Environmental Health, Collette O'Hara at the LFB and many others. GTLA's main demand remained an independent health and safety review. They continued to pinpoint the gas pipes' location and raise issues about noise in the new cladding and broken lifts. GTLA were not reassured by Laura Johnson writing: *"RBKC would never put the residents of our housing at risk"*³³.
100. Meanwhile back at the Council positions were entrenched with Laura Johnson commenting on 21st April: *"What on earth can we do with this now. If they wish to take legal action then that is their prerogative and we look forward to receiving notice from whomsoever they appoint."*³⁴
101. The obvious answer expected by the residents: A timely, full health and safety inspection of the physical aspect of the premises including structural problems as requested by GTLA, instead of prevarication and obstruction might have avoided residents paying the ultimate price for the Council's negligence with their lives.
102. There is a natural overlap between Topic 1 issues and elements of Topic 2/3. As we have previously and continue to submit, the residents through their lived experiences in the Tower understood and foresaw the problems with the refurbishment. They complained and made their concerns known to the TMO. They are also experts. The very problems concerning technical deficiencies, failure by corporate bodies to act upon and implement legislative measure and policies, poor maintenance and repairs, the paucity of the fire safety advice and fire risk assessment, the disregard and failure to adequately if at all, cater for the needs and requirements of vulnerable residents, all sadly came to pass with devastating and tragic consequences on 14th June 2017.
103. There was a legislative framework in existence at the relevant time, as well as a plethora of policies for the local authority and fire service designed to properly meet the needs of the residents and effectively discharge RBKCTMO and LFB responsibilities in this regard. Against this backdrop those clients we represent are particularly aggrieved that there was no effective or insufficient effective regard given to the fire safety of residents, in particular the most vulnerable.
104. The question of vulnerable residents within the Tower encompasses more than solely physical disability. Mental health, learning disabilities and individuals who may present particular risks such as hoarders; are all categories of individuals who the TMO should have considered with the utmost care by the TMO, the fire risk assessors and the LFB Fire Safety Teams The Inquiry has already heard evidence in Phase

³² paras 166 - 209... 0056 – 0073.

³³ IWS00001335_0057

³⁴ RBK00033165.

- 1 from residents such as Sam Daniels³⁵, regarding his father's vulnerabilities and the tragic consequences of him being unable to leave his flat. Others the Inquiry heard about included: Mr Bonifacio, the El Wahabi Family³⁶ and those on higher floors with children such as the Belkadi family.
105. There was clearly an understanding by the Fire Safety Teams in relation to specialist housing such as sheltered accommodation of the need to address individual residents with specificity and tailor fire safety plans accordingly. That simply was not done for Grenfell Tower. Although not a specialist housing provision for vulnerable residents, this village in the sky was nonetheless home to myriad individuals with varying needs and disabilities. Critical thinking and an appreciation of the specific obligations and duties owed to the vulnerable residents was something singularly lacking from Janice Wray and the TMO.
106. Fire Safety Inspectors had become an endangered species. The HM Inspector of Fire Services in England and Wales, was scrapped in 2000 and in 2017, there were only 150 fire safety inspectors. There had been 200 a decade before. In the period before the fire, Fire safety teams from Hammersmith and Fulham and RBKC were effectively "rationalised" and within 6 months those from RBKC had left, leaving a dearth on local knowledge on the ground. Matt Ramsey FSO **LFB00032092_0003**: "therefore, it was not possible to allocate someone to Grenfell Tower who had historically dealt with this building". The bi-monthly meetings and legislative framework of notices and enforcements, were there in part to:
- (a) Identify those residents who were particularly vulnerable via disabilities.
 - (b) Having identified those with those particular characteristics to put in place packages and measure, namely the PEEPs to meet those needs.
107. This simply was not done. The inquiry already knows from the Phase 1 evidence, the paucity of the contingency plan and planning by RBKC and the TMO. At the time of the fire the information pertaining to vulnerable residents was woefully out of date. The failure to identify the vulnerable residents, address their specific fire safety needs and put effective measures in place represents a total failure to adequately protect those most in need and we say represents serious breaches of the Equality Act and PSED owed to the residents of Grenfell Tower.
108. Our clients say loudly and clearly that there are key questions which demand answers. These include:
- (a) Why were the voices of the residents simply ignored?
 - (b) Why was there an abject and total failure to identify and provide effective plans tailored to individuals, especially the most vulnerable residents, to ensure that they had the best possible chance of surviving a fire?
 - (c) Why were the concerns raised about Carl Stokes and the efficacy, efficiency and inadequacy of his fire risk assessments not acted upon?

³⁵ Gave evidence on 10.10.18. Witness statement: IWS00000608

³⁶ Hanan Wahabi gave evidence on 08.11.18 Day 70. Witness statements: IWS00000074, IWS00001146. Phase 1 report Part 2 references: 10.191 – 10.196, 10.266 – 11.43.

(d) Was there a sufficiently robust approach to monitoring and enforcement by LFB fire safety teams?

TOPIC 2: The Regulatory Reform (Fire Safety) Order 2005 (FSO) and Fire Risk Assessments (FRAs)

109. The context for topic 2 is that there was, at all relevant times, no Fire Safety Strategy (FSS), or other fire safety engineering design basis document in place. An FSS directly influences the design starting point for other engineered systems within a building. It is a key requirement in any building design that the different construction and engineering professionals adopt an integrated design approach. Without an FSS the basis of an integrated approach does not exist. Exova failed to provide an adequate FSS, the import of which was not recognised by Exova, the TMO, RBKC Building Control or the Design and Build contractor Rydon. Lip service was paid to the FSS. As early as 2010 when visiting electricians undertook work on the building, they were not aware of the compartmentation boundaries. Consequently, routine maintenance work compromised the integrity of fire compartmentation walls. In 2010³⁷ electricians drilled through the electrical room's fire compartmentation wall. Mr Stokes raised this in his 2010 FRA. The renovation project was an opportunity to have the building's fire performance designed by a competent engineer and reduced to writing. Despite being flagged, neither Exova, the TMO, RBKCB nor Rydon took the opportunity to remedy it.
110. By 2010 Grenfell's fire safety was in a perilous state. KCTMO reached an agreement with the LFB that any remedial works identified in FRA assessments would be made fully compliant within 5 years³⁸. In fact, as per Dr Lane's analysis, over the next 5 years the risk level rose from medium to intolerable in June 2016³⁹, meaning that the premises should not have been occupied until the risk was reduced. Properties were designated into different potential risk categories, high, medium or low⁴⁰ and a £300k fund was made available for works in 2010-2011⁴¹ arising out of FRAs. Presumably, the intention was to reassess for following years. The fact that 5 years were allowed for remediation says everything one needs to know about how seriously the issue of fire safety at Grenfell was taken. The FRA of a building known to be out of compliance is obviously a highly important and safety critical matter⁴². The TMO ought to have been aware of the heightened risk arising from the Tower and should have had Stokes' fire risk assessments scrutinised by a qualified professional, namely a Chartered Fire Engineer⁴³.
111. In summer 2010 Stokes was invited to tender for the KCTMO's FRA work [as CS Stokes]. After the contract for medium risk building FRAs was awarded, KCTMO asked Stokes to carry out his first 'independent' FRA for Grenfell Tower, completed in December 2010.⁴⁴ He previously undertook the 2009 FRA as a sub-contractor for Salvus and also FRAs for other "high risk" KCTMO buildings around

³⁷ CST00000704.

³⁸ RBK00052567.

³⁹ BLARP20000027_0490. Fire risk categorised by Dr Lane as PAS79:2012 *intolerable*

⁴⁰ TMO00842341_0001.

⁴¹ TMO10006116.

⁴² BLARP20000027_0291, Dr Lane quantifies and analyses the extent of the non compliances.

⁴³ As Dr Lane made clear at the end of her Module 1 evidence.

⁴⁴ CST00003063_0009.

that time.⁴⁵ Stokes would go on to conduct 4 other FRAs⁴⁶ on the Tower during the course of the refurbishments, the last on 20th June 2016, around the time the works completed. The TMO retained him as its fire safety consultant until June 2017⁴⁷. He was the only person instructed by the TMO to conduct the Tower's FRAs over that time. He further conducted FRAs for all 100 KCTMO blocks⁴⁸.

The KCTMO Health & Safety Committee

112. The KCTMO Health & Safety Committee, chaired by Executive Director (accountant Anthony Parkes) and later Barbara Matthews), met on a bi-monthly basis and reported to the Executive team.⁴⁹ It:

*“was deliberately comprised of representatives at different levels of seniority and, as stated, from different service areas of the business. Members included Janice Wray, Adrian Bowman, the Executive Director of Operations, the Director of Assets and Regeneration, the Director of Housing, Operations Manager (Repairs Direct), Managing Director (Repairs Direct), Facilities Coordinator, Policy and Compliance Manager, Neighbourhood Managers, Safety Representatives, the Assistant Director of Home Ownership, the Head of Housing Support Services, the Sheltered Housing Team Leader, the Head of Contract Management and the Executive Assistant.”*⁵⁰

113. The composition of the H&S Committee was thus drawn from senior managers from other unrelated departments. It was the main forum for setting and reviewing health and safety policy and strategy, actively monitoring compliance with all relevant statutory provisions, facilitating employee consultation on health and safety, piloting health and safety equipment, and commenting and advising on the impact of new legislation⁵¹. Committee members had no demonstrable experience in safety matters, it was more oriented to broad governance issues as opposed to safety management. There were no engineers, technicians or system owners. It was a framework within which safety suffered. Maintaining compliance of technical and engineering systems requires technical input which often requires professional engineering expertise; it is not governance based alone. Nor, of course, were the tenants and leaseholders represented on this Committee, even though their health and safety was at stake.

114. Wray appears to have drafted all H & S Committee Health and Safety updates. These should have dealt with technical matters, although it is difficult to see how this is possible given Wray's own evidence:

“My background is in occupational health safety, I do not possess the technical knowledge or expertise

⁴⁵ CST00003063_0010.

⁴⁶ CST00003063(CST00002803 is the 2010 FRA) FRA of Grenfell Tower was conducted by Carl Stokes on December 2010, CST00003063 (CST00030041 is the low risk contract URN) Carl Stokes entered into contract for low risk buildings on 24 August 2011, CST00000472 FRA of Grenfell Tower was conducted by Carl Stokes on 20 November 2012, CST00000093 FRA of Grenfell Tower was conducted by Carl Stokes on 17 October 2014, CST00000087 FRA of Grenfell Tower was conducted by Carl Stokes on 26 April 2016, CST00000100 FRA of Grenfell Tower was conducted by CS on 20 June 2016.

⁴⁷ TMO00842341

⁴⁸ TMO10037422_0002.

⁴⁹ TMO00873380 para 10

⁵⁰ TMO00873380 para 12 WS of Barbara Matthews

⁵¹ TMO00843882 TMO's Annual Health and Safety Report 2015/2016.

*that would be required to determine whether a particular building feature complied with the relevant legislation and guidance.”*⁵²

115. TMO’s key policy document for fire safety was called the Fire Safety Strategy (FSS)⁵³. In November 2016, the TMO Health and Safety Committee and RBKC agreed that the TMO FSS would be revised^{54,55}. This was reviewed and updated in 2017. Matthews said she oversaw this review, which was led by Wray, with progress recorded in the Health and Safety Committee meeting minutes.⁵⁶ Wray noted that the main changes they *“intended to implement were a more proactive approach to the installation of self-closing devices to flat doors across the stock, an increase in the frequency of FRAs and a requirement for Fire Action Notices in the communal entrance lobbies of all blocks”*⁵⁷. At the time of the fire this new FSS was still in final draft stage⁵⁸. The TMO FSS documents did not look at fire safety in the building as a whole, thereby producing an integrated fire strategy for the building’s performance. Neither did the TMO assemble a group of technical experts or engineers to inform them of the building’s performance as a whole. Wray was not sufficiently experienced to have undertaken such a role.
116. Matthews relied heavily on Wray to produce safety reports each March, which she would present to the board and RBKC’s scrutiny committee⁵⁹. Although Matthews states in her witness statement that *“The ongoing review programme follows best practice as set out in the KCTMO Fire Safety Policy Strategy”* and that *“Progress with completing the FRA Action Plan recommendations are monitored by the Health and Safety Committee which receives a breakdown with age profile of all actions outstanding per team”*⁶⁰, the KCTMO Fire Safety Policy and Strategy document did not set out any review programme at all. As Dr Lane emphasises, generally the committee was ineffective at progressing outstanding actions from Stokes FRA action plans⁶¹.

Carl Stokes

117. The TMO’s faith in Stokes was not universally held by others. In a bi-monthly meeting between the TMO and LFB on 5 January 2016 Rebecca Burton (LFB) *“raised her concern that the Fire Risk Assessor sometimes makes statements which are not justified or supported and that FRA reports need to include justification for statements made”*.⁶² She emphasised that discussions with LFB officers needed to provide names, dates and confirmation of the outcome of discussions *etc.*⁶³ Stokes’ October 2014 FRA

⁵² TMO00000890_0016.

⁵³ TMO000873380 para 66.

⁵⁴ TMO10015595.

⁵⁵ TMO00000890_0038

⁵⁶ TMO000873380 para 66-67

⁵⁷ TMO00000890_0041

⁵⁸ TMO00000890_0042.

⁵⁹ TMO000873380 para 20.

⁶⁰ TMO00843882.

⁶¹ BLARP20000027_0149.

⁶² LFB00000061.

⁶³ LFB00000061_0004.

differed significantly from Leon Taylor's FRA of June 2014⁶⁴ in respect of escape methods, self-closing devices, intumescent strips, closing devices, and fire safety notices and signage, and level of risk.

118. The TMO relied on Stokes to give advice on the regeneration works that was more in keeping with the expertise of a consulting engineer than an unregulated fire risk assessor with no formal engineering qualifications. As Dr Lane puts it, "*KCTMO appears to have instructed Mr Stokes to undertake ad-hoc inspections of the works; Mr Stokes recorded these inspections in letters to KCTMO. I have seen no evidence as to how Ms Wray or KCTMO addressed issues raised by Mr Stokes in these letters which do not appear to have been part of any of KCTMO's formal processes or procedures*⁶⁵". In any event these matters were outwith Stokes' competence. The Consultant's Brief refers to *the normal standards of the profession*⁶⁶. A Fire Risk Assessor, notwithstanding the enormous public importance placed on this area of work is not a profession of itself and is routinely not undertaken by professionals, *i.e.*, chartered fire engineers; self-evidently there are occasions where it must be.

Façade and external envelope of the building

119. The TMO excluded the building's façade from Stokes' scope of work. He does not appear to have taken exception to this, despite the fact that his brief asked him to consider "*the compartmentation of the building and any possible shortcomings with it*". Compartmentation cannot be considered when 1 wall is excluded from the scope. On any analysis the exclusion of the façade from assessment is incredible.
120. Stokes came close to considering the façade in the October 2014 FRA Action Plan in relation to the external face of the building, recommending the contractor provide: "*(1) the scope of works covering the cladding? How it would be fixed to the building (2) what fixings would be used (3) the fire rating of the cladding and the fixings (4) BC's acceptance of this fixing and cladding to be used?*⁶⁷" However, this assessment's contents appear to have more to do with Building Regulations compliance than fire safety. Crucially, Stokes did not take these matters with regard to the external facade any further.
121. Clearly, these matters were of critical importance and urgency. On 19th August 2016 there was a fire on the 18th floor of Shepherd's Court. The cladding on the outside of the building comprised polystyrene and plywood insulation panels. Tests concluded they were the likely cause of the fire spreading up the outside. The similarities to Grenfell were striking. Flames began pouring from the open window of a 7th floor kitchen, quickly spreading up the side of the building. Eight months later (6 April 2017), the LFB wrote to Laura Johnson highlighting that testing of the panels showed that the combustibility of the composition of the panels at Shepherd's Court did not meet the levels expected for conformity with building regulations⁶⁸⁶⁹. This letter caused Wray to inquire of Stokes whether the cladding complied

⁶⁴ TMO10001286.

⁶⁵ BLARP20000031_0136.

⁶⁶ CST00030040_0009.

⁶⁷ RBK00059414.

⁶⁸ TMO10016603.

⁶⁹ TMO00000890_0015.

with building regulation requirements.

122. In an email to Robert Black and Matthews, Wray stated: *“I had checked with Carl Stokes, who had advised that we did not have any blocks with cladding of the nature described in the LFB’s letter. I further advised that Carl had investigated the details of the installation with Rydon when the works were on site and he confirmed that the installation complied with the cumin (sic) requirement of the Building Regulations”*⁷⁰⁷¹. In fact, Wray had misrepresented Stokes’ 2-line email *advice* which had not addressed the nature of the cladding simply that *Grenfell was clad but the cladding complied with the requirements of the Building Regulations, lots of questions asked of Rydon’s and answers received back from them*. This is an abject failing on the part of Stokes and a powerful illustration of the non-regulated nature of fire risk assessors. It is all the more egregious given that, following the Lakanal House fire in 2009, the fire industry pushed the government very hard to require fire risk assessors to have certain qualifications or be registered, a register yet to be established.
123. The last FRA completed before the June 2016⁷² fire, shortly after completion of the works, noted that the Tower appeared to have appropriate fire separation and compartmentation and, from a visual inspection of the structure of the building no areas appeared to raise concerns about structural damage to the building or fire stopping issues.⁷³ Stokes made these unqualified comments but did not:
- (a) Assess the material of construction of the cladding;
 - (b) Complete any invasive assessment of the material of construction of the cladding;
 - (c) Seek the input of a chartered fire engineer;
 - (d) Consider the material classification or material safety data sheets for the cladding;
 - (e) Suggest that invasive assessment should take place.
 - (f) Make any form of assessment or inquiry of the basis upon which Building Control assessed the cladding.
124. The 2016 FRA entries were made when Stokes was unsighted of any *formal records and was made without any relevant information about the “facade scheme”*; these entries therefore amount to unsubstantiated comments on a topic he knew nothing about, had made no meaningful effort to assess and was himself in the round, unqualified to assess. Had he sought out the Building manual he would have identified that it contained no fire performance information about the infill panels, an inaccurate BBA Agrément certificate and an inaccurate Celotex RS5000 thermal insulation datasheet⁷⁴. It is incredible that Stokes could have assessed the façade as tolerable, without this information which he had failed to obtain.

⁷⁰ TMO10016666.

⁷¹ TMO00000890_0015.

⁷² CST00000100.

⁷³ CST00000100_0024.

⁷⁴ BLARP20000032_0113.

125. Both Williams and Wray now rely heavily on the form of words in Stokes' FRA assessment, that the building appeared to have the appropriate fire separation and compartmentation; which is remarkable given they were both keenly aware that Stokes was not instructed to cover the external façade of the Tower. Dr Lane concludes: *[neither] Mr Stokes nor Ms Wray or her superiors in the KCTMO, demonstrated competent understanding of the hazards posed by the works at the time, and they did not make a suitable an sufficient assessment of the risks to the relevant persons, during works in Grenfell Tower*⁷⁵; emphasising the unqualified, unregulated and amateur nature of fire risk assessors and the TMO/RBKC's wholly unjustified reliance on same.

Evacuation

126. Evacuation planning was never part of TMO procedures for Tower residents. In fact, Wray took a dismissive view of the requirement for evacuation plans and PEEPs generally: *"It was also not our role to capture where disabled and vulnerable people might be living in the Tower. This type of information, where available, was kept by the Neighbourhood Management Teams, which were part of the Operations department"*⁷⁶. That approach is contrary to the non-delegable strict duty the TMO were under to ensure so far as reasonably practicable under the FSO and the HSWA 1974 that residents were safe from harm. It also ignored guidance on the topic. As the TMO's safety officer, the responsible person under the FSO, Wray should have ensured the TMO discharged its evacuation planning safety duties. The TMO did not engage with this at all. It did not take residents' safety in the event of fire seriously. What they did do was lacklustre and insufficient.
127. Wray is at pains to point out that the TMO *"provided fire safety information to new and existing tenants and leaseholders on our website and through letters. Furthermore, regular fire safety information was included in the TMO's quarterly magazine "Link" which was hand delivered to all properties by a third party company. Fire Safety articles were also frequently included in "'Home Ownership News" which was a regular newsletter for leaseholders."*⁷⁷ Her evidence is in stark contrast to Cllr Judith Blakeman who noted that following the refurbishments, *"residents received no advice about fire safety and only after several representations were instructions as to what to do in the event of a fire installed on the walls of the communal hallways. The advice was to stay put in their flat (unless that was where the fire was) and await rescue by LFB, which would happen. It was left to the residents themselves to be proactive in order to obtain this advice"*⁷⁸. The statements across the entire BSR group suggest that the TMO's practice in relation to the provision of fire safety information was deficient. Many residents reported they were not given fire safety advice or information about what to do in the event of a fire.
128. Evacuation planning necessitated that the performance of the building was incorporated into the

⁷⁵ BLARP20000031_0007.

⁷⁶ TMO00000890_0038.

⁷⁷ TMO00000890_0004.

⁷⁸ MET00045751_0007

evacuation plan. That is not something that can or ought to be undertaken by residents. It should have involved consideration of many different matters including the SVS, use of lifts, sequencing of resident movement, communication with the LFB, marshalling *etc.* There should have been a considered and workable plan. There was none.

129. The LFB Fire Safety Team met KCTMO on a bimonthly basis. At a meeting on 1st April 2014 Daniel Hallissey advised of a new LFB campaign ‘plan your escape’, which amounted to information for landlords and tenants available through the LFB website and addressed some of the issues raised by the Lakanal house fire⁷⁹. It is not clear what efforts were made to disseminate this material to the tenants.
130. Stokes included emergency escape references at various points in his FRA Action Plans.
- (a) On 30th September 2009 he recommended emergency escape route signage be replaced with signage in accordance with current British Standards containing a pictogram in line with HMG Guidance⁸⁰. The original signage telling residents to leave the building was only taken down after the April 2010 fire. There was no signage of any sort until late 2016⁸¹⁸².
 - (b) In the 2012 FRA Stokes represented that information concerning the evacuation strategy for the building had supposedly been provided to all residents in the tenant’s handbooks, *via* letters and briefing sheets of “*what to do in the event of an emergency*” and articles on fire safety advice and emergency procedures were included in the resident’s magazine ‘Link’. New Grenfell Tower residents were given a handbook and walk around. The evidence indicates that, at least in 2016, there was no Tenant’s Handbook⁸³.
 - (c) In the 2014⁸⁴ FRA Action Plan Stokes recommended Rydon be asked for their evacuation policy and FRA;
 - (d) In the April 2016 FRA Action Plan⁸⁵ Stokes makes the same point asking *I would recommend that the contractors, Rydons are asked for a copy of their evacuation policy and procedure for a fire incident within the area of this building under their control. As a minimum this policy should have their procedure for the evacuation of their employees, how the TMO residents will be alerted to any incident in the contractors’ areas and how Rydons will manage any incident.* Stokes therefore assumed the Principal Contractor should have evacuation procedures and that they would cover residents. He was less concerned about how the TMO gave similar advice to the residents.
 - (e) In his June 2016 FRA Stokes said: “*For the residents of this building there is a “stay put” evacuation strategy, this means the residents can remain within their own dwelling during a fire incident in this building unless the fire is in their dwelling or that their dwelling is otherwise*

⁷⁹ LFB00000070.

⁸⁰ CST00000019.

⁸¹ IWS00000500.

⁸² IWS00001335 at paragraph 21.

⁸³ IWS00001343 and IWS 00001503

⁸⁴ CST00000458_0008.

⁸⁵ CST00000451.

*affected by the fire. In which case they should immediately evacuate their dwelling and call the Fire and Rescue Service. The Fire Service or TMO employees will arrange for a general evacuation of the whole building, at any time if this is appropriate to do so. Alternatively the resident can leave their dwelling at any time if they so wish to do so*⁸⁶.

131. It is obvious from these FRA entries that Stokes understood evacuation planning was essential in the event of fire. However, he appears to suggest that evacuation planning can responsibly be effected *ad hoc*, by either the Fire Service or residents themselves, which is contrary to government guidance⁸⁷ and represents a serious breach of duty and a flagrant disregard for resident safety. There is no reference in any FRA of a documented emergency plan. Neither did the TMO/ Wray produce any document on the subject: this was a gross breach of duty⁸⁸⁹ to the BSRs.
132. In the June 2016 FRA, Stokes mentioned the possibility of evacuation. It is lamentable that he never sought to recommend that evacuation planning should be enshrined within KCTMO's procedures, or that evacuation training was put in place within the Tower.
133. Senior members of the TMO Health and Safety team had different views on the existence of and application of evacuation planning and PEEPs in the Tower. None of them took the time to consider the consequence of no plan being in place.⁹⁰

Personal Emergency Evacuation Plans (PEEPs) and disabled and vulnerable residents

134. There were no KCTMO drafted PEEPs (individual plans for means of escape from fire) in place in the Tower for any of the residents. This was despite the existence of well-known and long-established guidance on vulnerability.⁹¹ Some 20 or so Tower residents were known to social services and were vulnerable in one way or another.⁹²⁹³ It is noteworthy that of all the guidance documentation it is Mr Todd's PAS 79:2012 which does not deal with vulnerability⁹⁴.
135. Stokes did not carry out any PEEPs at Grenfell; he understood that Wray's team drafted them.⁹⁵ As with so many of those involved with the Tower, he relied upon an unjustified assumption.
136. Matthews noted there were no evacuation plans for vulnerable residents (or any residents) in Grenfell Tower as any such plans would have directly contradicted the Tower's⁹⁶ 'Stay Put' fire strategy. It is

⁸⁶ TMO00873380 para 53.

⁸⁷ BLARP20000028 _ 0006.

⁸⁸ Reg.8 The Management of Health and Safety at Work Regulations 1999.

⁸⁹ Article 15 Regulatory Reform (Fire Safety) Order 2005.

⁹⁰ See, e.g. TMO00873400, Witness Statement of Anthony Parkes para 27: Parkes was Director of Financial Services at the TMO from August 2009 to June 2015.

⁹¹ HM Government fire safety risk assessment – sleeping accommodation (2006), HM Government Guide – Fire Safety Risk Assessment Means of Escape for Disabled People (2007), Local Authorities Coordinators of Regulatory Services (LaCoRS) Housing – Fire Safety – Guidance on Fire Safety Provisions for certain types of existing housing (2008) {CST00002516}, Local Government Association – Fire Safety in Purpose Built Blocks of Flats (2012). BS 9991: 2015 Fire Safety in the design, management and use of residential buildings.

⁹² RBK00059428_0001.

⁹³ BLARP20000034_0011.

⁹⁴ BLARP20000034_0043 – 0059.

⁹⁵ CST00030186_038.

⁹⁶ TMO00873380 para 52.

staggering that Director of Health and Safety Matthews, believed ‘stay put’ could contradict evacuation planning. Safety planning is designed to ensure a safe system of practice. It is not confined to a single control method, neither is there an inherent assumption that any 1 method is infallible. Ensuring evacuation planning was in place would not have contradicted LFB advice, but consistent and supplementary and should have been in place as part of the TMO’s non-existent emergency planning.

137. When considering evacuation of disabled and vulnerable residents Wray noted the allocation of properties to residents was the responsibility of RBKC⁹⁷ *“to the best of my knowledge, the RBKC did not have a policy restricting the floor height of properties allocated to vulnerable residents. However, Grenfell Tower had a “stay put” policy which was based on the concept of compartmentation. It was not therefore anticipated that residents would have to evacuate their flat unless the fire was in their flat, in which case they were advised to leave the flat, close the front door and call the LFB.”*⁹⁸ Wray’s view was, if residents raised fire safety concerns, they would investigate and if necessary, advise Stokes.⁹⁹
138. The general duty placed on KCTMO under HSWA 1974 was to ensure insofar as was reasonably practicable that all residents were safe. That non-delegable duty was not vitiated by any resident’s mental health or physical vulnerability. On the contrary, it placed a burden on the TMO to ensure any vulnerabilities were accommodated. Thus, the TMO should have ensured that there were in place adequate PEEPs for disabled and vulnerable residents.
139. Stokes also advised not to provide a Premises Information Box; a box stored in the Tower in a location known to the LFB where fire relevant information¹⁰⁰ could be found. His advice was at odds with fire officers *“asked about providing of premises information packs, I would strongly recommend that these are not provided”*¹⁰¹. There was no practical reason why this was not provided and important reasons why it should have been.
140. The TMO, as the Responsible Person¹⁰², failed to undertake suitable and sufficient Fire Risk Assessments. An FRA’s primary purpose is to advise the Responsible Person what general fire precautions¹⁰³ must be taken. The TMO and RBKC failed to ensure suitable and sufficient FRAs were obtained and did not seek appropriate professional advice where residents’ safety was in issue. Stokes advised the TMO the lifts were firefighter lifts, even though MF had pointed out to him, that this was not the case¹⁰⁴. On the night of the fire, there was an avoidable loss of life when residents used the lift and exited into smoke-filled lobbies. Others with limited mobility and mental health vulnerabilities may

⁹⁷ TMO00000890_0028.

⁹⁸ TMO00000890_0028.

⁹⁹ TMO00000890_0028.

¹⁰⁰ Documents and drawings showing the location of operating instructions key switches, gas isolation valves *etc.*

¹⁰¹ CST00000185. Letter from C Stokes to C Williams re comments raised by the LFB following a site visit to Grenfell, on 12th March 2014. Stokes subsequently visited site and took photos in March 2014. Exhibit contains material re maintenance certificates.

¹⁰² Article 9 of the Regulatory Reform Fire Safety Order 2005 (FSO).

¹⁰³ Defined by Article 4 RRO as including: (b) measures in relation to the means of escape... (c) measures for securing that, at all material times, the means of escape can be safely and effectively used.

¹⁰⁴ CST00000185_0003.

have lost their lives because they did not feel able to utilise the lifts to evacuate. It is truly astounding that the TMO would suggest PEEPs were not required for residents and yet in their Fire Safety Policy and Strategy mandate their own staff had to have PEEPs in place whenever a member of staff was *not fully able-bodied and who may need assistance to be alerted to the fire alarm and / or require assistance to evacuate from the office*¹⁰⁵.

141. Dr Lane and Mr Todd make no reference to each other's opinions in their respective reports, the contents of which are diametrically opposed to one another. Mr Todd inexplicably excludes from the scope of FRAs the external envelope of the building. As a matter of inexorable logic, basic engineering, and risk assessment practice it is inconceivable that any suitable and sufficient FRA would not include the envelope of the building. Similarly, and in our view absolutely necessarily, Dr Lane advances that all passive protective measures must be included.
142. Mr Todd takes a dim view of fire risk assessor competence stating: *"In my opinion little, if any, special competence is required, in relation to the principles of fire safety, to enable a competent fire risk assessor to carry out a Type 1 (non-intrusive) FRA for a high-rise block of flats with a straightforward layout, such as Grenfell Tower*¹⁰⁶". This in our view is an inherently dangerous position to take promoting what would amount to a *race to the bottom* in fire risk assessment standards and the duty of care extended to residents in similar blocks.
143. The third of the general areas on which Mr Todd and Dr Lane disagree is Evacuation. In Mr Todd's module 3 report he maintains the position set out in the Local Government Association Guidelines that it is not *"normally practicable for a freeholder or landlord to make special arrangements for evacuation of these residents in the event of fire ... In blocks of flats, it is, normally, wholly unrealistic to expect the housing provider to prepare Personal Emergency Evacuation Plans (PEEPs) for all residents who might need assistance with evacuation in the event that it becomes necessary (i.e., on the instructions of the fire and rescue service)"*. That position is at odds with PAS 79: 2012 that states that *"adequate procedures will normally address the arrangements for evacuation of disabled occupants"*.
144. The TMO were aware of the vulnerability of certain residents and took no action to provide for them. For example:
- (a) Elpidio Bonifacio was registered blind and had mobility issues, both he and his wife were elderly, they lived on the 11th floor.¹⁰⁷;
 - (b) Raymond Bernard, who lived on the top floor of the tower, had severe arthritis and mobility issues his sister had written to RBKC trying to get him rehoused from the top floor. Mr Bernard died in the fire¹⁰⁸;

¹⁰⁵ TMO00858525_010.

¹⁰⁶ CTA00000011_0012.

¹⁰⁷ IWS00001085 Witness statement of Elpidio Bonifacio

¹⁰⁸ WS Reference to follow

- (c) Steve Power was a vulnerable resident – he had a lung condition, emphysema, and had recently been treated for bowel cancer. He was housed on the 15th floor. He relied heavily on the lifts and he too died in the fire¹⁰⁹.

145. In summary:

- (a) There was, at all relevant times, no Fire Safety Strategy in place;
- (b) Stokes was not qualified (academically, vocationally or by experience) to carry out the complex FRAs that Grenfell required;
- (c) The FRAs were not suitable and sufficient they were wholly inadequate, in particular in that they did not deal with the Façade and external envelope of the building;
- (d) There was no or no adequate evacuation plan and no emergency plan;
- (e) No proper consideration was given to vulnerable residents; and,
- (f) No consideration was given to PEEPs.

TOPIC 3

Fire Doors

146. The original doors were subject to S4.3.2.3. of British Standard CP3 Chapter 4 Part 1 (1971) which specified a Type 3 fire resisting door which was *free from collapse* for not less than 30 minutes with a resistance to the passage of flame for not less than 20 minutes. Such door should be fitted in frames with a rebate of not less than 12mm so they can interlock and should be fitted with an automatic self-closing device. Client evidence suggests the original doors were more robust and had greater capacity to withstand fire than the subsequent replacement doors variously installed over the next 45 years¹¹⁰.
147. In 2008 the TMO sought financial approval for around 9000 doors sets.¹¹¹ The TMO's door replacement programme bid evaluation document emphasised the need for better security and energy efficiency, that more doors might also need to be replaced following a FRA, and that contractors would also have to meet Building Regulations requirements including having a 60-minute fire door where dwellings were above the 5th floor (Approved Document B, Vol. 1, Table A 2, Vol. 2, Table A2). The London Housing Consortium (LHC) was consulted and confirmed that only Manse Ltd were able to provide doors of that specification. Consequently, Manse Ltd were identified as preferred supplier. The TMO and Manse Masterdor Ltd entered into an undated JCT Standard Form contract from 14th March 2011 to 31st March 2012.¹¹² A further contract for flat entrance door replacement and associated work was executed on 19th January 2011¹¹³. Neither of those documents specified the doors' performance requirements. There is reference to a Health and Safety File being completed (incorrectly as a sub-set of the building manual), which we now know, from Dr Lane's module 1 work, was never completed.

¹⁰⁹ IWS00001036 Witness statement of Rebecca Ross daughter of Steve Power

¹¹⁰ Hanan Wahabi IWS00000074_0005.

¹¹¹ TMO00866675.

¹¹² MAS00000086.

¹¹³ MAS00000039.

148. Stokes' FRA¹¹⁴ (30th September 2009), assessed each dwelling door as FD30, noting fire doors on the staircase compartment were not fitted with intumescent strips and cold smoke seals, in line with current standards, indicative of FD30s standard doors and best practice. It recommended the TMO introduce and implement a system of formal checks on tenant fire doors and all other fire compartmentation doors to ensure fire compartments remained fit for purpose¹¹⁵. It further recommended confirmation be sought that each dwelling had a FR30¹¹⁶, *sic*, standard door with self-closing device. Stokes appears to have fallen into error since ADB¹¹⁷ indicates FD30s doors were required.
149. On 27th January 2010 Wray informed the TMO Health & Safety Sub Committee meeting¹¹⁸ that:
The main issues being raised were in relation to:
- 9.1 Inspection and if necessary replacement of flat entrance doors in enclosed blocks to ensure they present a sufficient level of fire resistance, are self-closing and fitted with intumescent strips and cold smoke seals.*
- 9.2 Need to install smoke alarms within dwellings across the stock. Currently approx. one third of dwellings have these installed*
- 9.3 Where flat entrance doors are demised to lessees, can they be persuaded to replace these with the appropriate fire rated door? Can we enforce this in respect of leaseholders? If not it is the fire assessors view that we would need to adopt an "evacuation strategy" within our blocks and not "defend in place" and this has significant implications for the installation of automatic detection in the common parts etc.*
150. These notes evidence that Wray was well-aware of the import of fire doors and, in particular, that there were related shortcomings as early as 2010. The leaseholders' doors were not subsequently replaced and neither was an evacuation plan put in place. Furthermore, this issue highlights that the non-compliance of the doors went beyond the doors themselves and impacted on the Tower's fire safety strategy as a whole. It is likely many leaseholders would not have been able to afford a change. Given the relatively low number of leaseholders (approximately 10% of tenants) the TMO should surely have included them in the replacement programme.
151. In 2010 Rand and Associates did a selective survey of fire doors across the TMO estate¹¹⁹, revealing that intumescent strips and cold smoke seals were missing more often than they were in place. None of those doors would have passed FD30s criterion for smoke seals. None of the doors surveyed had automatic closers on them.
152. On 4th November 2010 Wray met with others to discuss the fire door programme. The minutes noted

¹¹⁴ CST00000334.

¹¹⁵ CST00000334_0016, para 3.4.

¹¹⁶ *Opere Citato*.

¹¹⁷ CEP000005809_0136 Table B1 Provisions for Fire Doors.

¹¹⁸ TMO10000641_0003 paragraph 9.1.

¹¹⁹ TMO00866665.

- the need to start work by January 2011 and that LHC (who had a framework for 3 contractors) put together a tender list. It was minuted¹²⁰ that the TMO had a £300k budget for an anticipated 18-month programme. The TMO-produced spreadsheet entitled “*Buildings where fire doors could be fitted*”¹²¹ dated 15th Nov 2010 lists Grenfell Tower as having 120 flats and in the 1st priority category. On 19th January 2011, the TMO produced a summary of tenders received¹²². Manse Masterdor were significantly cheapest of 3 quotes. The other 2 contractors offered £302k and £300k whereas Masterdor quoted £241k.
153. The first door was fitted on 25th April 2011 and the majority of doors installed in May and June 2011. However, the odd door appears to have been fitted later *i.e.*, January 2012 and a few in August 2013¹²³.
154. On 5th July 2011 an email exchange between Abigail Acosta (KCTMO) and Andy Marshall¹²⁴ (KCTMO) confirms the door programme would be finished by 31st October 2011 and that Masterdor would inspect the doors after 5 years. There is, however, no evidence that those checks were ever done. By February 2013 the replacement programme had still not been completed, with the TMO serving a formal notice of breach of contract on Masterdor¹²⁵.
155. By October 2011, 101 of 106 doors listed, had been replaced¹²⁶, the last fitted on 19th August 2013¹²⁷.
156. On 11th October 2012 the TMO wrote letters before action to leaseholders giving them 2 weeks to show their doors were compliant or 5 weeks to replace the door, notwithstanding communications from tenants that the original doors were safe and working. After correspondence with the GTLA, the TMO confirmed that current leaseholder doors were compliant¹²⁸.
157. On 26th April 2016 Stokes confirmed 15 flats had original doors¹²⁹. Various non-compliances were noted in the 20th June 2016 Significant Findings & Action Plan¹³⁰ including, non-compliant entrance doors and newly-fitted doors which did not have cold smoke seals. Incredibly, some of the doors had had their intumescent strips painted over. One flat had its letter box missing¹³¹, a breach of the tower’s fire-stopping requirements. Some staircase doors did not fully close and the 16th floor door was damaged. There were multiple examples of fire safety breaches.
158. On 17th November 2016, The London Fire and Emergency Planning Authority sent a Notification of Fire Safety Deficiencies (a Deficiency Notice) in respect of Grenfell Tower to Wray in her capacity as the Health and Safety Manager of RBKC¹³². Deficiency Notices are a normal precursor to prosecution

¹²⁰ TMO00866673.

¹²¹ TMO00855437

¹²² TMO00866698.

¹²³ MAS00000003.

¹²⁴ TMO00867453.

¹²⁵ MAS00000072.

¹²⁶ TMO00863067.

¹²⁷ MAS00000003.

¹²⁸ IWS00001335 para 90-105 and TMO10033113.

¹²⁹ CST00000087.

¹³⁰ TMO10017691.

¹³¹ CST00001554.

¹³² CST00000065.

and attach schedules of the inspecting fire officer's fire safety audit observations and identifying FSO breaches. The schedule identified a number of breaches including:

- (a) Fire doors that did not properly close or fit into their frames; Art 11 breach;
- (b) A breach in a service duct; Article 11 breach;
- (c) No suitable system of maintenance was in place for fire doors protecting the single staircase used in the event of escape; the staircase doors did not close into their frames. The implication being that self-closers were either not working or absent. There was a concern about the fire-resistance of protected evacuation routes for want of maintenance; Article 17 breach;
- (d) Items were stored in the building's common areas thereby impacting on residents' ability to utilise escape routes. Fire doors along the escape route did not close; Article 14 breach.
- (e) General fire precautions to prevent smoke spread via shafts risers and ducting were inadequate; Article 8 breach;
- (f) Fire Action Notices were not displayed in common areas; Article 15 breach – a breach of the most basic of provisions and reflective of how seriously the TMO took its fire protection duties.

159. Problems with fire doors not fitting their frames, several fire doors to the staircase not fully closing and flat doors not self-closing had been raised on many occasions in the FRAs. These failures highlight a systemic failure on the TMO's part omitting to take action not just in Grenfell but also in other blocks.

160. In December 2016 a safety board update¹³³ was issued following deficiency notices issued against 4 TMO properties; Lonsdale House, Portobello Court Estate, 9 Colville Square, Brandon Walk, Lancaster West Estate and Grenfell Tower. This referred to several notices queried with the LFB and expressed surprise at having received the notices. It is remarkable that a deficiency notice does not carry any enforcement power and that the LFB¹³⁴ did not follow up these notices. Had the LFB 31 utilized their power to serve statutory enforcement notices under the FSO instead, which as a matter of law require satisfaction, the Tower's long term non-compliant fire safety status may have been in better order.

161. On 16th March 2017¹³⁵ KCTMO's Health and Safety group met to review the 'Fire Strategy' and provide an update on 'self-closers. Section 3 of the document covers the inspection and maintenance program for self-closing devices. Wray pointed out:

"This issue was also discussed with RBKC on 1st March and in conclusion it has been agreed that, at this stage, we will not be instigating a dedicated inspection / maintenance programme for these devices. Concern was expressed that the real value of such a programme in terms of improving resident safety is impossible to quantify and so it is difficult to justify committing limited resources to a programme which would then be ongoing indefinitely". (emphasis added)

162. Wray notes that a number of Fire Action Notices had been ordered and would be fitted during regular

¹³³ TMO10015719.

¹³⁴ LFB00032092_0008.

¹³⁵ Although Ms Wray has signed this update 10th March 2017.

inspections of the different blocks.

163. LFB Senior Fire Safety Officer James Finn visited the Tower and produced a Senior Fire Safety Officer's Report (18th June 2017). It is plain from the text that it has in part been revised post-fire. Finn observed:
- (a) Many of the door self-closers were either missing or broken¹³⁶. There is some evidence to suggest that door closers were inadequately fixed to doors by the use of short or insubstantial screws¹³⁷.
 - (b) The gas service to flats penetrated to the stair core was surface mounted and boxed in common areas having been routed through a protected stair core. The officer indicated that this design option needed to be investigated to justify the approach;
 - (c) There were a number of covered smoke detectors¹³⁸ including one at the base of the gas line at 1st floor level in the service riser. It was also unclear which fire alarm systems functioned when the commercial detector actuated;
 - (d) It was not possible to determine if the system was operating correctly and he indicated further investigation was required, in a separate report;
 - (e) The ground floor entrance level ventilation arrangements needed to be confirmed. A number of *motorised windows* (AOVs) appeared to not have any detection to operate them, a possible commissioning omission.
164. It is of great concern that the officer did not have sufficient material available to him at the time of his inspection to obtain a comprehensive knowledge of how the SVS was intended to operate. The absence of documentation and lack of clarity of the SVS's performance and operational capabilities caused the officer practical difficulties. If confusion reigned at the time of inspection when a senior officer had time to consider the operation of the system, it is not surprising that firefighters on the night were unable to fully understand the operation of the system.
165. It is unclear what action was taken by the TMO to rectify the many outstanding fire doors failures prior to the fire. However, minded of the history of non-compliance, it is likely that either no action or insufficient action was taken.
166. On 26th April 2018, the Government Legal Department on behalf of the MHCLG wrote to the Inquiry¹³⁹ setting out the results they had obtained having tested¹⁴⁰ Manse Masterdor doors in various London Boroughs to ascertain their fire resistance. Of 14 Manse Masterdor doors tested only 1 survived past 30 minutes. The only compliant door was manufactured in 2009, indicating MM's manufacturing after 2009 had a direct effect on door quality. MM technical manager Jim Duncan is noted by other witnesses to have instructed changes to manufacturing that affected the doors' integrity. Production team leader

¹³⁶ MET00017099_0015.

¹³⁷ CST00000911 & TMO00867783.

¹³⁸ Counsel's emphasis.

¹³⁹ CLG10003021.

¹⁴⁰ To BS EN 1634-01: 2000: British = BS 476 Part 22: 1987.

George Whitton¹⁴¹ states Jim Duncan, Garry Fox and Dan Jones changed the way they glazed doors. He was told to remove the pads on locks and down the lock strip, and to use intumescent strips instead of fire sealant¹⁴². He states there were arguments about the changes and that he was not happy with the changes as he believed they affected the doors’¹⁴³ integrity. MM line supervisor Clive Allsop also confirms¹⁴⁴ that in the period 2009-2014 *“Jim Duncan, Garry Fox and Dan Jones instructed us to remove intumescent strips and pads. We put less on the locking mechanisms and frames. We also changed suppliers of intumescent strips from previous working instructions.”*

167. George Whitton confirms the impetus behind the drop in manufacturing standards was to save money¹⁴⁵: *“They were looking for ways to save money and costs. We were specifically asked to remove products and items from doors. Looking back now I can see the integrity of the doors were compromised. Anything that could be made cheaper was made cheaper, and anything that could be removed was removed.”*
168. Clive Allsop also gives evidence of quality and safety being comprised with the aim of cost savings¹⁴⁶.
169. Our clients were subjected to this poor build quality. The frame of Zak Chebiouni door was made of plastic with sealant around the edge, the sealant came off the frame¹⁴⁷, *“resulting in a compartmentation breach. If you stood in front of the door you could feel a draught at your feet”¹⁴⁸*.
170. Hanan Wahabi’s replacement door, door closer broke shortly after it was installed, it was never fixed, the door never functioned properly¹⁴⁹. Mr Wahabi was not alone¹⁵⁰.
171. The lobby fire doors would often not close¹⁵¹, no doubt restraining the smoke ventilation system from maintaining a stable positive pressure across the stair lobby, negating the design operability for fire fighters in the stair well.
172. In short, there was a long and sorry history of defective and inadequate fire doors at Grenfell Tower. The TMO never addressed this satisfactorily or all. The LFB attempted to do so, but ineffectively. The doors’ poor quality had a significant impact on the spread of smoke and flames throughout the building.

LIFTS

The first lift project 2003-2006

173. In August 2004, Apex lifts were appointed by Butler Young Lift Consultants (BYLC), to refurbish all

¹⁴¹ MAS00000349.

¹⁴² MAS00000349_0003.

¹⁴³ MAS00000349_0003.

¹⁴⁴ MAS00000347.

¹⁴⁵ MET00040070_0002

¹⁴⁶ MAS00000347_0002

¹⁴⁷ IWS00001979_0002.

¹⁴⁸ Ibid.

¹⁴⁹ IWS00001714_0003.

¹⁵⁰ Samuel Daniels IWS00002065_0003, door would not lock closed, Rabia Yahya IWS00000498_0003 door closer causing door to not close properly, door closer loosely attached, removed and never replaced.

¹⁵¹ Bellal El-Guenuni, IWS00002034_0003.

3 Tower lifts to BYLC's specifications¹⁵². The specifications set out the detail and operation for 'Fireman's Control' but not for Fire Fighting Lifts. The concept of a firefighting lift had been in force for years prior to this first and principal lift project. By 2000 statutory guidance was provided by ADB 2000 section 18.11 stating that *firefighting lift installations should be constructed and installed in accordance with the recommendations of Section 3 of BS 5588-5:1991*¹⁵³. BYLC should have considered modernising the lifts to meet a firefighting lift standard, so far as was reasonably practical¹⁵⁴. BYLC's contract documentation for lift refurbishment works, for Project 1 was dated 1st October 2004¹⁵⁵. When completion of the lift works occurred in February 2006, the lifts were not compliant with BS EN 81-72: 2003¹⁵⁶ or fulfilled the criteria under BS 5655-11: 1989¹⁵⁷ or with BS 5588-5 1991¹⁵⁸. Clearly, BYLC breached their own specification¹⁵⁹.

174. There are no contemporaneous reports, minutes, designs or FRAs to say either the TMO, BYLC or Apex considered compliance with the objectives of firefighting lift requirements⁹. Cognisant of the undertaking of all 3 duty holders¹⁶⁰ they all should have been keenly aware of the requirement for Grenfell lifts to have a firefighting capability. The failure to upgrade lifts in 2004 and lack of consideration in the intervening years was a grievous breach, the ramifications of which had grave consequences in 2017.
175. Robin Cahalarn, employed by the TMO as Lift Engineer until December 2012, claims in his statement: *"In terms of the possible upgrade, I do not recall the reference to the costs meeting the recommended standards and upgrade but from my knowledge at the time, I would anticipate that each lift within the portfolio would have cost more than £10,000 each to upgrade... [to a firefighting lift]*. Mr Howkins, however, points out¹⁶¹ that a cost of £20,000, is about 3% of the total contract price of approximately £600,000. 3% is a small proportion of the overall contract price, particularly given the importance of the firefighting lift features.
176. Mr Howkins opines: *"I would have expected a reasonably competent lift consultant to have considered modernizing the lifts to the firefighting standard to the extent that it was reasonably practicable to do*

¹⁵² APX00005619.

¹⁵³ BLAS0000033, Appendix L, para. L.3.3.2.

¹⁵⁴ RHO00000003_0111, para.217 & BS 5655-11: 1989 BSI00001728 BS 5655-11:1989 - Lifts and service lifts. Recommendations for the installation of new, and the modernisation of, electric lifts in existing building.

¹⁵⁵ APX00005619.

¹⁵⁶ BS EN 81-72: 2003 - Safety rules for the construction and installation of lifts. Particular applications for passenger and goods passenger lifts. Firefighters lifts, BSI00001725. Which variously set out the requirements for lift design including the protection of electrical equipment against water, rescue of trapped fire fighters, control systems to provide lift operation functions, protected power supplies, back up power and communication systems This standard was widely regarded as best practice by 2005.

¹⁵⁷ BS 5655-11: 1989 [BSI00001728], - Lifts and service lifts. Recommendations for the installation of new, and the modernisation of, electric lifts in existing building.

¹⁵⁸ BS 5588-5: 1991 - Fire precautions in the design, construction and use of buildings, Part 5: Code of practice for firefighting stairs and lifts, [BSI00001721].

¹⁵⁹ APX00005541_022, cl.2A.05

¹⁶⁰ Under both the HSWA 1974 and the CDM 1994.

¹⁶¹ RHO00000003_0140, para.318.

177. Of note in Project 1 BYLC had failed to incorporate into the specification all of the following features:
- (a) Emergency trap door;
 - (b) Firefighting lift well water protection;
 - (c) Firefighting lift control systems;
 - (d) Changeover from primary to secondary supply after operation of the firefighting lift ('secondary power supply');
 - (e) Fire service communication system;
 - (f) Fire resistant landing doors.

The second lift project 2014 to 2015

178. Rydon's Letter of Intent to Apex¹⁶³ Clause 2.18.1 stated: "*All workmanship is to comply with all manufacturer/suppliers' instructions and recommendations and current relevant British standards & codes of practice*". This meant the current relevant Standards in force at the time: BS: 9999¹⁶⁴, BS:5588¹⁶⁵ & BS EN81-72 were incorporated into the contract as part of the standard terms, as confirmed in Apex's Lifts Contract Guarantee (set out in the annexed standard terms to the Lift Escalator Industry Association). That document confirms the signatory, Apex, will perform workmanship contracted to the applicable British Standard Codes of Practice & nationally implemented relevant EU standards & the 1997 Lift Regulations:

"Relevant Standards

Standards of

1. *materials, only where the Member assumes responsibility for their specification, selection or approval under the Contract*
2. *workmanship – being or equivalent to those recommended or required by any of the following at the time of making the Contract:*
 - a. *Applicable British Standards or British Standard Codes of Practice.*
 - b. *Applicable national standards implementing European Standards.*
 - c. *The Lift Regulations 1997 or other statutory provisions that are directly relevant to the Work and required under the Contract.*"

179. Mr Howkins' view is that "*The Lift Regulations 1997 were in force at the time of Project 1. In my opinion they would have applied to the lifts installed as part of Project 1 and also to any safety components which were installed as part of Project 2.*"¹⁶⁶

¹⁶² A view also shared by Mr Howkins, RHO00000003_0111, para.219.

¹⁶³ APX00000025 0009.

¹⁶⁴ BSI 00000064, BS 9999: 2008 Code of Practice for Fire Safety in the design, management and use of buildings.

¹⁶⁵ BS 5588-5:2004 Fire precautions in the design, construction and use of buildings. Access and facilities for fire-fighting [BS100000087].

¹⁶⁶ RHO00000003_0050, para 36.

180. By 2013 the standard for fire fighter's lifts, consisted of the following features¹⁶⁷:

- (a) Fire resistance of firefighting shafts – b) the side internal to the fire-fighting shaft of any exterior wall facing or adjacent to the accommodation should have a fire resistance of 2 hours¹⁶⁸;
- (b) Minimum footprint (Dual Doors), to accommodate a full-size emergency stretcher. The minimum rated load shall be 1000kg and the dimensions of the car 1100mm wide by 2100mm deep as defined in ISO 4190-1¹⁶⁹;
- (c) Speed of travel ability to travel the length of the building in under 60 seconds¹⁷⁰;
- (d) Trap door with access to lift shaft;
- (e) Signage – In buildings provided with more than one lift, such as Grenfell Tower, fire-fighting lift cars should be clearly and conspicuously marked with a notice conforming to BS 5499-1 stating *“Fire-fighting lift: Do not use for goods or refuse”*¹⁷¹;
- (f) Ingress protection rating to IXP3 rating;
- (g) Fire control switch;
- (h) Firefighters' car control panel;
- (i) Lift communications systems – A lift communication system conforming to BS EN 81-72¹⁷² should be provided as part of the fire-fighting lift installation and should be separate from the fire service communications system¹⁷³;
- (j) Secondary form of electrical supply;
- (k) Location of secondary power supply:
*“the machinery space and associated equipment for a fire-fighting lift should not be sited below the lift well, and should be protected from malfunction caused by water and be protected against fire in accordance with BS EN 81-72¹⁷⁴ ... The fire-fighting lift machinery space is most effectively protected by incorporation within the fire-fighting shaft. If the lift machine is sited directly within the lift well, thus obviating the need for a separate machinery space”*¹⁷⁵;
- (l) Secondary power supply switch over rate; and,
- (m) Fire resistance of landing doors.

181. Mr Howkins observes:

¹⁶⁷ BS EN 81-72:2003 [BSI00001725] & BS 5588-5:2004 Fire precautions in the design, construction and use of buildings. Access and facilities for fire-fighting [BSI00000087].

¹⁶⁸ BSI00000087_0023, para. 7.1.5. (b).

¹⁶⁹ BS EN 81-72: 2003, - Safety rules for the construction and installation of lifts. Particular applications for passenger and goods passenger lifts. Firefighters lifts, [BSI00001725].

¹⁷⁰ BS EN 81-72: 2003 - Safety rules for the construction and installation of lifts. Particular applications for passenger and goods passenger lifts. Firefighters lifts, [BSI00001725].

¹⁷¹ BSI00000087_0031, para 7.2.7.

¹⁷² BS EN 81-72: 2003 - Safety rules for the construction and installation of lifts. Particular applications for passenger and goods passenger lifts. Firefighters lifts, [BSI00001725].

¹⁷³ BSI00000087_0033, para. 8.4.

¹⁷⁴ BS EN 81-72: 2003 - Safety rules for the construction and installation of lifts. Particular applications for passenger and goods passenger lifts. Firefighters lifts, [BSI00001725].

¹⁷⁵ BSI00000087_0031, para.7.2.9.

“In relation to Project 2, Apex’s involvement was far more limited. Given the scope of works which they were contracted to carry out, I do not think that Apex had a duty to flag the issue of the lifts’ non-compliance with relevant standards and codes to TMO or any other body. In this regard I have no significant criticism of Apex.”

182. Mr Howkins’ opinion that Apex owed no duty to the TMO in Project 2 is open to serious question. Irrespective of whether or not Apex acted in the capacity of contractor or designer under the Construction (Design and Management) Regulations 2007, it was subject to CDM regulations mandating competence, co-operation, co-ordination irrespective of any other common law or implied duties. Further, as Apex was principal contractor in the 2003-2006 project, it should have been well aware of the lifts’ shortcomings. It would be extraordinary for its involvement in a latter project to vitiate its duty from an earlier one, where the same failure remained unremedied. Apex was in breach of *its* collateral guarantee¹⁷⁶ specifically, paragraph (b), ‘*to comply with the Relevant Standards when performing the Contract*’.
183. One can see the discrepancy as between the TMO’s internal standard *Fire Safety Policy and Strategy*¹⁷⁷ for Fire Fighting Lifts and those features which should have been installed. At no point does the TMO document set out any authority for having adopted the standards contained therein, neither does it reference a single standard. When one has regard to the standards that have to be considered, the combined effect of which give definition to the concept of a Fire Fighting lift, it is obvious the TMO document is grossly inadequate and that the TMO undertook no reasonable review when compiling this Internal Policy Document.
- (a) There is no mention, at all, of internal trap doors allowing egress from the lift shaft.
 - (b) There is no mention of Ingress Protection (water protection) for electrical cabling or instrumentation, a necessary safety precaution if lift shafts become flooded with fire water.
 - (c) Whilst a fireman’s switch is referenced, real confusion and mistakes arose at the time of the refurbishment; an inappropriate switch was installed, which was not properly tested and there was confusion over the location of the installation – and over TMO’s adopted terminology.
 - (d) No reference at all is made of a secondary or standby power to lifts. CIBSE Guide D 2015 recommends the primary electrical supply be from a sub-main circuit exclusive to the lift and independent of any other main or sub-main circuit. A secondary supply should have sufficient capacity to maintain the firefighting lift in operation for at least 2 hours, support any auxiliary equipment such as lighting, ventilation or pressurisation plant and, if required, to be able to recover all other lifts to a specified safe location, one at a time within the firefighting shaft.¹⁷⁸ Failure to

¹⁷⁶ RYD00031772.

¹⁷⁷ TMO00858525.

¹⁷⁸ The Chartered Institution of Building Services Engineers (CIBSE) produced a guidance document in 2015: CIBSE Guide D 2015.

install a secondary power supply is likely to have decreased the operational time of the lift on the night of the fire, which may well have contributed to the loss of life as the lift could not be used for evacuation or egress purposes over the same duration as a lift with a secondary power source.

- (e) A fire service communication system was required under the *Lift Regulations 1997*. A schedule to the regulations provided for “*Essential Health and Safety Requirements Relating to the Design and Construction of Lifts and Safety Components*”. Under paragraphs 4.5 and 4.9.

“4.5 *Cars must be fitted with two-way means of communication allowing permanent contact with a rescue service.*

4.9 *The means of communication referred to in Section 4.5 and the emergency lighting referred to in Section 4.8 must be designed and constructed so as to function even without the normal power supply. Their period of operation should be long enough to allow normal operation of the rescue procedure.*”

184. Notwithstanding the statutory requirement, as a matter of basic common sense, basic safety precautions and good practice, this facility ought to have been installed. Had it been installed, the LFB would have been able to marshal the movements of residents and direct their own operations.

	Fire Fighting Lift Features as set out in TMO’s Fire Strategies 2012 & 2016	Required Features under Howkins Lift Report that were missing from Grenfell Tower Lifts ¹⁷⁹
1	1. Minimum car size (1100mm wide x 1400mm deep) for 8 persons capacity (630kg).	-
2	-	Emergency trap door (‘trap door’)
3	-	Firefighting lift well water protection
4	4. Fireman’s Control Switch fitted. When operated this causes the lift to return to ground floor and open to allow the fire fighters access. It stops landing calls being registered and allows the authorised person <i>e.g.</i> , LFB operative to take control of the lift (by applying a constant pressure on any call button).	Firefighting lift control systems

¹⁷⁹ As they were omitted from the Butler and Young Specification, RHO00000003_0135.

5	2. Dedicated power supply serving lift (3 phase). Additionally, ancillary items such as lift alarm, lighting etc. are also served by their own dedicated power supply	Changeover from primary to secondary supply after operation of the firefighting lift switch ('secondary power supply')
6	3. Two way communication on new lifts includes connection to Customer Service Centre/out of hours monitoring service when the lift alarm is activated	Fire service communication system.

Comparison of the TMO's Firefighting Lift requirements taken from The TMO's *Fire Safety Policy and Strategy dated May 14*¹⁸⁰ with the as installed missing requirements as set out in Mr Howkins Report.

185. In a section of the Tower's 20th June 2016 Fire Risk Assessment¹⁸¹ entitled *use and layout of the building*, Stokes inaccurately states: *"Both lifts installed in this building are firefighting/evacuation lifts according to the TMO's documentation, these fighting/evacuation lifts have their own independent dedicated power supply and fire fighters control switch"*, implying he understood the categorisation on of the lift had consequences for the safe use of the building as a whole. All the experts agree the lifts were not firefighting lifts. It would appear he did not have regard to the British Standards covering Fire Fighting Lifts, nor had he properly inspected the lift installation. Had he done so he would have identified that there was no duplex power installed in the lift shafts or any of the other matters raised *ante*. The second possibility is that having inspected the power supply to the lifts he lacked the competence to identify a secondary power source. Cognisant of the high level of ingress protection required for firefighting lifts and distinctive nature of duplex cabling it is more likely Stokes had not inspected the lift shafts or asked for photos at all.
186. Two months later, the TMO FRA actions log¹⁸² stated: *"there is no fireman override switch fitted to the ground floor entrance hall to lift lobby area door. There is one fitted to the building entrance/exit door. Action for this risk: no action required. This has been agreed with the building control officer. Contrary to the 2016 Risk Assessment no fireman's switch has been installed on the ground floor of GT, from resulting miscommunication between the managing bodies."* It appears once more that Stokes has not inspected the ground floor lift lobby area at all. Had he done so he would have identified that no fireman's switch was installed at that location.
187. Whilst the TMO's own action log indicates there was *"miscommunication between the managing bodies"*, minded of the importance of the location of the fireman's override switch, it is inconceivable that something so important could have been *'miscommunicated'*. This particular construction management failure arose from a combination of no FSS being in place, a lack of design management

¹⁸⁰ TMO00858525.

¹⁸¹ RBK00013251_0017.

¹⁸² TMO10021405, Fire risk assessment by block A regarding actions log includes Grenfell.

coordination and of appreciation on the construction team's part of the import of designing in fire safety features. Ultimately, there was no overall understanding of how the building would operate in a fire.

188. Further confusion appears to have arisen from the term used for the fireman's override switch applied to the front door to the building, as well as the fireman's control switch to the lift. It was the fire override switch that Paul Steadman of the TMO is supposed to have tested weekly¹⁸³.

TMO failed construction management of the Contractors and confused lift recall instructions.

189. In September 2015 Williams emailed¹⁸⁴ Lawrence (Rydon) to confirm the lifts would be recalled to the level 2 walkway and not the ground/street level in the event of a fire. The next day, 11th September 2015, Lawrence replied to Williams, Artelia's Neil Reed and MF's Matt Smith explaining Grenfell had no working systems to send lifts to ground in case of fire. Failure to recall a lift to level 2 would have made the location of a fire cordon and fire services bridgehead there a nonsense. Lawrence also confirms a fire alarm was not the reason for the lift being re-called to the ground floor, as there is no audible alarm in the communal areas and the alarm panel by the entrance door was not functional as the previous system depended on a concierge, who was removed when the panel was relocated to level 2. The final recall position of the lift does not appear to have been resolved at that time.
190. In April 2016 Blake (Rydon) emailed¹⁸⁵ Smith at MF about the smoke detection system being activated. Once again Williams asked if, in a fire, the lift would return to the ground floor and Dave Hughes (Rydon) replied it would not. According to the FRA 2014¹⁸⁶ action plan, the LFB's staging post in event of fire was to be the ground floor, even though the fire cordon for residents was on the new walkway. From the Metropolitan Police's report¹⁸⁷ the fire control switch on level 2 was never connected for use.
191. Confusingly, at this very late stage Williams appears to expect Rydon's Dave Hughes to produce the Fire Strategy document when she asks for a copy of the latest document. This question belies a fundamental lack of understanding of construction management as well as the responsibilities and competencies of different duty holders.
192. TMO estate manager Siobhan Rumble's¹⁸⁸ statement claims lift inspections were carried out weekly and involved a checklist, part of their function being to ascertain '*Whether the Fire Brigade Drop Key was working correctly*'. The TMO has not yet provided any evidence of a checklist, or of any weekly checks.
193. The WSP report¹⁸⁹ on lifts produced for MPS of August 2018 confirms the Tower's lifts were not interfaced with the lobby smoke detection systems, the level 2 fireman's switch was disconnected and ground floor switch inoperable possibly due to corrosion/damage to the switch. It is clear from the evidence of Paul Steadman and Robin Cahalarn that the TMO did not test the fire control switches

¹⁸³ TMO10049875_0004, para.18.

¹⁸⁴ MAX00005515_0004.

¹⁸⁵ RYD00076122.

¹⁸⁶ TMO00873865.

¹⁸⁷ MET00019973_0020.

¹⁸⁸ TM000000891_0008, para.38.

¹⁸⁹ MET00019973.

weekly, as required under BS 5588-5 1991 according to Mr Howkins.¹⁹⁰ Had it been tested, the TMO would have identified that it was not operative and should have fixed or replaced it.

194. The LFB's inability to take control of the lifts using the fireman's control switch on the night allowed residents to gain access to lifts, which ultimately resulted in firefighters losing control of the lift. When that realisation took hold, vital equipment was placed in lift doorways to ensure the LFB retained control.
195. According to the WSP report¹⁹¹ on lifts produced for the MPS, which checked the condition of the Windcrest Auto diallers, different telephone numbers for rescue services were programmed into the auto diallers unclear if these were manned by trained staff at times – all of which would be a breach of paragraph 4.2.1 of BS EN 81-28¹⁹². Further, both auto diallers were not programmed with the location of the lifts. The effect of this was that in the event of a trapped passenger the rescue service would not be able to identify the location of the lift in accordance with 4.1.6 of BS EN 81-28. Furthermore, the back-up batteries were defective.
196. Finally, it should be noted that the TMO had forewarning of the importance of the operability of a fire control switch. On 30th April 2010, during a fire in Flat 64, a lift failed to respond when called by LFB, slowing their response to the fire floor. Three people were injured¹⁹³ and 60 evacuated.
197. On 28th February 2011 Wray forwarded an email to Stokes she had received from Robin Cahalarn discussing firefighting lifts. Mr Cahalarn stated: *“As recently discussed, standards on fire fighting /evacuation lifts, which are not retrospective? have become a lot clearer over the last year, none of the TMO lifts are firefighting or evacuation lifts. The TMO stock do have some of the requirements, but the cost to meet the recommended standards would prevent us upgrading our lifts.”* It follows that very early on, both the TMO and Stokes were aware of the shortcomings of the Grenfell lifts.
198. In summary, the lifts were, at all relevant times, not firefighting or evacuation lifts, and they were, furthermore, defective and inadequate. Those with mobility issues depended on these lifts to self-evacuate. The TMO were fully aware of these shortcomings but took no adequate steps to address the same. history of the issues themselves.

GAS

199. The Fire broke out at approximately 01:15 on the morning of 14th June 2017. Cadent were first contacted by the LFB at 03:22, Jason Knightley arrived at 03:48. Dave Edwards approached the command unit at 05:35 to ask if Cadent should disconnect the gas supply and was told by Commissioner Cotton they would be in touch if needed. At 07:45, Jason Allday approached the LFB about disconnecting the gas supply and was told to go ahead. Gas supplies to the Tower were isolated at 23:40 on 14th June, more than 18 hours after Cadent had offered assistance to the LFB. Isolation had involved 3 separate cut

¹⁹⁰ RHO00000003_0181.

¹⁹¹ MET00019973.

¹⁹² BS EN 81-28: 2003 – Safety Rules for the Construction and Installation of Lifts.

¹⁹³ LFB00010934, LFB's Notifiable Fire Report.

and cap operations; *i.e.*, digging into the earth to locate and isolate the gas supply on all 3 lines.

200. One of the original 2" steel risers was ruptured sometime during the fire. Mr Hancox concluded: *"At least 18 and probably 26 or more gas meter installations were damaged giving rise to "open ends" feeding the fire in addition to the ruptured riser"*.¹⁹⁴ The time taken to isolate the gas supply was woefully prolonged. As 1 witness put it: as soon as the gas was isolated the fire went out like a light.

Gas riser and lateral replacement project October 2016.

201. Due to a failure in an existing gas supply line a new line had to be installed by tRIIO. In his witness statement tRIIO Contract Director Matthew Dolan¹⁹⁵ confirms tRIIO and KCTMO agreed to run the new gas riser through a protected stairwell.
202. In compliance with edition 2 IGEM/G/5¹⁹⁶ (the industry standard for gas installations within MOBs), tRIIO's designer was obliged to consider the most appropriate design option based on consideration of a number of factors, namely safety, security, future access and maintenance. IGEM/G/5 sets out a hierarchy of options to consider, the first of which, and the default safety position, is to run the riser outside the building. This was tRIIO's standard approach as it is less disruptive to tenants, easier to install and would be naturally ventilated. Oral discussions between tRIIO and KCTMO concluded that running the riser outside the building was not an option given the Tower's¹⁹⁷ exterior cladding. Beryl Menzies'¹⁹⁸ expert report, makes plain this was against current guidelines. There is no evidence of any consideration of alternative design options, and no enquiry into the feasibility of running pipework outside the building. Ironically tRIIO seems to have considered that externally routing the pipework would have negated any guarantee given to the cladding.
203. tRIIO maintained a CDM Design Risk Register¹⁹⁹ (DRR). The DRR was a generic document designed to assess whether a design risk assessment is required for a design. A risk assessment, as per paragraph 4.2.1.1 of IGEM/G/5 Edition 2, was not deemed to be necessary by tRIIO. As a result, highly flammable gas was planned to be routed through a protected staircase which was the only escape route for residents. That decision was not properly considered or risk-assessed.
204. The boxed-in pipework was subsequently risk-assessed but only because on 21st March 2017, tRIIO was informed that flanged compression joints had been installed onto pipework rather than welded joints, as per the design²⁰⁰. As a consequence, the tRIIO designer decided to undertake a design risk assessment. It is of concern that such a situation did not mandate a risk-assessment in the first instance. Moreover,

¹⁹⁴ RHX00000012_0224.

¹⁹⁵ MET00012711.

¹⁹⁶ RHX00000005.

¹⁹⁷ MET00012711_0009, para 34 and CAD00003005_0011-12, para 39.

¹⁹⁸ BMER0000001_0153, para 560.

¹⁹⁹ TRI000000369 dated 15th Nov 2016. Design Risk Assessments have not been required since the CDM 1994 was in force. That regulation was repealed by the CDM 2007. Notwithstanding that design risk assessments of fundamental importance

²⁰⁰ TRI000001796_0002.

the generic nature of the ‘template’ risk-assessment is of itself a concern Mr Hancox points out that the generic document²⁰¹ did not include several important safety considerations, a serious criticism being the lack of ventilation of the riser in the stairwell in the event of fire or mechanical failure. These failures will only ever arise in buildings of multiple occupation. They were not included in the tRIIO generic risk assessment and are therefore unlikely to have been included in that of other multiple occupation buildings. There is no control measure that could mitigate the risk posed by running a highly flammable and thereby inherently dangerous gas line through an evacuation route. In the event of fire there is a possibility that the pipework or pipework ancillaries may fail. We know from Mr Hancox’s evidence that many of the meters inside the flats had not survived. At the point of pipework or ancillary failure the gas would ignite. There is then the possibility that the gas would burn in the protected stairwell rendering it useless as an evacuation route.

205. A pro forma template fire inspection and risk assessment²⁰² was carried out by Andrew Radley (tRIIO site manager) on 5th December 2016. That document also made no observations about running the gas line through a protected staircase.
206. Between 7th March and 24th March 2017, KCTMO informed²⁰³ tRIIO that residents had raised concerns about the newly installed exposed gas pipework in communal areas and stairwells. One email²⁰⁴ questioned the riser being in the fire escape and mentioned that vandalism and antisocial behaviour were daily occurrences on the staircase and the exposed gas pipes might be an easy target for vandalism. Anthony Cheney (TMO) also conveyed to tRIIO that residents were concerned that *you have installed a gas riser up the only fire escape and area of extensive vandalism*²⁰⁵²⁰⁶. Emails were escalated to the Contracts Director Mr Dolan who simply replied that the pipework was constructed of seamless carbon steel and would be difficult to vandalize and, in any event, had to be installed internally in the Tower²⁰⁷.
207. What is extraordinary is that it seemed to take Shah Ahmed and Judith Blakeman’s emails for either the TMO or Cadent to do anything about the gas pipe works. The TMO were purely reactive.²⁰⁸ Far from providing effective H&S management of the building, the TMO seemed to have no grip on events and no understanding of the proper demarcation between tRIIO/Cadent and themselves as building manager. It was ultimately the Grenfell Tower Leaseholders’ Association’s complaints that prompted the TMO to do anything about the safety of gas renovation works²⁰⁹, and even then what they did was inadequate.

Loss and inaccessibility of Isolation Valves

²⁰¹ RHX00000012_0156.

²⁰² TRI000001760.

²⁰³ MET00012711_0011, para 45.

²⁰⁴ CST00001242.

²⁰⁵ TRI000001082.

²⁰⁶ Our clients continue to express concern over the routing of the gas line through the stair well, Hanan Wahabi [IWS00001714_0006].

²⁰⁷ MET00012711_0011, para 46.

²⁰⁸ Statement of Stephen Mason [MET00019984_0011/CAD00000004_0008, paras 42 and 43].

²⁰⁹ TMO00846916.

208. A riser survey²¹⁰ undertaken by Cadent Gas Ltd at the end of September 2016 did not locate any isolation or service valves on either of the 2 gas supplies entering the Tower. A subsequent Hazard and Operability Study (HazOp) specified the investigation of the reported absence of those valves. It seems nothing was done about it. Mr Hancox suggests the areas were ‘lost’ during landscaping for the renovation project. This appalling act of incompetence resulted in a breach of Regulation 13 of the Pipeline Safety Regulations 1996, i.e., a failure to maintain the Landlord Supply and Residential Gas Supply No. 1 in good order.
209. The replacement service installed in 2017 suffered a similar fate. No trace was found of a valve surface box at the expected location of the Pressure Isolation Valve either by Mr Hancox, the Metropolitan Police Service or CORGI Technical Services.
210. The installation of isolation valves on pressurised gas lines is ubiquitous, commonplace and an extremely basic safety provision. It is highly unlikely isolation valves would not have been installed. Failure to locate valves on both occasions was likely due to contractors building over areas where the valves were installed.
211. Mr Hancox concludes Cadent should have been able under normal circumstances to access the BIV s in the basement for Residential Gas Supply No. 1 and to the IIV for Residential Gas Supply No. 2.²¹¹ In fact, these valves were located at height in the basement and not readily accessible. Mr Hancox fails to opine on this specific point. Isolation valves as a matter of standard practice should be readily accessible. Those isolation valves designated as having or in addition to their normal duty also have a safety function *i.e.*, isolating a supply in the event of mechanical failure or fire, should be readily accessible.
212. The evidence shows a complete lack of information that would have assisted Cadent or the LFB in locating the isolation valves.
213. The effect of this litany of failures is that the Tower’s gas supply took much longer to isolate than would otherwise have taken. Our clients consider this an extremely important point. The fact the supply could not be isolated for many hours was as a direct result of incompetent design decisions and inadequate construction management decisions taken many months before the fire.

MAINTENANCE

214. Maintenance is a somewhat protean issue, but it is of considerable importance. In a sense, maintenance, or rather the lack of it, underpins many of the issues to be dealt with in topic 3.
215. The key questions for the Inquiry are:
- (a) How adequately did the TMO maintain and repair the Tower?
 - (b) What contribution did the TMO’s failures in relation to maintenance and repair make to the events

²¹⁰ CAD00002024.

²¹¹ RHX00000012_0074, para 177.

leading to the fire?

216. From 1996 onwards, RBKC had delegated to the TMO all relevant repair responsibilities.²¹²

217. It is apparent that these responsibilities were not well discharged. As long ago as 2009, following a detailed investigation, Maria Memoli reported:

*“There are a number of tenants, leaseholders and freeholders within the Borough of Kensington and Chelsea who feel aggrieved that their problems have not been resolved by the TMO despite several years of complaining... The residents' main concerns are around: Cyclical repairs, Major works, Management charges, Service charges, Customer care, Probity and ethics, Communications, Performance and Monitoring, Trust and confidence. In turn these have been themed into issues of physical environment, finance, behaviour and governance, with the underlying cause of discontent being lack of customer care with several departments of the TMO seemingly more at fault than others. With the changes made to the Constitution and the election of a new Board, the TMO now needs to tackle not only the governance, but the real operational issues around the services it provides to meet the demands of the residents within the Borough; to show true leadership; to lead by example, by being mature... The new Board needs to win the hearts and minds of those disgruntled residents who have had grievances going back several years. The Board must understand its constitutional and legal role and take collective responsibility to spearhead the TMO in its improvement plan.”*²¹³

218. In December 2009, Robert Black reported to the TMO Board that the “*RBKC Adjudication Report...[had] now been published and the RBKC and the KCTMO have an agreed strategy to manage any issues which are arising.*”²¹⁴ This was a reference to John Butler's Adjudication Report on long-standing complaints of residents of the TMO.²¹⁵

219. Despite the “agreed strategy”, matters did not improve over the next few years. Tenants and leaseholders were in frequent communication with the TMO with a view to persuading them to carry out their obligations in respect of maintenance adequately. However, the TMO often seemed unwilling or unable to do so.²¹⁶ This lack of attention to maintenance had disturbing consequences. For example, in February 2014, RGE Services, a specialist company engaged by MF to report on the vent system, told them that they “*have stated every [sic; sc. “of every”] service to the TMO that in the event of an activation, we cannot guarantee that the system will work*”.”²¹⁷

220. These failures had serious consequences. In March 2014, the LFB carried out an inspection and noted a number of maintenance failures, with worrying effects:

“A significant number (approx. 25%) of automatically opening vents within the common parts of the

²¹² RBK00018516, Management Agreement Contract between RBKC and TMO, 28/02/1996.

²¹³ IWS00001462_0003, Investigation report on the long-standing complaints of the KCTMO by Maria Memoli, 10/04/2009.

²¹⁴ TMO10000619_0002, ENC 13 - Chair & Chief Executive Report, 03/12/2009.

²¹⁵ The report was said to be attached, but is not on Relativity. A draft is at RBK00030039, 31/08/2009.

²¹⁶ See, for example, TMO00831599, email chain between Tunde Awoderu of the GTLA and the TMO concerning a complaint re fire safety and fire doors, 14/11/2012 to 15/08/2013.

²¹⁷ MAX00022683_0001, email chain about the design of the Grenfell Smoke Extract System, 03/02/2014.

premises were found not to be in working order. No suitable system of monitoring was in evidence to identify deficiencies with the smoke ventilation system... Approx. 20% Emergency Lighting luminaires appeared to require maintenance as no LED was lit. Approx. 25-30% AOV vents (Held by solenoids ?) were in the open position which indicates general failure to maintain the system²¹⁸.”

221. The TMO, on occasion, seems to have noted its maintenance failings, but appeared incapable of addressing them adequately.²¹⁹
222. Moreover, as with so many other aspects of the refurbishment, there was a striking lack of clarity as to who was supposed to be dealing with maintenance issues during the currency of the works or thereafter. Thus, in January 2014, JSW, in submitting their quotation to Rydon for Mechanical, Electrical & Plumbing Services, set out at “Schedule 03 - General Exclusions/Clarifications” that they had excluded all costs associated with routine preventative maintenance of plant during the construction period or during defects.²²⁰ This exclusion was to be the subject of debate and confusion subsequently.
223. As the refurbishment works were coming to an end in summer 2016, the focus shifted from Rydon and its sub-contractors to the TMO. In certifying Practical completion of works in July 2016, JSW noted: *“the responsibility for the correct operation of each system and all equipment maintenance regimes, fully in accordance with the manufacturer's requirements, for all the mechanical equipment installed under this contract rests with the development owners, from the above date.”²²¹*
224. However, as early as October 2016, issues relating to the maintenance of the completed system were apparent. An inspection by Lakehouse noted the actuators were not working correctly on the AOV system.²²² There were also recurrent issues with the boilers.²²³ There were multiple examples from our clients of the lifts being commonly out of use and the lift doors not closing over extended periods of time resulting in service outages.
225. Nonetheless, the TMO seems to have taken the view that it could handle maintenance issues entirely in-house. On a site visit with Williams on 24 October 2016, Mr Whyte of JSW recalls that he: *“mentioned to her that it was important to set up a maintenance log and use people who understood the plant and equipment. This involved regular, sometimes daily, physical checks of the equipment and the display panels to see if anything was out of the ordinary. I formed the impression that the TMO would get these checks done by their on-site caretaker rather than by their external maintenance contractor, Engie.”²²⁴*
226. This complacency was not justified by events. There were recurrent problems, e.g., with Grenfell Tower

²¹⁸ LFB00083856, Premises Inspection and Data Collection Form, 14/03/2014; the LFB gave formal Notice of these and other Deficiencies regarding Grenfell Tower to the TMO on 24 March 2014: LFB00032101.

²¹⁹ See, for example, TMO00852751_0003, KTM Commercial Gas Servicing & Maintenance Meeting Minutes, 14 January 2016, section 7.

²²⁰ RYD00003361_0005, Letter from JS Wright to Rydon enclosing quotation, 30/01/2014.

²²¹ JSW00001958_0002, Paul Featherston (J S Wright Co Ltd) - Practical completion letter – remaining elements, 18/07/2016.

²²² LAK00000358_0015, Lakehouse Inspection Certificate for AOV, 24/10/2016.

²²³ See, for example, TMO00860979 email chain between Kemal Mehmet, Anthony Cheney, Steve Smith and Charlie Saul regarding concerns on causes of low pressure lockouts, smoke vents, fire alarm logs, 12/10/2016.

²²⁴ JSW00001892_0024, Witness Statement of Alan Whyte, para 146.

boilers being locked out due to fire alarms going off.²²⁵ This was very concerning as:

*“It is not good practice to have the boiler BMS control the fire alarm, it should to some extent be separate as the systems are not reliable enough... The entire gas system should shut down in the event of alarm activation at the main solenoid. Unfortunately the older boilers do not reset, there is very little can be done to avoid this.”*²²⁶

227. Moreover, there was a lack of clarity as to which company was obliged to carry out regular maintenance. For example, when a further boiler issue arose in early 2017, Rydon and JSW disagreed as to their residual obligations, Rydon arguing that “JSW are contractually bound to provide Planned Preventive Maintenance and Reactive Maintenance (M&E) at Grenfell until 4th July 2017”.²²⁷

228. There were also problems with the old BMS system not working with the new BMS system. JSW reported in March 2017:

*“The report compiled by Enegi, [sic; sc, Engie] confirm suspicion that the existing BMS system is antiquated (Trend tech no longer support this panel and parts are no longer available) and poorly maintained (as most of the plant which is run from this controller has been put into local hand on the control panel and has been like this for a while). I would strongly advise the existing system is toughly inspected and serviced, and under no circumstances the new installation altered or added to until the end of the DLP”*²²⁸.

229. This lack of clarity extended to the maintenance of the lifts as well. Mr Wallis of PDERS (responsible for lift maintenance), who inspected the lifts in April and May 2017, has confirmed he did not see a copy of any O&M Manual when he began working on the lifts at Grenfell Tower.²²⁹

230. In conclusion, what is noticeable here, as with so many aspects of the TMO’s performance, is its absence from the scene and inability to get to grips with maintenance problems Grenfell Tower needed a systematic plan for Planned Preventive Maintenance and Reactive Maintenance, put in place by the TMO. The TMO then needed to follow up assiduously to ensure that what was planned and agreed was put into practice. None of this happened. At best, various organisations responded *ad hoc* as problems arose. Often this response consisted in little more than the assertion that some other body needed to deal with the issue. All of this contributed to the poor state of the building on the night of 14th June 2017.

231. The post-fire audit report on Repairs Direct is an indictment of just how shocking the TMO’s own in-house repairs and maintenance organisation was, concluding: *“It is a reasonable statement that the service (1) isn’t good quality; (2) performs poorly; (3) is expensive.”* The report’s health check also noted (amongst a catalogue of other failings) it had accrued a backlog of 5,400 outstanding repair jobs.²³⁰

²²⁵ See TMO00861347, emails between Engie and TMO, 12/12/2016.

²²⁶ TMO00861365, emails between Engie, TMO and Gas Contract Services, 12/12/2016.

²²⁷ RYD00085807_0001, email from David Hughes to Alan Whyte, 25/01/2017.

²²⁸ JSW00003738_0001, email from Alan Whyte to David Hughes, John Hegg and Jonathon Earl, 06/03/2017.

²²⁹ PDR00000036_0002, para 9, Witness Statement of Mark Scott Wallis.

²³⁰ TMO00862541.

Conclusion on topic 3

232. In summary, the evidence on Topic 3 shows the TMO, and its advisers, never got to grips with a range of key issues. In particular:
- (a) The fire doors were defective and dangerous in numerous respects, and, as the LFB reported at the time of the fire, they likely provided no protection;
 - (b) None of the lifts were firefighting or evacuation lifts;
 - (c) A litany of failures meant the Tower's gas supply took much longer to isolate than it should; and,
 - (d) The Tower was not adequately maintained;
 - (e) Due to a pre-considered decision not to plan escape routes there was no evacuation plan.
233. It should be noted briefly, at this stage, that the SVS was designed to be non-compliant and was not useable on the night. In view of the Inquiry's recent correspondence, we do not deal with these issues in this opening, but will return to the SVS in due course.

Overall Conclusion on Module 3

234. The concept of social housing should stand alongside the NHS, free education and a comprehensive benefits system, as fundamental tenets of our civil society. A hallmark of an effective, functioning civil society is how we treat and care for those most vulnerable in that society: children, the elderly, those with physical and mental health disabilities, those who suffer from cognitive functioning impairments.
235. Grenfell Tower was part of RBKC's social housing stock, which should have provided, affordable homes, secure homes, safe homes, stability and quality control for all those who need it. This was basic and fundamental. However, a culture has been allowed to develop and take hold, wherein social housing was and is the poor relation, and not to be afforded the same care, attention to detail, scrutiny and most importantly safety as its more well to do relatives
236. For those living in the Tower, it was social housing in another sense, it created its own mini society and community, where people could bring up children, work, have careers and build relationships. A society where people looked out for one another.
237. RBKC and KTMO were the Local Authority bodies responsible for ensuring the Tower met the needs of its residents and was fit for purpose. To look out for the residents. They failed abjectly on all fronts, with horrendous and tragic consequences.
238. There were systemic wide-reaching safety related breaches at every stage of the engineering lifecycle design, specification, procurement, installation, commissioning and maintenance. A root cause was the absence of construction and engineering professionals project managing all of the different projects over many years in the Tower.
239. There were no emergency planning procedures, even at the most rudimentary level, with no floor numbering or fire safety signage and a complete failure to close out actions from FRAs for years. The FRAs and fire safety management decisions were safety critical and had long term consequences for the

survivability of the residents. The absence of a professional body to regulate fire risk assessors has enabled non-qualified semi-skilled practitioners to undertake safety critical work. Sub-standard fire risk assessment and fire safety management put the lives of the residents at risk. The fire has evidenced the extent to which sub-standard practice is now prevalent in buildings of multiple occupation. FRAs and management can only be effective if conducted by competent assessors, are accurate, evidence based, comprehensive and tailored to the particular environment and occupants and make reasonable adjustments/modifications for special characteristics. Carl Stokes' FRAs were simply not acceptable and there was a lack of rigour and oversight from the TMO in response to these defective assessments.

240. The LFB's role in oversight and management of fire risk assessment and the provision of fire safety advice is important. The legislative framework of notices and enforcement was there, but used too sparingly and with little effect in relation to RBKC generally and Grenfell Tower specifically. They too should have provided a safety net for residents via Fire Safety Inspectors and Home Fire Safety Visits, but sadly again this was lacking. The fact that some of those who died on 14th June 2017 had for the most part ineffectual Home Fire Safety Visits on 10th June 2017, is an unbearably tragic irony.
241. In the face of all those failures, there should have been the contingency plans. However, these were literally not worth the paper they were written on. They were outdated and incomplete and all residents but particularly those most vulnerable, left with little or no special consideration of their needs and requirements in the event of a fire.
242. The incompetence of TMO project managers, directors and safety personnel was directly responsible for allowing this state of affairs to develop. The truth was that the building's safety was not at the center of TMO/ RBKC considerations. Their minds were pre- occupied with profit margins, cost cutting and a race to the bottom. This characterised their thinking and in no small part drove their policies.
243. This was institutional neglect and marked wholesale failings on every level. The disregard for the most basic safety measures designed to protect residents was at points reckless, at others calculated and cruel. These failings represent breaches of both housing and human rights legislation as set out above in paragraphs **5 and 47-71**.
244. Residents' complaints pre-dated the Tower's Refurbishment. There were clear patterns which emerged in terms of areas the residents were particularly concerned with and the major recurring deficiencies and problems. These included a systemic problem within RBKC regarding fire doors, complaints concerning passive fire safety systems, windows, the management of repairs and maintenance.
245. The TMO was the principal point of contact between the LA and residents, but these lines of communication were faulty and faltering, providing the bare minimum to satisfy the TMO's erroneous belief that they were listening to residents' voices. They were not.
246. Grenfell Tower was the eyesore which for RBKC required cosmetic surgery to make it more palatable to its elegant and wealthy neighbours. The refurbishment gave Grenfell Tower a superficial facelift,

whilst neglecting underlying deficiencies and creating a far more dangerous malaise. This was a sick building.

247. The residents saw the symptoms, and even suggested the cure. They were ignored and marginalized at every turn.
248. Far from providing effective safety management the TMO had no effective control over the building and no understanding of the demarcation between their own gas system duties as the Tower manager and that of TRIIO/Cadent.
249. The TMO then carried out works, as described in Modules 1 and 2, which involved fixing highly flammable cladding products to the Tower turning it into a death trap. The building was, in view of the series of failings identified above, singularly ill-equipped to respond to or withstand a catastrophic fire.
250. It will be the Inquiry's task not only to allocate responsibility for all the things that went wrong but also to mark out a safe way forward in the future. We will return to recommendations for the future in our closing submissions.

Michael Mansfield QC

Adrian Williamson QC

Sam Stein QC

Alison Munroe QC

Andrew Dymond

Austin Stoton

Thalia Maragh