IN THE MATTER OF THE GRENFELL TOWER INQUIRY

BEFORE SIR MARTIN MOORE-BICK, MS THOURIA ISTEPHAN AND MR ALI AKBOR OBE

MODULE 4: AFTERMATH

CLOSING SUBMISSIONS ON BEHALF OF THE BEREAVED, SURVIVORS AND RESIDENTS REPRESENTED BY TEAM 2

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1. INTRODUCTION

"Grenfell has completely changed my life, my family's life, and the life we had before Grenfell is almost non-existent. I thought we lived in a country where the people we vote for and the people that are put in place to look after its people, its most vulnerable people, would help, would come swooping in, and it never happened. The sad part about that, Mr Millett, is that they never planned to. They don't care about us. They care more about themselves, their pockets, and I won't go into detail, because you questioned these crooks, you sat here and spoke to these criminals who acted so fraudulently and with this constant detachment. I mean, how many more politicians, ministers and lords are going to insult our dead families before something is done about what happened to us? And it's sad. I've almost completely lost faith in humanity. I've almost completely lost faith in the world because it's always the same thing everywhere. We suffer, and they prosper. And I've said this before: the system isn't broken; it was built this way specifically to benefit them. Our families died in the most public and horrific way possible, and here we are, five years later, with no arrest, no accountability, but yet, the ones who were put in charge or the ones who were involved have been able to prosper since the fire, and how can we allow this to happen? I feel like as time goes on, the general public have forgotten about us, or every time they hear about us, they're fed up, and this is the problem. People need to see themselves in us. People need to understand that what's happened to us and what's happening to us is also happening to them. Putting aside these corporates that behave the way they behave, because it's in their nature, it's what they do, but the government, the government's duty is to protect us, to look after its people. But yet, only last week, a lord was sitting here, calling our families nameless, getting the numbers mixed with

Hillsborough, and couldn't even say Grenfell, said "Grenbell", and these are the people put in place Mr Millett to look after us."[1]

2. EVIDENCE OF KARIM MUSSILHY

2.1. We start where our openings ended, with the words of the BSRs. Karim Musshily who, with dignity, passion, and sincerity, articulated the thoughts and experiences of so many; ***"They don't care about us"***. Those words have reverberated throughout this entire Inquiry, at every point and intersection between the BSRs, local and central government and the corporate CPs.

2.2. The reality is they did not care about the residents when the Tower was being refurbished. They did not care when the residents were raising issues and warning of the consequences of inaction long before the fire. They did not care when those warnings came to pass. They did not care when people were at their very lowest, in the wake of the devastation. **They did not care. They never have.**

2.3. The TOR for Module 4 was to consider *"the response of central and local government in the days immediately following the fire"*. In particular, to focus on three main questions from the Inquiry's List of Issues. We can answer those in very short form:

- *(13a) What policies, procedures and plans were in place on the part of the Tenant Management Organisation, central and local government for dealing with a major emergency such as the Grenfell Tower fire?* **Uncoordinated myriad.**
- *(13b) What was the response of the Tenant Management Organisation, central and local government by way of the provision of emergency relief in the days immediately following the fire?* **Abysmal.**
- *(13c) Was the response adequate?* **No** *and in what respects was it inadequate?* **All.**

2.4. **The real question is why?**

- ***Why, despite a proliferation of documents, departments and individuals tasked with implementation, did the execution of these policies, procedures and plans fall so short?***

[1] {**Day 264, 12/04/22, 102:11-103:24**}

- ***Why was the provision of emergency relief from local and central government so lamentable?***
- ***Why was the response so inadequate in almost every respect?***

2.5. The evidence that has unfolded in this Module does to an extent answer these "why" questions. Some admissions and acknowledgements of mistakes have been made. However, we, on behalf of the T2 BSRs, say it must go further. There was a wholesale dereliction of duty and lack of leadership from the TMO/RBKC. Central government took a seat in the stands, as spectators to the unfolding mess, shaking their heads in disapproval at the poor performance of local government. No amount of hand-wringing now excuses their own tardiness and inaction. Where was the leadership from central government? Where was the pro-action? This was a national disaster that required a commensurate response.

2.6. In Module 4 we entered the rarefied working environments of planning and ministerial departments where acronyms abound. Every team has a sub-team. Every group, a sub-group, yet no one seemed to take control, leadership, responsibility, oversight, or accountability. This has been a Module awash with various bodies all allegedly tasked with the goals of contingency and emergency planning and its effective execution. Yet the reality fell well short and resulted in compounding the pain and suffering of the people, the survivors, residents and bereaved families, who were already at the nadir of their trauma.

2.7. What transpired in the aftermath of the Grenfell Tower fire was a catalogue of failures, ineptitude, and inefficiency from RBKC/TMO in the first instance. Theirs was a truly stunning display of abject failure, a blinkered approach to the disaster, characterised by a preoccupation with reputational damage to the council and a complete lack of leadership from the very top down. This exposed their woefully inadequate emergency and contingency planning. As the embers of the Tower still smouldered on 14 June 2017, it was clear that RBKC would not and could not meet the challenges of the aftermath and properly care for its own residents, who were in an acute state of despair and need. Were it not for the kindness of strangers, members of the public and the intervention of the voluntary sector, the BSRs would have been left entirely to fend for themselves.

2.8. Central government proved to be equally ineffectual. The creation of a Minister for victims of the Grenfell Tower fire and grandstanding announcements about rehousing were an ostentatious façade, hiding a government bereft of a response, policies, and initiatives of real value to the BRSs.

3. THE BSRs – THEIR LIVED EXPERIENCES

(a) Demonisation of Residents

3.1. Context is vitally important here and, in the context of the fire and the aftermath, battle lines were drawn by RBKC to create a "them and us" situation with the residents, who were characterised as the enemy, the complainers, the dissenters. It is within that framework that one must view the local authority's responses in the aftermath of this tragedy; for example, David Kerry:

"*Q. If you go to page 2 {MOL0000036/2}, under the heading "Local Authority", the first bullet point says: "General community feeling is of hurt and anger. This is being stoked by a small number of known local instigators who continue to fabricate stories in order to further their aims." What was that about?" "A. I think it was a suspicion that in amongst a great deal of completely genuine and justified criticism, it was within the scope of a handful of people, who were all the time, well before the fire, extremely antagonistic to the council, to make matters even worse. I think we thought something of that was going on, but we did not know, and there was nothing that we could sensibly do about it, even if it were true.*"[2]

3.2. However, there were no fabricated stories, no agitators, no agent provocateurs sowing the seeds of discontent. The horror stories emerging from the community in the aftermath of the fire were from the BSRs and all were very true.

3.3. Armed police presence at the Westway, RBKC staff not wearing identification, slurs against the community, all fostered an atmosphere of mistrust that made people wary. Some people were threatened with arrest and made to feel like criminals.[3] Those in authority had groundless concerns about public unrest and Grenfell Tower becoming the UK's equivalent

[2] {**Day 273, 05/05/22, 194:2-16**}
[3] See, for example, evidence of Nabil Choucair {**Day 267, 25/04/22, 31:3-25**} and Karim Mussilhy {**Day 264, 12/04/22, 36:5-37:15**}

of New Orleans.[4] This focus on public order detracted resources and focus away from relief efforts. **They did not care.**

3.4. It must be noted at the very outset that the abject failure of RBKC to respond to the fire in a co-ordinated, effective and compassionate manner left a leadership vacuum in the aftermath. That vacuum was filled by the voluntary sector. They were able to provide some relief to residents, survivors, and bereaved families in the wake of the disaster. This is perhaps best embodied by the Rugby Portobello Trust's ("**RPT**") Mark Simms: "*the North Kensington community was looking after its own people in the absence of anything coming from anywhere else…it's a sad indictment, really, that people were getting out of bed to help their fellow neighbours when other people weren't getting out of their offices to help our citizens.*"[5]

3.5. RBKC's dereliction of duty, in terms of leadership and the implementation of an emergency plan, not only exacerbated the grief and pain of the BSRs; it also caused serious and significant breaches of equality legislation and the Civil Contingencies Act ("**CCA**").

(b) Equality and Discrimination

3.6. The Equality and Human Rights Commission made submissions to this Inquiry at the conclusion of Phase 1[6] where they set out the relevant national and international legislation at paras 17-24:

"*The right to equality is fundamental in international law. It is found in all of the main international human rights treaties, including in Article 26 of the ICCPR and in Article 2 of the ICECSR."*

"For the UK, the most significant of these guarantees is found in Article 14 ECHR. Article 14 provides: "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status." Other "status" includes disability and age. In the UK, Article 14 is incorporated into domestic law by virtue of s.6 of the Human Rights

[4] See, for example, {**Day 281, 19/05/22, 126:2-18**}
[5] {**Day 275, 10/05/22, 208:13-209:5**}
[6] https://www.equalityhumanrights.com/sites/default/files/grenfell-inquiry-phase-1-submissions-january-2019.pdf

Act 1998. As with the provisions addressing the right to life, the UK is bound by Article 26 of the ICCPR and Article 2 of the ICECSR as a matter of international law."

3.7. We wholeheartedly agree with and endorse those submissions. It has become abundantly clear during this Inquiry, and particularly in Module 4, that whilst those in the local authority and other public bodies have a basic knowledge of the Equality Act and Public Sector Equality Duty ("**PSED**"), it does not go beyond that basic level. These pieces of legislation are overarching. They should inform any local authority in all aspects of its job; be that planning, policy development, training, delivery or implementation of services. What has been starkly brought to light in this Module is that equality legislation has not been and is not embedded within the thinking of this local authority and other public bodies.

(c) <u>Equality Act, PSED and the CCA</u>

3.8. RBKC as a local authority had obligations under s149 of the Equality Act. Specifically, to "*have due regard*" to the aims of the general equality duty when making decisions and setting policies. With respect to the PSED this meant having "*due regard*" to "*the need*" to:

(a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under [the 2010 Act];

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

3.9. The law makes it clear that the PSED must be exercised in "*substance, with rigour, and with an open mind*"[7] and that there must be *"a proper and conscientious focus on the statutory criteria.*".[8]

3.10. In particular by virtue of CCA Chapter 5, Emergency planning specifically states that plans *"should have regard to the vulnerable (i.e. those with mobility difficulties, those with mental health difficulties or who are dependent, such as children) and survivors and others*

[7] R (Brown) v Secretary of State for Work and Pensions (Equality and Human Rights Commission intervening) [2009] PTSR 1506 at §92

[8] R (Hurley) v Secretary of State for Business, Innovation and Skills [2012] HRLR 13 at §78

affected (those directly affected by the emergency or the anxiety of not knowing what has happened)."

3.11. CCA Chapter 7, Communicating with the public, stipulates that *"Cat 1 responders need both to plan their communications and to regularly test their communications arrangements to ensure they are effective. The message must be right for the targeted audience and this must be coordinated with other Cat 1 responders and engaging Cat 2 responders and the voluntary sector."*

(d) <u>Statistical Evidence</u>

3.12. The RBKC Borough Risk Register is an important document for emergency planners to assist them to make informed decisions.[9] This was overseen by David Kerry.[10]

3.13. The profile of RBKC's population at page 5 of the Borough Risk Register (BBR) showed the borough had an estimated population of 178,600 (see the 2011 census) and is *"a borough of extremes with some of the wealthiest neighbourhoods in the country as well as some of the most deprived."*[11]

3.14. Further, statistics show that "*North Kensington and parts of Earl's Court and South Chelsea face complex combinations of problems such as low incomes, relatively high unemployment and poor health and well-being*". Grenfell Tower was in North Kensington where:

(a) The population varied in age, sex, and religion;

(b) More than 1/5 of all households have a first language that was not English;

(c) Less than half of the residents (48%) were born in UK;

(d) 28% of the residents had arrived in the UK between 2001 – 2011;

(e) As a borough RBKC had the second highest proportion of Arab residents (4%) after Westminster.[12]

[9] {**RBK00036688/7**}
[10] {**Day 268, 26/04/22, 20:11–22**}
[11] {**RBK00036688/5**}
[12] {**RBK00036688/5**}

3.15. As RBKC's Civil Contingency Manager, David Kerry had a duty to ensure that the borough's civil contingency plans and policies had due regard to RBKC's general equality duty.

3.16. In his evidence,[13] Mr Kerry somewhat perfunctorily accepted the concessions made on RBKC's behalf in their opening submissions to the Module. Further he had to accept that:

(i) He and no one else in his department had been trained in the Equality Act or PSED.

(ii) They had not given due regard, or indeed any regard to equality legislation in the planning or implementation of their emergency and contingency plans in the aftermath of the fire.

(iii) Communication and information did not consider language and/or cultural diversity, nor were reasonable adjustments made to ensure it was effective for the target audience.

(iv) The borough's emergency and contingency planning was not subject to any Equality Impact Assessment.

(v) The delivery of the contingency and emergency planning did not have due to regard to vulnerable people, in particular children, pregnant women and families, the elderly or disabled. This was particularly starkly highlighted in the allocation of re-housing.

(vi) In its implementation, the contingency and emergency plans did not have due regard to ethnic and cultural diversity with regards to the provision of food and dietary needs.

3.17. In our submission RBKC failed in all respects under the EA, PSED and CCA.

(i) Their contingency planning and policies failed to have due regard to the vulnerable.

(ii) The information and communications were not right for the target audience.

(iii) Mr Kerry and RBKC failed to take appropriate steps having "due regard" to the need to "advance equality of opportunity" in particular with regards to the need to: "(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it."

[13] {**Day 268, 26/04/22**}

(iv) RBKC's contingency planning and arrangements should have been subject to the PSED and Equality Impact Assessment generally, with particular due regard to the protected characteristics including age (the elderly and children), ethnicity, religious and cultural needs, language need and disability. They failed to do so.

3.18. RBKC further breached the PSED and Equality Act as:

(i) The housing allocation policy (including temporary accommodation) for rehousing displaced people as a result of the Grenfell Tower fire should have been subject to the PSED and an Equality Assessment. No such assessment was conducted.

(ii) There was no advance planning to ensure that sufficient wheelchair accessible hotel rooms would be identifiable, both according to the PSED and anticipating the duty to make reasonable adjustments.

(e) <u>Those with protected characteristics</u>

3.19. The contingency plans and arrangements and RBKC's response to Grenfell Tower fire failed to take account of the special needs of:

(a) the disabled,

(b) elderly,

(c) children,

(d) pregnant women and women with young children,

(e) race (including ethnicity and national origins) and the need to provide accessible emergency advice and information to non-English speakers. There was a delay or failure to provide counsellors who spoke the language of the bereaved, survivors and residents),

(f) religion and belief – there was limited or a lack of flexibility in the accommodation offered to make allowances for Muslims meal times during Ramadan or attendance at prayers or meetings; the food provided was not culturally appropriate and in some instances halal food was not provided.

3.20. The Inquiry has heard the harrowing oral and read evidence from those who were directly affected in the aftermath. Their stories starkly illustrate the breaches of the PSED and EA:

<u>The Disabled:</u>

(i) Tower resident and survivor [redacted] gave evidence in Module 4. Her aftermath witness statement provides details of the undignified and thoughtless treatment of disabled survivors. That a young woman with mobility issues, who had just hours before escaped the Grenfell Tower fire, could be placed on a high hotel floor with access to a bathroom and toilet several floors below her room, speaks volumes to the disregard with which people were treated.[14]

(ii) [redacted] describes her experience as a disabled resident and issues which RBKC and the TMO were aware of. She says that in the early hours of 14 June: "*Someone called me about emergency accommodation. I don't know who they were. A woman's voice said she had a room for me at a hotel in Earls Court ... She did not give me any details or any choice. After the person hung up, I realised I had a room reserved but no way to get there, no money, no clothes. I didn't know what I was supposed to do. I was in my dressing gown.*"[15]

[redacted] further says: "*There were no adaptations or allowances for my mobility issues, I was given a room with a bath which I struggled to use. I reported my difficulties ... I was told I was going to be moved to a hotel room with a walk-in shower but this did not occur.*"[16]

(iii) [redacted] a resident of the Tower, was placed in hotel accommodation in the immediate aftermath. A suitability re-assessment expressly mentioned her mobility impairment & difficulty to use stairs. Although [redacted] disabilities and needs were known to the Council no adjustment was made to adapt the hotel accommodation to her needs. On one occasion [redacted] suffered the indignity of falling off the bed and had to be assisted by 2 security guards. Although she reported this to the occupational therapist, provisions for bed lever were delayed, leaving [redacted] having to purchase it without assistance of the Council. The lever from the council itself eventually did arrive, albeit too late. [redacted] remained in hotel accommodation until December 2018. Food and respite allowances were either delayed, not paid on one occasion and paid into the incorrect account on another, which was a point of discord with the Council when raised which was only resolved through [redacted] solicitor's intervention.[17]

Children:

[14] See, in particular, paras 31-34 of {**IWS00001699/5-6**} & para 34 of {**IWS00000121/7-8**}
[15] See {**IWS00001281/9**} & {**Day 264, 12/04/22, 130:14-24**}
[16] See {**IWS00001281/10**} & {**Day 264, 12/04/22**}
[17] {**IWS00001516**}. See in particular paras 22, 30-34 & 50 & {**Day 264, 12/04/22, 142:9-22**}

(iv) Rawda Said says the hotel she was placed in: "*... did not have a cot or any facilities for those with a baby ... eventually the manager of the hotel felt sorry for us and helped us with our needs including giving us a microwave which we could use for heating food/milk for our baby.*"[18]

(v) Wesley Ryan Ignacio lived in flat 62 on the 9th floor of the tower with his parents, his wife and their daughter. He states*: "It was difficult to sterilise the bottles in the hotel room. Initially we had no choice but to wash them out by hand until we had some money to buy a new steriliser. There was no urgent additional support from RBKC for our daughter."*[19]

(vi) [redacted] a Barandon Walk resident, received a call from a housing officer, Dionne Wilkes, three to four days after the fire: *"... I also informed her that my son had no uniform to go to school. She advised me to go to the uniform shop and go to Westway to stay there. I told her that I did not want to go and sleep in a gym because I was pregnant and had a* [redacted] *old, a* [redacted] *old and a* [redacted] *old ... She advised me to call for temporary accommodation to see if they could help me and gave me a number. After this phone call from RBKC/TMO, I can't remember being contacted by RBKC/TMO again."* As a result, she stayed with family for 10 days and was later placed in a hotel.[20]

(vii) Manuel Miguel Ferreira Alves and his family were offered: *"... one room with double beds for all four of us. It was completely unsuitable, especially as they knew that my children were young adults. They had also only offered us a two–night stay, so we decided not to sleep there because it would have been too disruptive for our family at what was already a very unsettled time."*[21]

(viii) Speaking in a national newspaper this week ahead of the 5th anniversary, Grenfell United chair Natasha Elcock said:

"*The driving force for me, as a mother, was always the 18 children we lost ... My uncle guides me from above. But those children didn't have a chance to see life. They didn't stand a chance. We couldn't not fight for justice for them and everybody else we lost.*"[22]

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[18] {**IWS00001729/21**} & {**Day 264, 12/04/22, 142:9-22**}
[19] {**IWS00001829/14**} & {**Day 264, 12/04/22, 141:24-142:6**}
[20] {**IWS00001263/2**} & {**Day 264, 12/04/22, 154:7-24**}
[21] {**IWS00001587/18**} & {**Day 264, 12/04/22, 136:4-19**}
[22] https://www.mirror.co.uk/news/uk-news/grenfell-tower-fire-survivor-vows-27192860

(ix) The Equality and Human Right Commission's Report, ***"Following Grenfell"*** based on interviews with families, found that many children who lost a friend or family member or their home in the fire, which claimed 72 lives, struggled to access help.

"There are so many children going to the same school and still affected," one respondent said. *"They just don't know where to turn, because there aren't the services available."*

"Supporting families who lost friends and loved ones that night should have been a primary concern, but especially the children involved," said David Isaac, the commission's chair. *"While authorities sought to respond to the disaster, children received disjointed mental health and educational support. Their needs and rights have slipped through the cracks."*[23]

(x) In our submission, the treatment of children and families generally was inexcusable. The lack of joined-up thinking between the housing department and Children's Services is another example of RBKC's complete system breakdown.

Pregnant Women:

(xi) [redacted] lived in flat 14 with her husband, brother and friend. They were given one room with one double bed for four people. She was pregnant at the time, and she says: *"I was unable to get onto the bed as it was too high off the floor, so I slept either on the sofa or the floor . I requested a mattress but the hotel did not provide one. One of the many volunteers that attended the hotel provided a duvet for me to sleep on. I was in a lot of pain and my back condition worsened while I was at this hotel".* [24]

Race, ethnicity and national origins:

(xii) The [redacted] family lived in flat 86 on the 11th floor. They stayed in the Westway Centre for 10 days and were the last to leave. [redacted] says: "*Staying and sleeping in the Westway was horrific. As a Muslim woman modesty is important and when sleeping I did not want to expose parts of my body. I found this very stressful. For two days after the fire, I stayed in the same clothes I was wearing on leaving the Tower; no one offered us a change of new clean clothes. All day there were people coming in and out, it was very public.*"[25]

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[23] https://www.equalityhumanrights.com/en/publication-download/following-grenfell-childrens-rights
[24] {**IWS00001296/4**} & {**Day 264, 12/04/22, 135:5-15**}
[25] {**IWS00001815/13**} & {**Day 264, 12/04/22, 128:1-9**}

(f) Religious beliefs

3.21. During the time of the fire, it was Ramadan and a number of residents were fasting.

(xiii) [redacted] says: "*The mosque delivered food and drink to us at our hotel. This was really important for us as it was Ramadan and we could only eat certain foods at particular times. The hotels did not seem to be able to meet this important need.*"[26]

(xiv) [redacted], who lived in Grenfell Walk, said: "*Breakfast was included but it was at a set time; I had to buy my own lunch and dinner as it was Ramadan the eating arrangements were completely unsuitable for me. For the last seven days of Ramadan, I went to a mosque in Paddington for iftar and would buy my own food to eat early in the morning before starting my fast.*"[27]

3.22. In our submission this situation must be urgently addressed and rectified. It is because equality legislation and the needs of vulnerable people were not embedded within RBKC's thinking and working practises that failings and breaches occurred. These breaches led to direct discrimination in the provision of services and treatment of individuals in the aftermath of the fire.

(g) Vulnerable residents

3.23. A theme throughout other Modules in this phase, and this Inquiry, (see in particular Module 3) has been the neglect of vulnerable residents. There was a general lack of awareness and indifference to the special needs, characteristics and requirements of various residents.

3.24. Town Clerk Nicholas Holgate epitomised this indifference and casual disregard with his lack of awareness as to RBKC's inability to identify vulnerable persons out-of-hours. David Kerry flagged this problem in emails in March 2017 and discussed during Humanitarian Assistance Board meetings. Mr Holgate admitted he should have been aware of this issue.[28]

3.25. He accepted that it was RBKC's responsibility to have up-to-date and accurate information about vulnerable residents: "*Q. Let me try it slightly differently. So far as RBKC*

[26] {**IWS00001729/16**}
[27] {**IWS00001946/10**} & {**Day 264, 12/04/22, 143:6-20**}
[28] {**Day 273, 05/05/22, 44:22-45:14**}

needed to have up-to-date and accurate information about who was living where and whether they had vulnerabilities or not in order to discharge its obligations under the contingency legislation, regulations and framework, that was RBKC's responsibility, even if the information wasn't held within the council? A. I think you must be right, yeah."[29]

3.26. It is baffling that the various departments of a local authority of the size of RBKC (Adult Social Services which includes Mental Health, Children's Services and Housing) would not all have their own specific register, lists and information regarding those who have contact with or are known to these departments. In 2017 this information was or should have been basic, essential and computerised.

(h) <u>Psychological support</u>

3.27. In August 2017, BBC Newsnight reported that 600 people had so far received counselling - including 100 children.[30] This was the tip of the iceberg. By October 2017 the Guardian was reporting that the mental health response following the fire was the biggest operation of its kind in Europe, according to one doctor, with the number of people affected likely to exceed 11,000.[31]

3.28. As with the other provisions of services for the BSRs, psychological and mental health support in the immediate aftermath was woefully inadequate.

3.29. Hanan Wahabi gave the following stark response to CTI:

"Q. I'm going to turn now to psychological support. Were you aware of any counselling services or mental health support being available in the first week following the fire?
A. No."[32]

(i) <u>The BSRs were failed</u>

3.30. In the wake of this disaster, people needed basic human dignity and respect. Access to somewhere clean, warm and safe to rest their heads, sustenance for their bodies, financial support to get them through the day. Clear, understandable, up-to-date information and communications. An understanding and appreciation of their needs, any special needs and

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[29] {**Day 273, 05/05/22, 78:6-14**}
[30] https://www.bbc.co.uk/news/av/uk-41045051
[31] https://www.theguardian.com/uk-news/2017/oct/30/grenfell-tower-mental-health-response-largest-of-its-kind-in-europe
[32] {**Day 267, 25/04/22, 125:8-12**}

characteristics and, accordingly, reasonable adjustments. The provision of rest centres was key to this. RBKC failed the BSRs.

(j) Rest centres

3.31. Despite David Kerry's best efforts during his evidence to deflect and avoid taking responsibility, Nicholas Holgate had to accept that RBKC was responsible for setting up rest centres, the services they provided, access, and the information given to residents about them.[33] In every aspect, RBKC failed. Mr Holgate had to accept the following failings and deficiencies:

- Staff arrival mid-morning "*obviously isn't acceptable*"[34]
- The absence of senior RBKC staff / leadership and the misjudgement of the council in not having staff present in numbers.[35]
- The Westway was under-resourced.[36]

3.32. The Westway presented a particularly egregious situation for the residents, survivors and bereaved families.

- There was the insensitivity of the police cordon, which again illustrates a hostile approach by RBKC, seeing residents and survivors as "the enemy". It was aptly described by Rupinder Hardy as being like a crime scene.[37]
- Residents and survivors described the interviews at the Westway as robotic and little more than tick box exercises. This was corroborated by Mark Simms of the RPT.[38]
- The lack of coordination meant that people had to repeat and therefore relive their story to myriad individuals and agencies, causing further distress and trauma. It was, in the words of Mark Simms: "*inhumane and cruel*".[39]

3.33. William Thompson says: "*I remember joining a queue to speak to a woman at a desk, I think from the NHS or a social worker but I'm not sure. The person in front of me had escaped the tower with nothing at all except what he was wearing and the person at the*

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[33] {**Day 273, 05/05/22, 54:4-8**}
[34] {**Day 273, 05/05/22, 53:21-23**}
[35] {**Day 273, 05/05/22, 102:13-15**} and {**Day 273, 05/05/22, 105:8-14**}
[36] "*we under-resourced the coverage of the Westway as a – as the management of a centre.*" {**Day 273, 05/05/22, 199:17-200:1**}
[37] {**Day 276, 11/05/22, 10:9-22**}
[38] {**Day 275, 10/05/22, 193:7-18**}
[39] {**Day 275, 10/05/22, 204:1-5**}

desk asked him for identification, like a passport or a driving licence, and insisting one needed to be produced before any help would be given. I made clear I had known him for years and that he was a Grenfell Tower resident but it was pointless as I was also asked for identification documents and I did not have any to show I was from the tower."[40]

3.34. Jenny Dainton says, speaking about the Westway Centre: "*I found it was more formal and bureaucratic compared to the Rugby Club. I believe it had been set up by RBKC. You had to wear wristbands to get through security. There were lots of different organisations here including the DVLA, Home Office and RBKC. They all sat behind tables, which I felt created a barrier between them and me. I found the Westway to be impersonal.*"[41]

3.35. On the subject of the wrist bands Zoe Dainton who lived in flat 12 of the Tower, says: "*It also meant that journalists in the area could easily identify you.*"[42]

3.36. Branislav Lukic, who lived at flat 84 on the 11th floor of the Tower, says: "*I felt really lost and did not know what to do. No one around the Tower told me where I could go to sleep or what I could do to get help ... The next day, I wanted to get back to the Tower to see what was going on ... I was directed to the Westway Centre ... The Westway had been set up as a centre for survivors ... There were what seemed like hundreds of mattresses on the floor of the centre for people to sleep. I can't remember how long I slept there for – I think it was two nights. I do remember that it felt very strange there. There were about 20 of us amongst all of the empty mattresses. It was a very sad place to be. It really felt like it was somewhere for people that did not have anywhere better to go.*"[43]

(k) **Information and communication**

3.37. Information and communication should have been clear, straightforward and effective for the target audience, but this simply did not happen. This is inexcusable. These are basic matters of which any competent local authority or public body should have been capable, even in a disaster of the magnitude of the Grenfell Tower fire.

3.38. Robert Black accepted this as a failing on the part of the TMO:

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[40] {**IWS00002110/34**} & read on {**Day 264, 12/04/22, 122:3-14**}
[41] {**IWS00001804/24**} & read on {**Day 264, 12/04/22, 123:6-17**}
[42] {**IWS00001974/31**} & read on {**Day 264, 12/04/22, 123:2-5**}
[43] {**IWS00001760/4–5**} & read on {**Day 264, 12/04/22, 127:6-21**}

"*I have become very aware that actually there were mistakes made and people faced – being given terrible news because we'd done it incorrectly or not identified mistakes. So, I'll have to take – in terms of as a company, we have to accept that that was our responsibility and we failed to do it correctly.*"[44]

3.39. The information vacuum was a repeated issue. Emma Spragg of British Red Cross ("**BRC**") highlighted how this hindered their ability to provide support.[45]

3.40. Rupinder Hardy advocated for a "tell us once" system to be implemented in future.[46]

(l) **Information to families about missing loved ones**

3.41. This was an issue that caused particular heartache for the families yet, as openly admitted by Nicholas Holgate, it was not a priority for RBKC: "*I have to say that wasn't absolutely at the top of my list, but I realise, of course, that it's a very important service.*"[47] The nonchalance of Mr Holgate must be compared to the evidence of survivors such as Nabil Chouchair, and his brother Hissam Choucair and their desperate search for information about their 6 family members:

"*It was. Yeah, it was very, very unclear. It was…so unorganised….you would think, in a situation, in an emergency, in a catastrophe, there is some sort of plans, some sort of organisation, but … everything was just falling apart, and it was just so unorganised. It was so unhelpful, you know, it was like we were trying forever, but with no help, you know, with no clear sense of help or exactly what, you know, we wanted to hear or know*

Q: If we go to your first statement, again... And you say there: "The preceding days became more and more painful as the reality began to sink in but we still did not give up hope." Did you get any further information or any help about how to get further information during those days?

A: No. No, we were left …. In the early days, we were left to ourselves …. to help ourselves and do what we can, do whatever, whatever way possible, to try and find whatever we can about our families."[48]

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[44] {**Day 275, 10/05/22, 106:19-25**}
[45] See {**Day 280 31:25-32:19 and 68:2-17**}
[46] {**Day 276, 11/05/22, 83:25-84:15**}
[47] {**Day 273, 05/05/22, 52:18-22**}
[48] {**Day 167, 27/07/21, 24:16 -25; 26:20 – 27:5**}

4. VOLUNTARY SECTOR

4.1. The voluntary sector filled the leadership vacuum created by RBKC:

(i) Michele Chiapetto lived in flat 155 on the18th floor with his partner, Berkti Haftom, and her son, Biruk, both of whom died in the fire. He says: "*Immediately after the fire, information about what to do or what was happening was not clear and it seemed the council and TMO had vanished. I went to the Rugby Portobello Club and for the first time found somewhere that was actually trying to help the Tower residents. They were trying to help the people who lived in the Tower as well as the bereaved ... I knew Rugby Portobello because I went there with Biruk for the homework club. It meant I knew it and was comfortable going there. They focused on people from the Grenfell Tower ... it created a space where we could be without lots of people. It was somewhere that understood what was going on and who wanted to help.*"[49]

(ii) Hazel Burke, a resident from Barandon Walk, describes being outside on the street until 4 am when St Clement's Church opened. She states: "*I did not know where else we could have gone apart from the Church at this time. ... I know that the Rugby Club, Harrow Club and Methodist Church also opened and offered assistance ... St Clement's Church, and other churches, mosques and local community groups played a vital role in supporting the community at that time.*"[50]

4.2. It must be seen as another failure of RBKC that the community and voluntary organisations were not effectively involved in emergency planning.

4.3. Neither the Clement James Centre ("**CJC**") or RPT were invited by RBKC to be involved in emergency planning activities or training, although both Chief Executives said they "*absolutely*" would have welcomed such an approach.[51]

4.4. The CJC and RPT were on a list of centres that could be opened and had provided an out of hours contact number, but RBKC failed to use this on the night of the fire.[52]

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[49] {**IWS00001780/4–5**} & read on {**Day 264, 12/04/22, 114:7-23**}
[50] {**IWS00001544/7–8**} & read on {**Day 264, 12/04/22, 115:19-116:10**}
[51] See Clare Richards {**Day 275, 10/05/22, 125:10-25**} and Mark Simms {**Day 275, 10/05/22, 182:10-18**}
[52] See Clare Richards' evidence {**Day 275, 10/05/22, 124:19-125:15 and 127:11-17**}

4.5. Both the CJC and RPT reported that they had to contact RBKC and ask for representatives to attend. Clare Richards shared her surprise at this: "*I have to say, I naively thought there would be a team of people in the case of an emergency of this scale that would be there to coordinate but that definitely wasn't the case.*"[53]

5. LOCAL GOVERNMENT RESPONSE – TRAGEDY COMPOUNDED BY INDIFFERENCE

(a) Inadequacies in planning by RBKC/TMO

5.1. In their written opening submissions, it was said on behalf of RBKC:

"3. The Council is committed to candour in its approach to the Inquiry. It has been guided by this commitment in reflecting on its role in relation to Module 4 issues and setting out its position on them in this Opening Statement.

[…]

5. In this Statement, we have set out a number of specific failings in the Council's response to the Grenfell Tower fire and in the steps that the Council had taken to prepare for an emergency in the borough. These include the following: • The arrangements which the Council had in place before the fire failed to set out how different parts of the Council would coordinate their communications. The Council failed to provide the public with clear, consistent communications after the fire. As a result, individual residents missed out on receiving support to which they were entitled. • The Council's provision of rest centres was initially disorganised. The lack of visible presence I leadership from the Council contributed to the problem. The Council had not trained enough rest centre managers before the fire. There was a shortage of senior managers at rest centres on 14 June. • The Council did not run an adequate number of emergency response training events and exercises before the fire; there was insufficient attendance at the training events and exercises that were held.

6. The Council apologises for its failings.[54]

5.2. Whilst these concessions and acceptance of failings and breaches are acknowledged, they are obvious and do not go far enough. Our families do not believe RBKC should be applauded for stating the minimum. This Inquiry needs to shine a light on this local

[53] {**Day 275, 10/05/22, 127:21-24**}
[54] {**RBK00068467/1-2**}

authority's poor practices and statutory breaches. As well as being candid, RBKC must take responsibility for their failings and there must be accountability.

5.3. The Council had a duty to assess the risk of an emergency occurring within the borough. Cabinet Office Guidance entitled "Emergency Preparedness" stated: *"Risk assessment is the first step in the emergency planning and business continuity (BC) planning processes. It ensures that Category 1 responders make plans that are sound and proportionate to risks."*[55]

5.4. RBKC's Borough Risk Register[56] did not list a major fire in the Table of Risks. There was no designated Lead Government Department for a major fire and the National Risk Register did not include an entry for urban or tower block fires, whilst unreassuringly for those who live in urban areas, i.e. the vast majority of the population of this country; it does have an entry for wild fires. The London Risk Register[57] also did not include an entry for urban or tower block fires. These glaring omissions lead to the inevitable sinking feeling as to the quality and reliability of the risk register and any subsequent planning.

(b) <u>TMO</u>

5.5. The basic stance taken by TMO witnesses is that the TMO was not a Category 1 responder, it was immediately obvious from the scale of the fire that the TMO's Emergency Plan was not relevant so that RBKC's Emergency Plan would prevail and that the TMO then did what it was asked to do on an ad hoc basis to assist in the response. As Mr Black put it, the TMO *"had no formal role except to provide resource and support to RBKC when requested by them to do so. That is how it was planned and operated"*.[58]

5.6. This reveals a fundamental failure on the part of both RBKC and the TMO to appreciate what the TMO's role could and should have been in the event of a large-scale emergency. The TMO was not just a TMO. It was an arm's length management organisation (ALMO) with responsibility for the management of the entirety of RBKC's housing stock (some 9,000 units, including leasehold). It therefore had to perform the functions of a local

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[55] Chapter 4 (Local responder risk assessment duty)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61027/Chapter-4-Local_20Responder-Risk-assessment-duty-revised-March.pdf
[56] {**RBK00003970**}
[57] {**GOL00000240**}
[58] {**TMO10048970/3**}, at para 15

authority's internal housing department. An authority's housing department is, of course, part of the authority itself and, therefore, part of a Category 1 responder. As such, it is fully integrated within the authority's Emergency Plan and provides staff trained to act as part of a co-ordinated response with other local authority departments, *e.g.* Homelessness Services, Adult Social Care and Children's Services. RBKC and the TMO should have realised this obvious point. It should never have been the case that the TMO had *"no formal role except to provide resource and support"* on an ad hoc basis. The TMO should have been a fully integral part of RBKC's emergency planning. The failure to ensure that this was the case vastly reduced RBKC's capacity to respond effectively to the fire.

5.7. Indeed, although this was not appreciated at the time, it appears that at some point in the past the TMO had realised that it was expected to work alongside RBKC in response to a major incident within the framework of its own Emergency Plan, which stated:
"The plan is primarily for managing local KCTMO emergencies on, within, or surrounding our properties and estates, one which can be managed within the resources available to the KCTMO. However, this plan can also be used for large scale major events which would overwhelm the KCTMO's ability to manage on its own, and which would involve the RBKC council resources. The difference being the scale of the emergency and the number of people affected by it".[59]

5.8. In his oral evidence, Mr Black accepted that he misunderstood the TMO's role in the event of an emergency response led by RBKC[60], there was no reason why parts of the TMO's Emergency Plan could not have been activated alongside RBKC's response[61] and that he had never sought to clarify the TMO's position in the event of a major emergency.[62] He accepted that the TMO's role as stated in the Emergency Plan envisaged that TMO staff involved in an emergency response ought to have been well equipped to undertake roles working alongside RBKC,[63] which included being able to set up rest centres.[64]

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[59] {**TMO10013898/13**}
[60] {**Day 275, 10/05/22, 14:13-22**}
[61] {**Day 275, 10/05/22, 8:6-22**}
[62] {**Day 275, 10/05/22, 15:7-10**}
[63] {**Day 275, 10/05/22, 9:13-17**}
[64] See {**TMO10013898/28**}: *"Ensure that residents' primary needs (i.e. shelter, food and warmth) are met as quickly as possible. You may need to open up a rest centre."*

5.9. RBKC and the TMO's failure on the night to work together as part of a planned, co-ordinated response is all the more shocking given the lessons that should have been learned from the Adair Tower fire in October 2015. On 11 November 2015, a meeting of the TMO's Executive Team was attended by Robert Black, Yvonne Birch, Sacha Jevans and Barbara Matthews. Better integration between RBKC and the TMO was considered necessary: *"Overall it was felt that RBKC were supportive but going forward it would be good for the TMO to be more involved with RBKC on their Emergency Planning strategy, so that contact numbers and roles and responsibilities are known by all."*[65]

5.10. Mr Black accepted that, despite this discussion at Executive Team level, at the time of the Grenfell Tower fire, the TMO still lacked a clearly and formally defined role in the event of RBKC's contingency planning systems being invoked[66] and emergency response training was limited to *"on-call staff and our out-of-hours contractors"*.[67] Indeed such was the lack of co-ordination between RBKC and the TMO on the night of the fire that RBKC did not even telephone the TMO's out-of-hours contact.[68] Instead of being part of an organised and co-ordinated response, the TMO *"co-worked on a reactive basis, responding to the situation as best [the TMO] could as it evolved"*.[69] Although Mr Black attended RBKC Gold Group meetings, he said that his role was just to provide information and *"just to be there and see what you could provide"*.[70]

5.11. The TMO's failure to appreciate the potential significance of its role meant that senior management and other staff were not properly trained in emergency response. While at the TMO, Black did not receive any training on emergency planning and response nor had he attended any joint training with RBKC about how its plan would work in practice or what role the TMO would have in the event of RBKC's plan being invoked.[71] Teresa Brown received no training in emergency planning and response while at RBKC.[72] She claimed that employees on the out-of-hours rota received training[73] but this is contradicted by one of those employees, Kiran Singh, who says that he *"attended no training or exercises in*

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[65] {**TMO00840414/2**}
[66] {**Day 275, 10/05/22, 17:21-25**}
[67] {**Day 275, 10/05/22, 17:14-20**}
[68] {**Day 275, 10/05/22, 127:11-24**}
[69] {**Day 275, 10/05/22, 20:18-20**}
[70] {**Day 275, 10/05/22, 29:11-21**}
[71] {**Day 275: 10:23-11:7**}
[72] {**TMO00894124/1**}, at para.3
[73] {**Day 274, 09/05/22, 14:4-9**}

the emergency plan".[74] This is highly significant as it was Kiran Singh who was primarily tasked with collating details of residents on the night of the fire, including the "safe/missing" list.

5.12. Mr Black accepted that, following the Adair Tower fire, staff should have been provided with more training[75] but staff received no training on working at rest centres or collating data in an emergency.[76] Understandably, they felt out of their depth, as exemplified by Mandy Warrier:

"Teresa [Brown] instructed me to go to the reception centre that had been set up at the Harrow Club. When I got to the Harrow Club, the manager of the Club essentially abdicated all responsibility for the reception centre to me. I began greeting people as they entered the centre, making a note of who they were and what they needed. I also made a list of any people who were allegedly missing. ... I recall feeling like I wasn't the right person to be running the centre as I had not received any training on running a reception centre, however I had no choice but to carry on." [77]

5.13. The total lack of co-ordination during the response is illustrated by the fact that not only did Brown never have any contact with Sue Redmond but she did not know that Redmond was the HALO or even what the HALO role was.[78] The lack of integration of the TMO within RBKC's emergency planning also meant that, once LLAG was invoked, the TMO failed to recognise the possibility of asking for additional assistance from outside and Black did not ask LLAG for extra help because the TMO was not a Category 1 responder.[79] On reflection, he accepted that lack of resources became problematic and he *"should have pushed more for Gold to include us".*[80]

5.14. The role the TMO undoubtedly should have been able to perform was to provide details of who was living in Grenfell Tower and the remainder of the Lancaster West Estate and to highlight those with vulnerabilities, *e.g.* households which included disabled or elderly residents or children. Taken together with records held by the RBKC, a fairly accurate

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[74] {**TMO00840373/2**}, at para.5
[75] {**Day 274, 09/05/22, 14:5-7**}
[76] {**Day 274, 09/05/22, 61: 8-14**}
[77] {**TMO10048986/4**}, paras 17-18
[78] {**Day 274, 09/05/22, 54:12-22**}
[79] {**Day 275, 10/05/22, 72:23-75:11**}
[80] {**Day 275, 10/05/22, 108:19-109:4**}

picture of Grenfell Tower's population should have been readily available. As Katharine Hammond put it in an email dated 15 June 2017: *"Surely a sensible person with access to their files could be working out ... decent estimates of occupancy (tenancies + electoral register + council tax)?"*[81]

5.15. The Inquiry also explored this issue in Module 3, during which it became clear that the TMO's records were woefully inadequate. The line maintained by the TMO and RBKC is that they are dependent on the information provided by residents and that the population of council blocks is necessarily shifting. Residents' personal circumstances also change. Illness or injury may render them temporarily vulnerable and this may not be recorded by the TMO. It is accepted that that details of residents in a block the size of Grenfell Tower will never be 100% accurate at any given moment. That does not excuse the difficulties that the TMO and RBKC had in providing reasonably accurate estimates for numbers for residents nor can it explain the failure to record vulnerable residents as demonstrated by Dr Lane's Module 3 report.

5.16. It is important to note that the tenancy data at the inception of a council tenancy should be completely accurate. The tenancy will (usually) be granted as a result of an allocation under Pt 6, Housing Act 1996, which will necessarily require the authority to have full details of the applicant's household including any vulnerabilities. In some circumstances, a non-secure tenancy of a council property will be granted to a homeless applicant under Pt 7, Housing Act 1996. In that case too, the authority will have full details of the applicant's household in their application form. Indeed, documents used by the TMO when signing up new tenants illustrate how the information should have been captured. The "Signup Data Entry Form" has space for the tenant's personal details and those of any "Authorised Occupants", together with space for recording the first language of each resident, any disabilities and details of next of kin.[82] There is also a "Tenancy Information" form which records certain information about the tenant and what was explained to them when the tenancy was signed.[83] It includes space for "additional support needs" to be recorded for the tenant and any other household member.

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[81] {**CAB0002896/2**}

[82] {**TMOH00018101**}

[83] {**TMOH00018096**}

5.17. The TMO also had provision for updating records through a "tenancy audit". The "Tenancy Check Visit Form" which was used included space for the composition of the tenant's housing and next of kin details.[84] There was also space for recording whether the tenant requires "any help to access" the TMO's services. There was no space, however, for recording any other needs that a resident may have, *e.g.* because of disability.

5.18. The inadequacy of the TMO's tenancy data was a long-standing problem. Shortly after Brown commenced employment at the TMO, the Executive Team meeting minutes of 2 April 2014 record that she thought: "*that our tenancy information was poor, and better information would help the CRM initiative. She had offered to draw up a plan to get the outstanding work done ready for the introduction of CRM ... The options were to do it over one year or catch up incrementally*".[85]

5.19. The importance of the TMO maintaining accurate tenancy data in the event of an emergency was emphasised following the Adair Tower fire. The minutes of a meeting of 11 April 2016 between Mr Kerry and representatives of RBKC's Housing Department and the TMO record: "*Housing confirmed that ... They can liaise with TMO to get full details of vulnerable evacuated tenants*".[86] Brown confirmed that this meant that the TMO would attend the scene of the emergency with its "*known list of residents*" and provide that information to RBKC, including any known vulnerabilities.[87] The meeting did not, however, prompt the TMO to take any new action to update its tenancy data. Instead, it persisted with a programme of tenancy audit and improving its CRM system.[88]

5.20. The meeting should have prompted the TMO to update the information in its Emergency Plan. Indeed, the same minutes record that the TMO would provide a copy to Mr Kerry.[89] Brown accepted that this was a "*perfectly good opportunity*" to update the Emergency Plan and the annexed sets of details for each tower block and estate.[90] The TMO failed to take that opportunity. The TMO's Emergency Plan stated that it included: "*Information on numbers of known vulnerable residents are included on the block/property*

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[84] {**TMOH00018669**}
[85] {**TMO00850821/5**}, at 6.1
[86] {**RBK00004660/3**}
[87] {**Day 274, 09/05/22, 19:25-20:4**}
[88] {**Day 274, 09/05/22, 21:25-22:8**}
[89] {**RBK00057975/3**}
[90] {**Day 274, 09/05/22, 23:11-15**}

details which form part of this plan."[91] The information specific to Grenfell Tower was completed by Damian Donnelly in 2002 and it had not been updated, despite the Emergency Plan being the 2016 version.[92] It therefore took no account of the refurbishment works and stated that there were 120 dwellings (not 129), approximately 330 to 360 residents, and that the likely number of vulnerable residents was 8 to 12. It contained no further information about the location of these residents nor the nature of their vulnerability. So far from being of assistance to the emergency services and RBKC in responding to the fire, it was actively misleading.

5.21. Although the TMO was the obvious first port of call for information on residents, RBKC departments, *e.g.* Adult Social Care and Children's Services, also had records which should have recorded the composition of a tenant's household and, more specifically, would assist in identifying residents with any vulnerabilities. Yet there was no sharing of data held on residents between the TMO and these departments, as both Brown and Redmond confirmed.[93]

5.22. During the response, Brown says that there was *"sort of constant information-sharing"* between the TMO and the Council about vulnerable residents which was based on the information in the *"tenancy list"*.[94] This collation of information wasted vital time, threw up conflicting information which had to be resolved and was inherently likely to lead to confusion and error. It was also necessarily going to have significant gaps because of the chaotic nature of RBKC's response. On the night of the fire, Brown was unaware of the community rest centres at the Al Manaar Mosque and St Francis of Assisi Church so that she did not send TMO staff to them and therefore had no means of collating information for residents who had taken shelter there.[95]

5.23. The TMO's data management continued to be ineffective. When the decision was taken on 14 June to provide emergency accommodation to residents of the Walkways who were disabled, elderly or had children, RBKC looked to the TMO to provide them with this

[91] {**TMO10013899/14**}
[92] {**TMO10013899/46-47**}
[93] See Brown {**Day 274, 09/05/22, 24:11-16** and **105:22-107:1**}; and Redmond {**Day 271, 03/05/22, 92:15-93-6**}
[94] {**Day 274, 09/05/22, 51:5-11**}
[95] {**Day 274: 31:10-25**}

information. David Noble gave a figure of 25 disabled residents[96] but failed to provide any details of the number of elderly residents or households with children, which Brown failed to notice.[97]

5.24. It is clearly essential that responders have information about those affected by an emergency which is as accurate as possible and available as soon as possible. It is unquestionably the case that the tenancy data quality would have been greatly improved if there was a single, existing database which had already collated the information available to the TMO and RBKC's social services departments. It is patently harder to reconcile inconsistent data during an emergency response. Adult Social Services and Children's Services were likely to have held more up-to-date and relevant information than the TMO given that their property visits would have been more frequent and inevitably focused on residents' vulnerabilities.

5.25. Why was such a database not created? It appears from evidence given by Amanda Johnson in Module 3 that there were concerns about breaching data protection rules.[98] There was, however, no reason why a data sharing agreement could not have been put in place between the TMO and RBKC. Even though sensitive personal data about vulnerable residents could not have been shared without the resident's consent, surely that consent would have been given if it was properly explained that it was to be used in an emergency. We suggest the Inquiry should recommend that such collated databases be kept by social landlords and local authority social services departments.

5.26. There remains the question of why the information on residents kept by the TMO and RBKC was so poor. There is an obvious answer to this, namely the remote attitude of the TMO and RBKC to the residents whom they were meant to serve. Far better knowledge of the Estate's residents would have been available if there had been proper engagement with residents and housing officers had been seen as part of the community. As was clear from the Module 3 evidence, the relationship between residents and the TMO/RBKC had broken down. It is this more than any other factor which led to the TMO's lack of information about residents.

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[96] {**TMO00869977**}
[97] {**Day 274, 09/05/22, 105:4-20**}
[98] {**Day 131, 17/05/21, 66:6-67:4**}

5.27. In addition to providing initial data about the residents, the TMO also undertook the task of recording those who were missing and who were reported to be safe. The Inquiry took Brown through the spreadsheets of the "safe/missing" list in its various versions at some length and demonstrated how terrible mistakes were made so that numerous residents were recorded as both safe and missing, leading to relatives being told that their loved ones had survived when that was not the case.[99] This poignant evidence is not only a damning indictment of RBKC and the TMO but also emphasises the need for a total change of culture in emergency response.

(c) Housing duties

5.28. RBKC failed to discharge its statutory duties to the homeless both in relation to emergency accommodation in hotels and subsequent temporary accommodation. RBKC's failure was compounded by the government's totally unrealistic promise that families would be rehoused within three weeks. It was not just the timescale that the government got wrong. As DLUHC accepted in its oral opening, it should have *"been clearer in the way that the commitment was communicated. It should have emphasised that affected people would be provided with temporary accommodation before being offered permanent accommodation, and that they weren't obliged to accept the first offer"*.[100]

5.29. "Permanent" or "settled" accommodation connotes a tenancy in social housing with full security of tenure, *i.e.* a secure tenancy granted by a local authority or an assured tenancy granted by a housing association. Allocation of such accommodation by local authorities is governed by Pt 6, Housing Act 1996, which requires an authority to have a scheme for determining priorities in allocating its accommodation. Put simply, the council waiting list.

5.30. Local authorities' duties to homeless persons are contained in Pt 7, Housing Act 1996. The extent of an authority's duty to a homeless applicant depends on: (a) eligibility;[101] (b) whether the applicant has a "priority need"; and (c) whether the applicant made themselves "intentionally homeless". Pending a decision on these issues, if the authority has reason to believe that a person may be homeless and may have priority need, the authority must

[99] {**Day 274, 09/05/22, 74:2-94:4**}
[100] {**Day 263, 11/04/22, 193:23-194:2**}
[101] A question of immigration status.

secure accommodation for them: s.188, 1996 Act. Any person rendered homeless as a result of a fire has a priority need[102] and plainly cannot be said to have made themselves homeless intentionally. It follows that RBKC owed every person made homeless by the fire the "full" housing duty under s.193(2), 1996 Act. Under that duty, RBKC was required to secure that accommodation became available to each of the homeless persons.

5.31. Accommodation secured under either s.188 or s.193(2) must be "suitable".[103] Suitability is a relative concept in that what may be suitable in the short term may not be suitable in the medium or long term. The duty can therefore be discharged in stages, permitting the use of hotel accommodation to address an immediate crisis while more suitable accommodation is found. It is to be emphasised, however, that at each stage the accommodation must be suitable for the applicant's household. Furthermore, in deciding whether accommodation is suitable, the PSED requires the authority to focus on the effect of an applicant's protected characteristics, *e.g.* disability or religion, and recognise that their particular needs might require them to be treated more favourably than a person without those characteristics.[104]

5.32. In practice, given the chronic shortage of social housing in England, pending an allocation under Pt 6, authorities commonly discharge their duty under s.193(2) by securing "temporary accommodation" let under an assured shorthold tenancy by a private landlord: a "private rented sector offer". Significantly, an authority can decide to end its duty under s.193(2) if an applicant is offered and refuses a suitable private rented sector offer: s.193(7AA)(b). Accordingly, most authorities operate a "one offer only" policy. The failure of RBKC and the government to make it clear that residents would not have to accept the first offer made to them caused victims of the fire great anxiety.[105]

5.33. In deciding whether accommodation is suitable for a household, the authority must consider: (a) their specific health needs; (b) the proximity and accessibility of the support of their family or other support services; (c) any disability; (d) the proximity and

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[102] Housing Act 1996 s.189(1)(c).
[103] Housing Act 1996 s.206(1).
[104] *Haque v Hackney LBC* [2017] EWCA Civ 4; [2017] H.L.R. 14.
[105] See email from Cllr Blakeman to Ellie Robinson, 20 June 2017, {**GLA00000030**}: *Assurances were also given last night both the Home Office minister Nick Hurd and Housing minister Alok Sharma that no one would be made intentionally homeless- along with many other reassurances. Can you please find out why this is not being communicated to the Survivors on the ground? Mr Thompson still fears being made intentionally homeless if he refuses an offer of housing."*

accessibility of medical facilities and other support services currently being provided to the household; and, (e) the significance of any disruption which would be caused by the location of the accommodation to employment, caring responsibilities or education.[106]

5.34. In their Module 4 opening, RBKC admitted multiple failings in relation to the provision of emergency accommodation, all of which Laura Johnson accepted in her evidence. Some residents entitled to emergency accommodation were not provided with it because they were not made aware of their rights.[107] Some were misled as to their entitlement.[108] Others were not provided with transport to get them to their hotels and had to rely on the kindness of strangers.[109] In seeking to match accommodation to families' needs, *i.e.* ensuring that the accommodation was suitable, RBKC made mistakes,[110] *e.g.* in relation to size of accommodation[111] and lack of appropriate facilities for the disabled or families with young children.[112] Extraordinarily, in the first few days, RBKC gave no consideration to the floor on which emergency accommodation would be provided so that some residents were placed in high-rise accommodation.[113] Families were placed in hotel accommodation but then left for days without RBKC contacting them to follow up on their support needs leaving them feeling *"abandoned"* by RBKC.[114] As many families were reliant on the food provided by their hotels, many Muslim families were unable to get halal food.[115]

5.35. In making these admissions, however, Laura Johnson was keen to emphasise the unprecedented scale of the emergency, suggesting that there were excuses for her department's failings.[116] Although the scale of the disaster must be acknowledged, it does not excuse the total inadequacy of RBKC's response. The failings of RBKC's housing department are part of RBKC's broader failure to comply with its duties under the CCA 2004, in particular proper training of staff and adequate planning. Aside from attending one event in 2015, Laura Johnson had no formal training in contingency management

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[106] Homelessness (Suitability of Accommodation) Order 2012 (SI 2012/2601).
[107] {**Day 272, 04/05/22, 94/4-13**}
[108] {**Day 272, 04/05/22, 84:15-22**}
[109] {**Day 272, 04/05/22, 121:15-24**}
[110] {**Day 272, 04/05/22, 116:20-117:6**}
[111] {**Day 272, 04/05/22, 118/25-119:12**}
[112] {**Day 272, 04/05/22, 119:16-120:18**}
[113] {**Day 272, 04/05/22, 117:7-22**}
[114] {**Day 272, 04/05/22, 128:13-131:13**}
[115] {**Day 272, 04/05/22, 133:5-17**}
[116] See, e.g. {**Day 272, 04/05/22, 120:15-16**}: *"we did our very best to try and place people somewhere in a very difficult situation, and we didn't get it right in every occasion..."*.

planning.[117] She played no part in two significant training exercises which took place in November 2015 and November 2016.[118] She was *"not confident"* that the housing team was aware of the housing contingency plan,[119] of which the version in force at the time of the fire was dated 2012.[120] She viewed emergency planning as something she would be asked to do by the *"corporate centre"* but she accepted personal responsibility for failing to update the housing contingency plan annually.[121]

5.36. RBKC's Housing Department failed to take basic steps which would have helped them to provide emergency accommodation and keep residents properly informed. As Laura Johnson accepted, having standing arrangements with hotels, or hotel groups, would have helped to avoid the difficulty encountered in booking rooms because hotels required payment upfront.[122] Given the problems families encountered in obtaining information from RBKC, it is remarkable that the housing helpline only operated between 8am and 10pm.[123] This is an extraordinary admission as the statutory *Homelessness Code of Guidance for Local Authorities* at the time required 24-hour access to homelessness assistance at any time, let alone during a period of emergency.[124]

5.37. As already noted, DLUHC has accepted that it should have made it clearer that the commitment to rehouse within three weeks was a commitment to provide temporary rather than permanent accommodation. Although this was not made clear to the families, this should have been clear to RBKC. An email from Fiona Darby (DCLG's Deputy Director of Homelessness) to Laura Johnson, dated 17 June 2017, summarised what had been promised:[125]

"... HMG will guarantee funding for the temporary accommodation for those made homeless by the fire. This will include those in Grenfell Tower, Grenfell Walk, and any

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[117] {**Day 272, 04/05/22, 11:16-19**}
[118] {**Day 272, 04/05/22, 24:1-25:6**}
[119] {**Day 272, 04/05/22, 9:5-9**}
[120] {**RBK00035406**}
[121] {**Day 272, 04/05/22, 9:13-25**}
[122] {**Day 272, 04/05/22, 60:6-23**}
[123] {**Day 272, 04/05/22, 93:1-7**}
[124] *"6.8. A need for accommodation or assistance in obtaining accommodation can arise at any time. Housing authorities will therefore need to provide access to advice and assistance at all times during normal office hours and have arrangements in place for 24-hour emergency cover, e.g. by enabling telephone access to an appropriate duty officer."* - Homelessness Code of Guidance for Local Authorities, July 2006, to which authorities had to have regard in discharging their functions under Pt 7: s.182, 1996 Act.
[125] {**RBK00001612**}.

households in the cordon that are homeless because homes are not habitable due to water damage etc.

"Government has committed to this rehousing happening within 3 weeks and within K&C preferably or surrounding boroughs (unless anyone wants to move further afield of course).

"As discussed this would be at least 1yr/ASTs [assured shorthold tenancies]/self-contained accommodation/as close to schools and GPs etc.

"This procurement needs to start now (running in tandem with the gathering of housing need etc.) as the properties will need [to be] fully inspected and may need basic furniture … etc. installing - if unfurnished. The quality needs to be good. The Government understands that the timeframe will mean that you may have to block book PRS [Private Rented Sector] accommodation on your best estimates of needs at this time and might not end up using some of it. Government will pay for what is not used. A balance needs to be struck given the absolute 3-week timeframe. Deposits/incentives might be needed to secure properties and if so the Government will fund this.

"Government will pay until settled accommodation can be established and there is a separate team here thinking about how we can help you provide the additional social housing tenancies required longer term. …".

5.38. In light of this email, astonishingly, Laura Johnson understood the commitment to be the provision of permanent housing. In her account of the meeting with Alok Sharma on 16 June 2017, she understood that the Prime Minister wanted to commit to rehousing victims of the fire *"locally and permanently within two weeks"* and her response was that it would take two years to achieve this.[126] In her oral evidence, she confirmed this misunderstanding: *"But I also knew it's a very difficult problem to solve, because there just aren't enough social housing units in London …, so supply was always going to be difficult in the wake of overwhelming demand … And I said on the Friday that I thought it would probably take around two years to rehouse everybody …".* Amanda Johnson shared this misunderstanding.[127]

5.39. The government was offering a blank cheque to cover the whole cost of temporary accommodation until permanent accommodation could be provided. Even if

[126] See Laura Johnson's witness statement at paras 54 (*"I told people in my team that the realistic scenario was that it would be 2 years before everybody was permanently rehoused"*) and 71 {**RBK00035592/14 & 18**}.

[127] See Amanda Johnson's witness statement at para.39c, where in her list of tasks was obtaining "second stage" accommodation from Housing Associations, with no mention of the private sector {**RBK00035228/9**}.

accommodation was booked but then not used, the cost would be met. RBKC Housing Department's senior management somehow totally failed to appreciate what was on offer. Days were missed during which progress in locating suitable temporary accommodation could have been made and RBKC's misunderstanding of the position added to the confused messages given to the families.

5.40. That said, given the number of families involved and the many factors an authority has to consider in determining suitability, as Amanda Johnson put it: *"the promise to rehouse everyone within three weeks [was] irresponsible as it was never achievable".*[128] RBKC was placed in a situation where it made offers of accommodation to families even when it knew it was unsuitable: *"The government's promise hampered our work. All of our efforts were directed into meeting the government commitment and working towards the list of available properties. We were making offers we knew survivors would refuse, in order to meet their three-week target, and to make sure everyone had an offer".*[129]

5.41. In its oral opening DLUHC said: *"Looking back, the department is of the view that although it was right to set difficult targets with the very best intentions, the commitments in fact made were too ambitious."* In light of the confusion and distress caused by this irresponsible commitment, this falls far short of the full and proper apology the families deserve. Given the shortage of housing in central London and the sensitivities involved in assessing the needs of families still suffering from trauma, hindsight is not required to realise that the commitment was unachievable. Yet the difficulty of the task does not excuse the fact that residents waited months or even years to obtain suitable accommodation. Scandalously, many still have not been provided with permanent accommodation. Tragically, Elzbieta Konarzewska died while still waiting to be properly accommodated.

6. CONTINGENCY PLANNING

(a) RBKC's Statutory Duties

6.1. Emergency Planning, preparedness and assessment of risk lies at the heart of the civil contingency planning and Statutory duty underpinning the Civil Contingency Act. RBKC's failings in relation to its statutory duties pursuant to the CCA (2005) were systemic and we

[128] {**RBK00035228/9**}, at para.43.
[129] See Laura Johnson ,{**RBK00035592/19**}, at para.72.

invite the panel to find that these systemic failings contributed to RBKC's abysmal response to the Grenfell Tower fire.

(b) <u>Internal oversight and Systemic Inadequacy of Contingency Management</u>

6.2. A systemic lack of internal oversight of RBKC's contingency arrangements, led to contingency plans not being updated, annexes left blank, in draft form, outdated or had been superseded.[130] David Kerry was seemingly left to his own devices with no oversight from his line manager Stuart Priestley or indeed Tony Redpath.[131]

6.3. Stuart Priestley was neither qualified nor did he have any prior experience in contingency management and so in effect relied on Mr Kerry's say so in relation to the CMPs and compliance with RBKC's statutory obligations. He admitted that apart from being aware of the existence of resilience arrangements he had had no training in London Resilience Partnership plans prior to the fire and although he had been aware of the existence of the plans he did not have a detailed understanding of them.[132] On Priestley's admission, his training in the role of silver command prior to the fire was inadequate.[133] He was also well aware that there were insufficient staff to fill emergency roles and although he denied recollection of the need to test evacuation plans being raised with him, as CMU manager, he had a duty to ensure systems were compliant, including ensuring testing of emergency plans in accordance with RBKC's statutory obligations.[134]

6.4. In any event, on Rebecca Blackburn's evidence, she had raised concerns about the need for sufficient training and exercise of the plans to be undertaken with management – including Priestley, his predecessor and Tony Redpath:[135]

"2.19. The view I held was that the RBKC Contingency Planning Unit did not conduct any large-scale emergency simulations outside of the LLAGILFB London Local Authority Training and Exercising Programme. This was based upon my own experience. The only exercise I was involved in during my tenure with RBKC was one that I organised for the London Olympics in 2012. This tabletop exercise involved all of the services within the Council.

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[130] {**Day 268, 26/04/22, 25:13–29:12**}
[131] {**Day 279, 17/05/22, 4:15-19**}
[132] {**Day 270, 28/04/22, 6:23 -7:7**}
[133] {**Day 270, 28/04/22, 7:13-20**}
[134] {**Day 270, 28/04/22, 8:10–10:10**}
[135] {**RBK00058170/9**}

2.21. ***I raised the issue verbally with RBKC Director of Strategy and Local Services Tony Redpath, RBKC Chief Community Safety Officer Stuart Priestley and Stuart Priestley's predecessor.*** *I am unable to recall the name of Stuart Priestley's predecessor. I recall that I raised the matter with Stuart Priestley quite soon after he assumed office as RBKC Director of Strategy and Local Services.....*

2.22. ***I informed all three of them of my concerns about the failure to conduct sufficient large-scale emergency evacuation plans outside of the LLAG/LFB London Local Authority Training and Exercising Programme to test the Contingency Management Plan, and my doubts that Contingency Planning Manager David Kerry would have been able to cope.*** *"*[136]

6.5. In oral evidence she confirmed that she had raised concerns about lack of training and testing "*with every senior director*", listing them, and recalling Tony Redpath's response that David would cope: "*he's been doing this job for this amount of years he's the advisor to the LAP panel...he's a professional, he'll cope*". She recalls being silenced by secondment and returning in 2016 to a deteriorated state of affairs with management turning a blind eye to the concerns raised.[137]

6.6. On one interpretation, Rebecca Blackburn's concerns about Mr Kerry's ability to cope in an emergency was prescient but, put into perspective, it was inevitable – as night follows day, how could the plans work if they had never been tested? In her view, the lack of training and exercise of RBKC's plan directly affected the council's response to the fire. Her evidence sums it up: "*people weren't 100% aware of what they were doing...we'd never done an out of hours activation exercise...although that contingency management plan is updated every year...I don't think they kept a record of what actually all the changes were but those activation processes are the same in 2013 as they were in 2017. They had never once been activated.*"[138]

6.7. RBKC's training was ranked amber in its self-assessment of its contingency arrangements submitted in 2016. The proposed actions were updating and reviewing the training analysis. This was never done and Rebecca Blackburn's response to the proposed action points

[136] {**RBK00058170/9**} at paras 2.19-21.
[137] {**Day 270, 28/04/22, 115:20–119:10**}
[138] {**Day 270, 28/04/22, 119:11–120:11**}

provide an insight into RBKC's attitude to contingency management: *"...just words on a piece of paper. There was never a training analysis done"* She also agreed that there was no substance to what was submitted in the MSL.[139]

6.8. It will be for the panel to consider whether Mr Priestley's lack of training and background in contingency management contributed to his lack of oversight and the general failings of the CMU and in turn RBKC's failed response to the Grenfell Tower fire. Although the CM team fell within his leadership remit as chief community safety manager, he had no prior experience in drafting contingency plans and so relied on Mr Kerry and his team's "*subject matter expertise*".[140]

6.9. Given the specialised nature of contingency planning and emergency / disaster management, there needs to be greater investment in these specific areas. Local Authority CMUs and those of responder organisations must be staffed with personnel, including managers who are trained in emergency and disaster management.

6.10. RBKC's lack of oversight of its resilience arrangements, lack of financial investment in contingency arrangement and non-compliance with the statutory obligations was symptomatic of a general failure to prioritise and invest in resilience arrangements and contingency planning. The systemic shortage of staff trained in emergency management was known across RBKC, including by Nicholas Holgate and the Board, yet RBKC was content to seek and rely on volunteers to staff the CMU, which appeared to have been ingrained in the culture and practice. David Kerry recalled in his evidence that "*it had been the philosophy at RBKC for as long as he was there to not have people appointed to roles and to be on rotas and certainly not to pay them to be on standby but to seek volunteers for these roles*".[141] David Kerry acknowledged that although RBKC would have required mutual aid in its response to the Grenfell Tower fire, the council was starting from a deficit: "*what we didn't have was sufficient staff to start with*".[142] RBKC was aware of the impact of inadequate staffing on the effectiveness of its emergency response but refused to address it. BECC staff on an ad hoc basis prior to the fire – arranging training courses as and when volunteers came in.[143]

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[139] {**Day 270, 28/04/22, 125:1-10**}
[140] {**Day 270, 28/04/22, 4:15-5:9**}
[141] {**Day 268, 26/04/22, 66:2-5**}
[142] {**Day 268, 26/04/22, 68:13-14**}
[143] {**Day 268, 26/04/22, 86:1-5**}

6.11. Mr Kerry noted that the lack of investment in adequate resilience staffing continued after Grenfell as evidenced in the Council's response to an incident in 2018 at its block of flats at Chelsea World's End – post Grenfell failings attributed to staffing inadequacy had not been actioned.[144]

6.12. It will also be open to the panel to conclude whether and the extent to which the failure to train staff and exercise the contingency plans contributed the Council's response to the fire.

(c) <u>The CMU's Response to the Fire</u>

6.13. David Kerry's apparent lack of urgency in his response to the fire raises many questions and weaves the familiar thread of neglect of which the residents of the Tower complained during the life of the building and which was sadly the experience of many members of the community in the aftermath. If Rebecca Blackburn's account is to be accepted: why was she told that there was no need to "*rush in, come in at normal 08:00*"?[145] Given the nature of the emergency, all hands on deck and an urgent, coordinated response were needed. In Rebecca Blackburn's words: "*if things had been followed, the BEEC should have been opened 3 o'clock, 4 o'clock, the BECC should have been established and phone calls underway*".[146] Further delay caused by a missing key appeared to have created a "perfect storm" save nothing was mythical about the consequences of an untested emergency unit that was lumbered with poor direction and governance. All of which set the scene of a failed emergency response which failed an entire community.

(d) <u>Institutional Defensiveness</u>

6.14. Although apologies were tendered on RBKC's behalf for its failings, contingency planning and response to the fire, the "*mea culpa*" was qualified by buck passing and defiance of the obvious. This is borne out in David Kerry's response to questions asked by CTI about RBKC's role in providing rest centre premises as set out in RBKC's CMP – although the plan clearly specified that its role in the immediate aftermath included: "*the provision of premises for Body Holding Centres, Survivor Reception Centres, Friends and*

[144] {**Day 268, 26/04/22, 68:15–69:19**}
[145] {**Day 270, 28/04/22, 126:5-10**}
[146] {**Day 270, 28/04/22, 128:17-131:12**}

Relatives Reception Centres...".[147] Mr Kerry sought to deflect responsibility to the Metropolitan Police[148] as he did when asked about the Council's duty to coordinate communication, even when confronted with RBKC's own admission of its failed communication.[149] Mr Kerry's response to the Inquiry on these obvious failings is indicative of RBKC's culture of institutional defensiveness – blaming someone else to escape responsibility.

(e) **The Adequacy of the London Resilience Framework**

6.15. RBKC as a Category 1 responder was a member of the London Resilience Forum (LRF) and had a statutory duty (pursuant to the CCA 2004) to cooperate with the London Resilience Forum in its preparation for and response to emergencies. Unlike Category 1 organisations which have clearly defined statutory duties under the CCA (2005) the LRF has no statutory powers or obligations and its *powers* are limited to its terms of reference.[150] Lack of oversight of contingency planning and risk management lies at the heart of RBKC's statutory failings: there was no internal oversight within RBKC of is contingency arrangements and operations nor was there external oversight by the Resilience Forum. It will be for the panel to determine whether the LRF's objectives of *strategic oversight of resilience arrangements* included ensuring that the organisation's contingency plan's arrangements complied with its statutory duties under the CCA.[151] Should it find that there was such a duty, there is of course ample evidence of a lack of oversight and in effect the LRF was in breach of its terms of reference in this regard. On the other hand, the very wording of this objective is woolly and the panel may readily conclude that it offers no real guidance as the meaning of "strategic oversight".

6.16. RBKC's contingency arrangements and management failings were systemic and were enabled by an inadequate / non-existent oversight framework. LRF's terms of reference placed the onus on the organisation to self-report issues of concern and to fulfil their

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[147] {**RBK00004396/7**}
[148] {**Day 268, 26/04/22, 32:22–36:21**}
[149] {**Day 268, 26/04/22, 45:18–23**}
[150] {**LFB00061162/1**} *The London Resilience Forum has no powers beyond those specifically mentioned within these Terms of Reference; however, organisations have clearly defined statutory duties under the Civil Contingencies Act (2004) (as amended').*
[151] {**LFB00061162/1**}: *To maintain strategic oversight of resilience arrangements of all relevant organisations in London, ensuring a cooperative and collaborative approach, in order to comply with organisation-specific requirements set out in the Civil Contingencies Act (2004) (as amended).*

statutory obligations under the CCA (2005).[152] At the time of the Grenfell Tower fire there was no national or regional oversight body with statutory powers to ensure compliance with the CCA (2005) or standardisation of CMP provisions and arrangements.[153] This remains the case to date.

6.17. The risk of fire in a high-rise was foreseeable and should have been identified as a risk on RBKC's risk register. Although this risk was ever present given the prevalence of tower block fires in London, including the Adair Tower fire in which Mr Kerry had personal involvement as the BECC, the risk of a tower block fire was never raised by RBKC of its own initiative nor with other organisations in the LRF. Mr Kerry's evidence of casual conversations with the LFB at BRF or other events, generically about matters to the exclusion of the risk of fires in tower blocks, also supports a systemic lack of oversight, risk assessment and management.

6.18. The panel has heard sufficient evidence from which it can make findings on the inadequacy of the resilience framework and the need for a national/ regional quality contingency management/ resilience compliance and quality assurance organisation/ authority which statutory powers.

(f) <u>Article 2 systems and operational duties</u>

6.19. In our opening submissions to Module 4 we invited the Inquiry to investigate whether the State had breached its Article 2 duties in its emergency planning and response to the Grenfell Tower fire.[154] In short, we submitted that firstly, there is a duty under Article 2 ECHR to provide an effective emergency services response. Specifically, the State's duty extends to *"the provision of emergency services where it has been brought to the notice of the authorities that the life or health of an individual is at risk on account of injuries sustained as a result of an accident*".

6.20. This includes both a systems duty and an operational duty. The systems duty requires *"the setting up of an appropriate regulatory framework for rescuing persons in*

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[152] 5. Accountability and Reporting: *The membership of the London Resilience Forum has collective responsibility for ensuring effective multi-agency resilience planning, and organisational responsibility for their obligations under the Civil Contingencies Act (2004) (as amended). All members are responsible for informing the London Resilience Forum of issues that are pertinent to the objectives of the London Resilience Partnership.*

[153] {**Day 268:37:20–38:10**}

[154] {**BSR00000124**}, paras 110-113.

distress and ensuring the effective functioning of such a framework": Furdik supra. The operational duty arises where the authorities know or ought to know of the existence of a real and immediate risk to the life of an identified individual. In such a case, the authorities must take measures within the scope of their powers which, judged reasonably, might be expected to avoid that risk. See, for a relevant example, *Kemaloglu v Turkey* (2015) 61 EHRR 36 where the school authorities failed in their operational duty to protect the life of the applicants' seven-year-old son, who died while walking home in heavy snow.

6.21. It is submitted that RBKC's failure to have an effective and updated contingency management framework, including adequate staffing trained in emergency management and its failure to test contingency plans and continuously assess risk at the time of the fire breached its Article 2 systems duty and we invite the panel to make this finding.

6.22. Further, RBKC knew or should have known of the associated risk to life that high rise ("**HR**") fires presented, which was a real and known risk at the time of Grenfell Tower fire, particularly in light of the history of tower block fires in London including the Adair Tower fire. However, the risk of fire in a tower block /high rise was not identified as a main risk in the borough's risk register. Having regard to Mr Kerry's inability to recall whether consideration was ever given to the risk of fires in a tower block, even after the Adair Tower fireand its absence as a recorded risk in the risk register, it is also open to the panel to find that on a balance, no consideration was given to the risk of fire in a high rise by RBKC and that it should have been as it was a known risk.[155]

6.23. RBKC should have identified HR fires as a risk in its contingency planning risk register and its failure to do so amounted to a breach of its operational duty.

7. CENTRAL GOVERNMENT – SOUNDBITES AND PLATITUDES

7.1. Soundbites and platitudes characterised the response of Central government. We were subjected to a parade of witnesses who simultaneously espoused regrets and apologises, whilst failing to properly take ownership of the disastrous manner in which the government dealt with this tragedy.

[155] {**Day 268, 26/04/22, 22:19–23:17**}

7.2. Katherine Hammond gave evidence in relation to emergency planning, identifying the roles of different category responders during the response and recovery phase of a major incident, as well as details of the Civil Contingencies Secretariat's responsibility to provide guidance to accompany the Civil Contingencies Act. She also gave evidence regarding emergency planning by discussing the key policies that discuss risk:

- National Risk Assessment ("NRA"): The CCS was responsible for producing the NRA and the 2016 NRA was released in Feb 2017.
- National Risk Register – Public facing version of the NRA.
- Local Risk Management Guidance: non-statutory guidance aimed at assisting Category 1 and 2 Responders intended to help them fulfil their local risk assessment duty under CCA and Civil Contingency Planning Regulations 2005. The Risk Assessment Working Group was a structure within LRMG to assist in developing local risk assessments and would encourage the inclusion of a wider range of participants to ensure the risk assessment is comprehensive.

7.3. It was hoped that she would shed some light on these topics, but at times her oral evidence seemed more of an object lesson in obfuscation and evasion.

7.4. This was epitomised in her evidence concerning the risk register. The NRA contained no reference to tower block fires despite the series of fires in years preceding. Ms Hammond attempted to downplay this and focus on the consequences, which she stated were covered by other risks. She eventually conceded an inference could be drawn from the lack of evidence that no serious consideration had been given to the risk.[156] Had it been on the NRA, she conceded, it would have provided a focus for local planners to assess and plan for the risk of such a fire.[157]

(a) <u>A response to fit the disaster</u>

7.5. The Grenfell Tower fire was an exceptional national disaster, which required an exceptional national response at governmental level. What we got was Nicholas Hurd MP. A man only 2 days into his own ministerial appointment as Minister of State for Policing

[156] {**Day 281, 19/05/22, 116:7-117:14**}
[157] {**Day 281, 19/05/22, 133:2-7**}

and the Fire Service. In answer to questions as to whether he was adequately briefed for the role he admitted he was not: "*I don't see how I could have been, given that this was day two.*"[158]

7.6. Hourly media updates on headlines about Grenfell Tower noted Mr Hurd's comments on the investigation: *"What we are dealing with here is a national tragedy."....."and there would be no room for plodding bureaucracy".*[159] Unfortunately, the self-same plodding bureaucracy he rightly foresaw, came to pass. There was a lack of pro-action coupled with slow, excessively administrative measures and lacklustre leadership.

7.7. Mr Hurd fairly neatly summarises the problem at the heart of the central government response; It was too slow:

"*..... I think it feeds into the bigger, wider problem, which is central government was too slow. Q. Can you explain why it was that, even as late as 29 June, you were of the view that government was still letting the local community down? A. By then, I had taken on the new role that you asked me about on the start, and as I've said in my witness statement I'd taken a decision to try and have personal meetings with families or individuals that wanted to see me, and through those meetings, as well as trying to help them with their personal issues, you know, a picture was forming quite clearly about how -- some of the failings that were still in the system and the way that people, you know, continued to feel let down. I would also say that because of the failure to grip it in the early days, the situation that John Barradell and others inherited was made even more difficult, and as I think others have said, if you don't get a grip on these things early, then it becomes very hard to reassert any sense that, you know, the system's got the situation under control. I think the perceptions were set very early and were very difficult to shift and, as I think Helen points out too, there was a huge problem in terms of trust.*"[160]

7.8. Whilst it would be churlish not to acknowledge admissions, our families nonetheless ask, why not show humility and acknowledge your limitations, **at the material time**? The sad reality was that Mr Hurd took on a role for which he was unqualified and untrained.

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[158] {**Day 282, 23/05/22, 148:16-148:23**}
[159] {**TMO10047965**}.
[160] {**Day 282, 23/05/22, 204:3-204:24**}

7.9. Mr. Hurd accepted in his evidence that:

(i) He found the instruction for him to chair recovery and Cabinet Meetings *"strange"* and "*you just do what you are told*".[161]

(ii) He believes that the meetings should have been chaired by someone more senior than him.[162]

(iii) It would have been appropriate for meetings to be at the most senior level from the start and that the lack of information as to what was happening on the ground was the fundamental problem.[163]

(b) <u>The handling of RBKC & lack of government intervention</u>

7.10. Mr Hurd regarded the meetings on the local response as extremely important, yet RBKC did not even attend these. Moreover, no one did anything to rectify this at the time. It would appear that many in central government were aware of the issues: Dame Melanie Dawes said in her statement: *"RBKC's response, and in particular their seeming lack of willingness to accept help created problems which affected not just the immediate aftermath, but also the Gold Command recovery efforts for some time to come."*[164] However, was it not incumbent upon Dame Melanie and her department to intervene in those circumstances.

7.11. Concerns about RBKC's handling and competence were raised by numerous sources from 15 June 2017 but Gold Command Recovery was not established until Friday. Ms Dawes admits: "*It is possible that a visit from the Department at a senior and expert level on Thursday would have accelerated this.*"[165]

7.12. There was a lack of enquiring minds within central government. A decision was made not to launch an intervention (statutory or otherwise) based on the replacement of RBKC Chief Exec and Leader and the fact that Gold had taken over. Discussions were held with Local Government Association on this and instead the Grenfell Recovery Taskforce was established on 26 July 2017.

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[161] {**Day 282, 23/05/22, 120:20-121:2**}
[162] {**Day 282, 23/05/22, 122:23-123:13**}
[163] {**Day 282, 23/05/22, 126:4-127:14**}
[164] {**CLG00030653**}, para 121.
[165] {**CLG00030653**}, para 121.

7.13. This lack of questioning extended to issues surrounding the walkways and other non-Tower tenants. Nick Hurd accepts that they were not sufficiently aware at the early stages: *"My honest answer to that is I don't think that meeting was sufficiently aware of that point, and I'm not sure if I -- my memory of the CRIP sheets or the sitreps, which is what the -- kind of the information feed at that meeting, I don't think they capture that truth adequately either, is my honest recollection."*[166]

7.14. The failure of Nicholas Holgate's leadership was obvious to all:

(i) Nick Hurd: "*Mr Holgate was trying to maintain a line that the council could cope on its own and the evidence was beginning to weigh very heavily that they couldn't.*"[167]

(ii) Jo Farrar: Mr Holgate's confidence was misplaced.[168]

(iii) Dame Melanie Dawes: Mr Holgate was completely overwhelmed by the task.[169]

7.15. Insufficient steps were taken to address these concerns that the TMO's leadership was not functioning. Despite considering the issue of an intervention during the weekend following the fire, a decision was made against intervention, due to the role played by Gold Command, (having taken over RBKC's leadership) and the replacement of Chief Executive and Leader of RBKC. This raises further issues regarding the pan London approach, legislation, effectiveness of the legislative framework and clear lines of activating the intervention.

7.16. In our submission there was a clear failure by central government to act upon known information that RBKC and its leadership were failing the people of Grenfell Tower. Nick Hurd had met with volunteers; he knew they were filling the leadership vacuum in the response. He knew of the complete lack of trust people had in the council. Central government knew the problems that existed, but due to the general lack of oversight, they failed to probe RBKC's capability and handling soon enough.

(c) <u>Operational Failings</u>

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[166] {**Day 282, 23/05/22, 145:7-145:17**}
[167] {**Day 282, 23/05/22, 173:10-14**}
[168] {**Day 284, 25/05/22, 123:5-8**}
[169] {**Day 285, 26/05/22, 126:19-127:11**}

7.17. The system of which Mr Hurd was a part was failing. Data provided did not add up and was inconsistent. Mr Hurd was losing faith with RBKC and its leadership by 15 June 2017:

"Well, I think this meeting was a defining meeting...., this was the first time, effectively, the council was kind of open to questions.....there was a growing concern about data, the reliability of data, and numbers, and he really wasn't able to answer some questions that anyone might reasonably ask him -- expect him to answer, and you've seen the reactions to the meeting. I think it was instrumental in the dropping of the penny across the system..... So my recollection, the focus of the discussion was around housing need. You'll be aware that the housing minister, Alok Sharma, had come to that meeting from parliament, where he had made effectively a guarantee about rehousing in the local area. You'll know that he'd been pressing the council leader, I think, the night before for numbers, numbers, numbers, and it became quite clear from the questioning and the investigation in that meeting that the council weren't on top of the numbers, both in terms of numbers of people in the tower and the broader housing requirement, and I can still see the faces round the room of incredulity."[170]

7.18. Further there were inadequate resources in place to monitor or oversee RBKC.[171]

7.19. Residents' access to the cash payment was an ongoing issue several days after the fire. Mr Hurd failed to explain why. Nor could he explain the difference in treatment of victims of fire and floods; flood victims were given a lump sum.

7.20. Mr Hurd would not accept that prejudice or institutional indifference towards the BSRs played a part in the response. We submit that the evidence of our clients, the admissions from RBKC, Mr Kerry and Mr Holgate show that it did. It is disappointing to see the former minister fail to acknowledge this. With classic political spin he said: *"What I do absolutely accept is that the response in the immediate aftermath of the fire was wholly inadequate and might have led some people to believe there was institutional indifference."*[172]

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[170] {**Day 282, 23/05/22, 168:13-170:8**}
[171] {**Day 282, 23/05/22, 171:7-171:13**}
[172] {**Day 282, 23/05/22, 196:5-196:20**}

7.21. No visits to rest centres by the minister, police cordons at the Westway, an AWOL leadership, voluntary groups filling the vacuum, rehousing in wholly unsuitable hotels, communications and information that literally did not speak to all the community, delays in financial provisions, no system for tracing missing loved ones. This was not a case of people wrongly "perceiving" institutional indifference. It was institutional indifference writ large and in full effect.

(d) <u>Training</u>

7.22. Ms McManus' role was to work with RBKC and draw on the experience & expertise of other responder organisations, to help develop an effective mechanism to ensure the coordination of offers of assistance & materials.[173] The reality fell well short. A feature across the departments was a lack of training in emergency planning.

7.23. Mr Hurd was not aware of the Civil Contingencies Act 2004 regulations, nor the statutory guidance Emergency Preparedness and non-statutory guidance, Emergency Response and Recovery.[174] He likewise had no training on civil resilience.[175]

7.24. Turning to Mr Hurd's closing remarks, the three most significant admissions were:

(i) *"Well, I'm ashamed, you know, of the failure of the system I was part of to provide, you know, fellow citizens with the most basic support and comfort that they had every reason to feel totally entitled to in arguably their darkest hour."*

(ii) *"I was part of a system that failed to be alive early enough to the possibility/probability that the Kensington and Chelsea Council would not be able to cope."* RBKC lacked the "moral authority" to lead and central government should have acted swiftly and it did not.

(iii) The manner in which BSRs were made to feel, impersonal, second-class citizens was totally unacceptable.[176]

(e) **<u>Limitations of RED's role & remit</u>**

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[173] {**CLG00005266**}
[174] {**Day 282, 23/05/22, 114:15-115:4**}
[175] {**Day 282, 23/05/22, 115:5-115:13**}
[176] {**Day 282, 23/05/22, 207:14-210:19**}

7.25. Multiple witnesses emphasised how RED was essentially a "conduit" or "bridge" between central government and local responders.[177]

7.26. They had no involvement at borough resilience forum level[178] and did not formally approve or sign off on emergency plans[179] nor play an active role in the response. Melanie Dawes admitted the remit was "*quite narrow*" and that the lack of assurance function was "*a gap in the system*".[180] She claims the remit has since been expanded "*to look for signs of stress now*".[181]

7.27. In our submission, government witnesses used the limitations of the scope of this role to defend RED's actions in the aftermath. However, this could not explain away:

- delays in the circulation of updates following SCG meetings which was the usual means by which RED kept abreast of developments and information.[182]
- Ms Hammond's comment that the reduction in RED prior to the fire was of concern: "*Do you agree that DCLG RED was under-powered and under-resourced? A. I think at the time RED was being reduced in size and, yes, I think that was an issue for concern, the reduction, and I think if you go to my email up the chain, there is a reference to reversing that reduction.*"[183]

7.28. In our submission all of this was known at the material time and no action was taken. Those in central government must take responsibility for these failings. There is no mitigation against the department's poor overall performance, on the basis that there had been a recent general election and ministers were new to their posts. Nor is there any excuse for emergency plans, resources and procedures that do not foresee large scale disasters which result in the displacement of large number of people.

7.29. There needs to be a sea-change in the response to disaster. With a large population and complex society "*the probability of something very unlikely happening is very high*".[184] In one year alone there was the Manchester arena bombing, the London Bridge terrorist attack

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[177] See, for example, McManus at {**Day 283, 24/05/22, 83:22-84:1**} & Farrar at {**Day 284, 25/05/22, 5:22-6:3**}
[178] {**Day 283, 24/05/22, 28:18-29:7**}
[179] {**Day 283, 24/05/22, 26:10-25**}
[180] {**Day 285, 26/05/22, 72:8-12**}
[181] {**Day 285, 26/05/22, 210:17-211:2**}
[182] {**Day 283, 24/05/22, 134:17-22**}
[183] {**Day 281, 19/05/22, 166:5-10**}
[184] Risk – Man-Made Hazards to Man, Cooper [1985] Clarendon Press p.11

and the Grenfell Tower fire. Unlikely disasters will happen. Predicting the type of disaster that will happen can be done to a certain extent but only the complacent would believe that all disasters can be predicted. What we do know is that when a disaster occurs it is likely that there will be deaths, injuries, loss of housing, splitting of families, displacement of people, loss of income, financial and property losses and psychiatric and psychological damage. Inevitably these and many more effects will be felt.

7.30. When rapid onset disasters occur there is an obvious need for effective disaster preparedness, early warning systems and a well-trained emergency response. A disaster preparedness strategy, emergency drills, and the establishment of a repository may further improve a city's ability to recover quickly from a disaster and will help the government have sufficient supplies for emergency relief and rehabilitation.[185]

8. RECOMMENDATIONS

(i) That the local authority commit to working with the Equality and Human Rights Commission in order that the Commission can assist in enabling the authority to ensure that equality and anti-discrimination good practice are embedded into the policies, training and delivery and implementation of services.

(ii) Contingency and emergency planning, training and implementation must involve Equality Impact Assessments and give due regard to vulnerable persons.

(iii) A centralised register of information on residents which adequately accounts for protected characteristics is made available without delay and disseminated to Category 1 Responders (as required) and specifically is made available to the LFB.

(iv) Mass casualty responses must be coordinated with timely and accurate information being provided to the bereaved in a sensitive manner.

(v) Independent oversight of contingency planning to ensure consistency across boroughs and proper scrutiny of plan contents to identify gaps, errors, and omissions.

(vi) Specialist training in resilience management and roles being remunerated.

(vii) The professionalisation of emergency response.

[185] *Atta-ur -Rahman, ... Gulsan Ara Parvin, in Urban Disasters and Resilience in Asia, 2016*

(viii) Pan London The Role and Power vested in London Resilience and effectively working with Local Authorities. In questions, CTI described London Resilience as bloated and not fit for purpose. We agree.

(ix) It cannot be left to the voluntary sector and charities to fill leadership gaps. The voluntary sector and community should be properly involved in contingency planning.

(x) Treating survivors, relatives, bereaved families, and all those affected by disasters with dignity and respect.

9. CONCLUSION

9.1. The response to the aftermath of the Grenfell Tower Fire was woeful and laid bare a catalogue of breaches and failings.

9.2. The BSRs demand and expect those responsible to take ownership of their failings and acknowledge these and all statutory breaches. It is only by such acknowledgments that the process of accountability can begin.

9.3. For RBKC these breaches and failings underpin a more engrained culture.

(i) Nicholas Holgate and David Kerry did not act to address the above breaches and failings.

(ii) RBKC's preoccupation with reputational damage held sway over their legal and moral duties and obligations to the survivors, residents and bereaved families.

(iii) RBKC knew/were worried that they bore some responsibility for the disaster. This impeded and coloured their response.

(iv) Rebecca Blackburn has laid bare the culture of inertia and complacency within RBKC.

9.4. The final words we leave again with our clients:

"First, to the community, volunteers, charities, and religious groups who rushed to our aid from all over the country and the world, who were present and supported us in the best way they could, words can never express my gratitude. Thank you for everything you did and continue to do.

I know the authorities, be they local or central government, may feel that they have contributed to the support during the aftermath. For me personally and my family, this is far from the truth. No one from government looked for us. No one helped us. We were left exposed and vulnerable, and when the authorities eventually did come, it felt like a tick-box exercise. We were treated like numbers, not humans. This is something that we still feel today. In my experience, in the eyes of local and central government, our Grenfell and North Kensington community are second class, the people with needs and problems. I cannot help but feel that had our community lived in a different part of the borough, on the more affluent side, had we been from a different class, had we been less ethnic, the response in the aftermath would have been immediate. It would have been present. It would have been felt. We may be different, we may be diverse, but we are people. Think of the different professions in the tower, of the challenges that so many from the BAME communities had overcome prior to the fire in 2017. Think of the dignity demonstrated by those of us impacted over the last five years. We are human beings. We contribute. We pay tax. We provide leadership in our communities….

…..This tragedy has pierced wounds in each and every one of us in ways that one cannot imagine. We may now and again put plasters to hide our wounds, but they are still there, and sometimes, many times, those plasters fall off. To this day, the support that we are given is only provided after jumping through hoops, whether it's fighting to get house repairs done or get the medical support we need. We are forever asked to prove that we have been impacted, forever having to prove our pain…..

….This duty of care needs to extend beyond us to the rest of the country, to the thousands of families who live in communities like us, like we had at Grenfell, who are still treated as second-class citizens. It needs to extend to the thousands impacted by the building safety crisis up and down the country. We are still impacted. We still hurt. We still remember. We haven't forgotten. All the issues we have, the PTSD, the mental and physical trauma that you see as problems in us, this isn't who we were; this is who some of us are now because of what the government did to us. Because of your absence, because you were not there, because you did not show that you cared, you have sapped all the energy from us. Those that caused this tragedy need to be held accountable. Their duty of care to us now has no limit."[186]

Hanan Wahabi

[186] **{Day 267, 25/04/22, 137:19-142:2}**

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13 June 2022