

THE GRENFELL TOWER INQUIRY

Combined G3 submissions on behalf of survivors, bereaved and community members CPs represented by Howe and Co, Bishop Lloyd & Jackson and Oliver Fisher solicitors

1. The failure to protect the residents of the GT and the community surrounding the GT impacts beyond the survivors, bereaved and community members we represent. It bears emphasis that it is our clients' settled intention to ensure that other communities do not suffer as they have done. This Inquiry's responsibility is to identify those failings precisely; the corporations, governmental bodies and individuals responsible; and to ensure that this is put right for the future.
2. In the recent *Daniels* judgment, Bean LJ emphasised the need for the Inquiry to produce its phase 1 "*initial report as quickly as reasonably practicable*" because "*It cannot be disputed that there is an urgent need to establish the facts of how the tragedy occurred on the night in question and to make recommendations designed to minimise the risk of such catastrophes happening in other buildings.*" (*R (Daniels) v Prime Minister* [2018] EWHC 1090 (Admin)). From the outset, the Inquiry will recognise that this disaster - with its huge loss of life, loss of homes and loss of community - was no accident. Let no one pretend that it was unavoidable, or that it came about by some 'perfect storm' or that it was an unfortunate constellation of unforeseeable events. It was no such thing.
3. On 3 March 2003, Bowsher J in the High Court (*Sahib Foods Ltd v Paskin Kyriakides Sands (A Firm)* [2003] EWHC 142 (TCC); appealed on other grounds (See *Sahib Foods Ltd v Paskin Kyriakides Sands (A Firm)*), asserted that by the time of a serious factory fire in 1994 it was becoming common knowledge to architects that composite panels with a combustible core would "*delaminate in a big fire*". The "*core will then rapidly degrade, that the melted cores will transmit fires to one another very rapidly, that exactly this had happened in numerous recent fires*". And that reasonably priced non-combustible options were readily available. Twenty-three years later, composite panels did just that on Grenfell Tower. They delaminated, they degraded and they caused fire spread - one to the next – with extreme speed.
4. If the Inquiry is to make effective interim recommendations in order to address the immediate risks to residents following Phase 1 of the Inquiry, regard must be had to the industry's long indifference to safety, as now recognised by the Hackitt Review - if these recommendations are to be truly effective in making people safe in their homes.

The Night of the Fire

5. We will refer to our clients' accounts in oral submissions, they will deal with the rapid spread of the fire, the horror of those who lost loved ones and the trauma suffered by those that escaped. Those accounts will highlight the fact that many perished because of the Stay Put policy and that there was no provision for the infirm or disabled. The accounts will also evidence the warnings that our clients had raised before the disaster. Similarly, we will refer to the warnings and concerns communicated by our clients and their lost loved ones with regard to the refurbishment.

Warnings from the residents of GT

6. When examining the Phase 1 issues regarding cause of the fire and making urgent recommendations for steps to make people safe in their homes in other residential blocks, it is important to have in mind the extent of the failures that will be examined more deeply in Phase 2. It was not just the residents of the GT who were being ignored.
7. The general problem of flammable cladding material, and the particular problems of composite panels with a highly flammable core, were very well known a long time prior to the refurbishment of Grenfell Tower. The owners, landlords, architects, designers, manufacturers, fire engineers, contractors and sub-contractors all had knowledge because it was commonly known.
8. Since the 1990s, there have been many similar disasters and near-disasters from Shanghai to Melbourne, from Dubai to Lakanal House, London. Hindsight could and should have been applied after the following fires (see Appendix A).
9. As a result of the Garnock Court Fire a disabled pensioner, William Linton, believed to be in his 80s, died and four other people were taken to Hospital suffering from the effects of smoke inhalation. The block was owned by North Ayrshire Council who ordered the removal of the cladding. There was a Scottish select committee review that reported in January 2000, and this led to the Building (Scotland) Act 2003, which introduced the Building (Scotland) Regulations 2004 which came into force on 1 May 2005. This act includes this mandatory regulation:

“Every building must be designed and constructed in such a way that in the event of an outbreak of fire within the building, or from an external source, the spread of fire on the external walls of the building is inhibited.”
10. The government well knew the Building Regulation framework was ineffective with regard to fire safety but did nothing about it. Successive Ministers and officials at the Department for Communities and Local Government Department for Communities and Local Government (DCLG) failed to act on clear warnings not least after Lakanal. Was that because of serial incompetence or had industry become too close to government? Celotex Director, Rob Warren, made clear on the company website that they were "*working inside government*" to influence policy and regulation of the insulation industry.
11. After six people died in the Lakanal House high rise social housing block fire in south London in 2009, the All-Party Parliamentary Fire Safety and Rescue Group called for a major government review of building regulations. As did the Coroner.
12. The All-Party group said that thousands of tower blocks were at risk because they had combustible exterior cladding. Three months before the fire, it protested the government's ongoing failure to review the building regulations as agreed following the Lakanal House fire, and pointed to the risk of another tragedy, to be told by the Government that the review following that 2009 fire would take place "*in due course*".
13. The BRE had itself expressly recognised the dangers of this type of cladding for years and had graphically shown in its materials (BRE 135) that inflammable materials in cladding represents a serious danger to life saying that:

“the risk of fire spread in multi-storey building is an issue of concern and recent fires have continued to highlight this. Since the external cladding system of the building offers one potential route for fire spread through a multi-storey building there is a need for guidance to address those concerns”.

What caused the fire?

14. How did a kitchen fire in one home lead to a fire engulfing and destroying a community of the Tower’s 120 homes and beyond which made up this vibrant community, with such catastrophic loss of life? Despite all of the warnings from other fires and despite the fact that the industry was aware of the risk from this type of cladding:

“The building envelope created an intolerable risk on the night of the fire resulting in extreme harm. It did not adequately resist the spread of fire over the walls having regard to the height and the use of the building. The active and passive fire protection measures within the tower were then required to mitigate an extraordinary event and as a result the consequences were catastrophic” Barbara Lane (2-39).

15. The arrangement and type of construction materials in the refurbishment caused, according to Barbara Lane (2-47):
- (a) Multiple internal fires many of which underwent a flashover fire;
 - (b) Multiple fires impacting flat entrance fire doors;
 - (c) Generation of large quantities of polymeric gas (i.e. from polymers such as polyurethane);
 - (d) Smoke egress (getting out) through flat entrance doors out to multiple lobbies;
 - (e) The need for smoke control on multiple lobbies simultaneously (which was never the intention of the relevant fire control guidance or regulations);
 - (f) The need for suppression on multiple floors by the LFB simultaneously (which was never the intention of the relevant fire control guidance or regulations);
 - (g) The very early and simultaneous requirement for external firefighting (aerial ladders, hoses able to reach up such a building and access for such equipment and water sources);
 - (h) The need to change the evacuation policy from Stay Put to another system and with no communication systems provided for within the building;
 - (i) The need for all mobility impaired persons to self-evacuate for which there were no facilities.
16. Of this, there can be little doubt - the refurbishment carried out from 2012-2016 turned this block into a highly combustible death trap.
17. Accountability is at the heart of this Inquiry. That requires conclusive answers to the questions of *“who took what decisions, when and why”* that placed this community in mortal danger. The rigorous pursuit of the truth about who was responsible is necessary to bring justice, justice that is rightly demanded by these families and by the country, and to afford meaning to this process for the bereaved.
18. This Inquiry will give detailed attention in phase two to which of the public authority and corporate CPs should have stopped the catastrophic decision to envelope this previously fire-safe building in fuel when the life imperilling safety issues were

obvious to all from at least the early 1990s. However, in order to get to phase two, the right questions must be asked within phase one.

19. Moreover, a year after the disaster, those who lost loved ones in the disaster, those who have been left traumatised; need to have the full cooperation of all CPs in bringing to light the gross failures which so obviously caused the fire and its deadly impact. This is not a game, this is not litigation nor is it a process where it is acceptable for public authorities or private corporations to remain silent. Those who are supposed to act in the public interest, those who take the public's coin must be required to be transparent and proactively to act with candour. The various public authorities and private corporations involved must tell us where responsibility lay, how they failed to discharge their responsibilities and what went wrong. They must tell us what they knew. If candour and frankness is replaced by smoke and mirrors, then those who have suffered so much from the disaster will suffer a second injustice.
20. How was such a combustible cladding system ever seriously countenanced as an option with which to envelope a high rise residential tower? Where were the safeguards? Where are the lines of responsibility? These are among the questions that demand comprehensive answers.
21. *Exova Warrington* was the fire consultant, appointed by the TMO (Studio E, para 3.4.4, SEA00014232) Rydon said that the fire engineering advice was provided by Exova who “*provided detailed advice and specialist input on fire safety during the Project*” (para 13(2) RYD00094204). The TMO state that Exova, “*noted that the proposed changes would have no adverse effect on the building in relation to external fire spread but this was to be confirmed by future analysis. TMO believes that Exova conducted that further analysis and gave such confirmation to Studio E although the precise terms of that confirmation are not known to TMO*” (TMO00837466).
22. Yet Exova, who have belatedly become a CP, claim that their significant involvement ended a year before Rydon was appointed and that “*further, Exova was not involved in discussions, or asked to advise, on matters such as the choice of materials to be used in the project, nor was it asked to certify any items for use in the project, or verify the quality of work carried out*” (para 4.5, EXO00001572). Their single “*Grenfell Tower Outline Fire Safety Strategy*” thus far disclosed (EXO00001106) does indeed states under “*Compliance with B4 (external fire spread)*” that “*It is considered that the proposed changes will have no adverse effect on the building in relation to external fire spread but this will be confirmed by an analysis in a future issue of this report.*” No reason is offered for this preliminary conclusion that the cladding system “*will have no adverse effect on the building in relation to external fire spread*”, nor is it even identified what changes are being preliminarily approved as having “*no adverse effect*”.
23. How can the evidence about such critical responsibilities remain so lacking, and the position of Core Participants so inconsistent? This Inquiry must get to the truth. The extraordinary lack of clarity as to who was accountable for fire safety already evident in the very limited material thus far disclosed highlights the importance of the Inquiry's interim recommendations following phase 1, which is the rationale for producing an interim report.

24. The Chairman has emphasised the flexibility with which the Inquiry will continue to approach the question of what falls to be considered in the phase 1 hearings and addressed in the interim report. That is absolutely vital if the Inquiry is going to fulfil the purpose of that interim report.

**Phase 1 recommendations to address safety of tower block residents
and the Hackitt Review and other Government advice and consultations**

25. In response to an application for funding to engage with the Hackitt Review, the Chairman ruled on 28 March 2018 that his own statutory funding powers were “*circumscribed*” in a way that does not permit him to grant our clients “*funding to enable them to make submissions to that review, perhaps supported by expert advice, on equal terms with the industry bodies from whom contributions have been sought*”, although “*I understand why those whom Mr. Stein represents would like to have a voice in Dame Judith’s review*”. The Chairman also stated that he had no doubt that the Inquiry would be considering Dame Judith’s report and that our clients will be able to scrutinise her work and make submissions on her conclusions at that stage.
26. Our clients therefore approached the Hackitt Review for support to enable them to participate in the working groups that the Review had established on that equal footing with industry. The secretariat stated in reply to our clients that “*The interim report highlighted that “residents need to be reassured that an effective system is in place to maintain safety in the buildings which are their homes” and we are intending to make recommendations to address this in the final report.*” However, they were told that they would have to engage with the Review without any support and the Review was reaching out to them by letters to residents group and drop in sessions. Our clients have for the most part received nothing from the Review whether inviting them to participate or explaining how in practice they could participate effectively without support. The list of persons/organisations who have engaged with the Review annexed to both the interim and final reports does not appear to include any Grenfell bereaved, survivors or residents, whereas voices associated with industry predominate.
27. Notwithstanding the Review having reiterated to our clients in correspondence that it was being conducted “*transparently*”, the secretariat furthermore declined to make available to our clients the papers and submissions that were being considered by the industry dominated working groups. The membership of the working groups (listed at Appendix G.2 of the final report) amply illustrates the lack of effective resident participation. Dame Judith’s position, as communicated by her secretariat, that Grenfell survivors required no support to participate on an equal footing with industry also sits uneasily with the recognition in the final report that funding would be required to support residents to engage effectively on safety issues with landlords (para 4.26).
28. The secretariat did however confirm that it was Dame Judith’s intention to give evidence to the Inquiry about her report. Our clients welcome that. It is now important that all material submitted to and produced by the Review in the process of considering its recommendations is disclosed to the Inquiry without delay, and then onwards to our clients, so that core participants can have a fair opportunity to formulate the questions that they would wish Dame Judith to answer about how and why she reached her recommendations, and so that they can understand the positions taken by industry voices in the working groups.

29. There is a stark incongruity in Dame Judith’s analysis of what is wrong with the construction industry and its regulators in her interim and final reports. She described the attitude she found in the industry to the safety of homes:
- “Indifference – the primary motivation is to do things as quickly and cheaply as possible rather than to deliver quality homes which are safe for people to live in. When concerns are raised, by others involved in building work or by residents, they are often ignored. Some of those undertaking building work fail to prioritise safety, using the ambiguity of regulations and guidance to game the system”* (p.5).
30. Further Dame Judith refers to the *“lack of clarity on roles and responsibilities”* and *“inadequate regulatory oversight and enforcement tools”*, this had *“helped to create a cultural issue across the sector, which can be described as a ‘race to the bottom’ caused either through ignorance, indifference, or because the system does not facilitate good practice”* (p.5).
31. Nevertheless, Dame Judith recommended that the industry should now take ownership of the approved guidance rather than government: *“An outcomes-based approach to regulation and a package of guidance that is owned by industry can facilitate innovation and reflect changes in building practices, techniques and technology”* (para 6.11). She considered that there should be no change to the outcome based regulation, recommending that the only *regulation* should be an expression of the desired outcome, i.e. that the industry should be required to *“reduce risk ‘so far as reasonable practical”* (para 6.12).
32. The Hackitt Review does not appear to appreciate that the handing of ownership of the guidance about what is *“reasonable practical”* to the industry is undermined by her own findings that the construction industry is primarily motivated by a race to the bottom to build homes as cheaply and quickly as possible, indifferent to whether the people in them will be safe, the very conduct which turned the Grenfell Tower into an inferno.
33. Confidence is not assisted by Dame Judith’s endorsement of *“desk top studies”*, which purport to predict how cladding will operate in a fire, enabling a cladding system to be incorporate combustible material without undergoing any fire test at all.
34. Dame Judith’s Interim Report had indicated for her *“direction of travel”* on desktop studies that *“During phase two of this review, the case must be examined for a requirement for product testing data to be made transparent and publicly available”* (para 1.93). However, her final report states that:
“While recognising that details of individual tests remain commercially sensitive and are of a proprietary nature, it is recommended that all test houses should produce an annual report providing summary details of the types of tests carried out and the numbers of passes and failures reported.” (7.18)
 The fact that manufacturers, developers, and the private testing bodies that they fund have successfully defended hiding adverse reports behind commercial confidentiality speaks volumes.

35. The professed commitment given to Dame Judith by cladding manufactures and developers to mitigating the fire risk from cladding is far from new. On 14 December 1999 the Select Committee on Environment, Transport and Regional Affairs reported on "*Potential Risk Of Fire Spread In Buildings Via External Cladding Systems*" following the cladding fire in Irvine, Ayrshire on 11 June 1999. It accepted that "*the evidence we have received during this inquiry does not suggest that the majority of the external cladding systems currently in use in the UK poses a serious threat to life*" because first there had been few deaths and second that "*Furthermore, the responsible attitude taken by the major cladding manufacturers towards minimising the risks of excessive fire spread has been impressed upon us throughout this inquiry*" (para 18).
36. The Select Committee said that "*Notwithstanding what we have said in paragraph 18 above, we do not believe that it should take a serious fire in which many people are killed before all reasonable steps are taken towards minimising the risks.*" It expressed concern about the 'limited combustibility' and 'class 0' standards and concluded that "*We believe that all external cladding systems should be required either to be entirely non-combustible, or to be proven through full-scale testing not to pose an unacceptable level of risk in terms of fire spread*" (para 20).
37. Our clients emphatically support RIBA's call that "*external wall construction for existing or new buildings with a storey 18m or more above ground to be comprised of non-combustible (European class A1) materials only*¹."
38. RIBA countenance no exception, and we submit that this standard should be imposed forthwith by regulation unless or until any safe alternative is established by way of transparent and genuinely independent testing genuinely replicating a real building environment.
39. We welcome the decision of the Housing Secretary, following reaction to Dame Judith's report on 17 May 2018, to consult on a ban on combustible materials, with what appears to be a clear indication that he intends to implement a ban. This consultation should be accompanied by an immediate suspension of the use of such materials.
40. We note Dame Judith's subsequent indication (despite her report's content) that while she did not know that the ban would be proposed and notwithstanding her previous professed views on prescription, she would support a ban, and, under questioning from the Housing Select Committee, Dame Judith made it clear that she agreed with RIBA's stance on prescribing such safety critical standards.
41. Had Dame Judith or her secretariat been more open to enabling our clients to engage with her on the same footing as the construction industry, her report might have been more responsive to public and high rise residents views rather than industry concern, and the adverse public and parliamentary reaction to her report, and the Housing Secretary's prompt intervention, might have been unnecessary.

¹ ".<https://www.architecture.com/knowledge-and-resources/knowledge-landing-page/riba-responds-to-hackitt-review-may-2018>

42. Our clients need the imposition of basic minimum standards now, without loopholes, to secure the safety of people living in these tower blocks. They need rules, not guidance that the industry can take or leave, pick or mix.
43. We submit that that is the sort of urgent recommendation to save people's homes from becoming or remaining death traps that is the very rationale of the interim, phase 1 report. That is reflected by the Prime Minister's statement that it is "*clear that we cannot wait for ages to learn the immediate lessons – and so I expect the Chair of the Inquiry will want to produce an interim report as early as possible*" and her position (stated on her instructions by GLD) that it is "*vital that the Inquiry conducts as expeditious an investigation as possible, not only to provide answers for all those affected by the tragedy who wish properly to understand what went on that night, but also to identify any ongoing risks that may be pertinent to other high-rise buildings of a similar nature*" (quoted by Bean LJ in *Daniels*, paras 4; 22).
44. Dame Judith told the Housing Select Committee on 17 May 2018 that she thought it was shameful that residents had been ignored when they expressed safety concerns. Yet she also reiterated to the Committee the position expressed in her report that residents of blocks identified as at risk through unlawful combustible cladding were already reassured by the remedial measures that had been put in place.
45. Almost a year after the fire, the Government announced on 16 May 2018 a reversal of its position by which it would now pay for the replacement of dangerous cladding on social housing blocks. Only a very small proportion had previously been replaced. The MHCLG's published building safety guidance has emphasised the need to ensure that the replacement for the combustible cladding should comply with regulations and not give rise to any new risk. Residents need assurance that the replacement cladding proposed for their blocks will not contain combustible materials. MHDLG advice since the fire has permitted combustible materials in the *replacement* cladding so long as it is of limited combustibility, or the cladding system has been approved by the controversial BS 8414 test, or, even in the absence of an applicable test, on the basis of a desktop study of the combustible system².
46. The dangers of approving combustible cladding based on desktop studies was recognised in the circular of 13 July 201 only by the instruction to building control that a desktop study "*should be checked rigorously*". This instruction took no account of the fact emphasised by the Local Government Association in submissions to the Hackitt Review that "*These reports are a matter of judgement and cannot be verified by building control*"³.
47. In the meantime, many residents are dependent upon an emergency simultaneous evacuation policy since compartmentation has been frustrated by the combustible cladding. They go to sleep at night in the knowledge that they may be awoken by a "waking watch" trying to evacuate them down a single staircase not designed for it, as a Grenfell type cladding fire spreads through the block.

²[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/633257/171013 - Circular Letter guidance on re-cladding final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/633257/171013_-_Circular_Letter_guidance_on_re-cladding_final.pdf)

³<https://www.local.gov.uk/sites/default/files/documents/LGA%20Building%20regulations%20and%20fire%20afety%20review%20submission%20final%20%28002%29.pdf>

48. Residents and social housing owners therefore require advice as soon as possible about what steps are required in order to replace the cladding in a way that is safe. Thousands of people are waiting in tower blocks like Grenfell for the recommendations of this Inquiry to make their homes safe again.
49. The onus on self-regulation by industry and industry dominated bodies, and for-profit organisations that depend on industry funding, must end. The cosy industry cabal must be replaced by a modern system of regulation, with real independence, expert capability that does not depend on direct industry funding, and lay representation of the public interest.
50. The Hackitt Review sets up a false dichotomy between prescriptive minimum standards and effective performance based regulation. The existing single relevant regulation B4 requiring that “*the external walls of the building shall adequately resist the spread of fire*”, like Dame Judith’s formulation (above), leaves it to the construction industry to choose their own “routes to compliance” and game the system, backed by tests and reports they fund themselves and therefore own.
51. It is difficult to conceive of any other system of regulation of an activity so eminently and utterly dangerous as building and maintaining residential high rise tower blocks where it would be left to the judgment of industry groups and private consultants and professionals paid by the industry to determine such fundamental questions as what is “adequate” protection from spread of fire for a diverse community of men, women, children the elderly and the disabled.

The response to the fire

52. The best fire safety measure is the one that prevents fire in the first place. But what about the secondary issue of the response to the fire? What was known by the London Fire Brigade (LFB) about the problems of cladding and the factors that were necessary to fight a major fire in a tower block generally and within Grenfell Tower in particular? We look at this point in a little detail because firefighting will be a significant consideration within phase one.
53. We emphasise that we draw a sharp distinction between the firefighters and the LFB. We all know and recognise the fantastic work emergency services do and on 14 June 2017 in the most extreme of circumstances. The LFB did not start the fire and they were not responsible for the gross failures associated with the building refurbishment. Nevertheless, we must not allow the heroism of individuals to blind us to the failures of the LFB itself and what the LFB knew or ought to have known about the fire risks of the Tower and its refurbishment, and whether the fire prevention equipment and other safeguards were sufficient and were serviceable are important matters for this Inquiry to scrutinise. Most importantly, the LFB should have known that the default policy of “*Stay Put*”/“*Defend in Place*” was compromised by the cladding, and as such the obvious need to develop a Plan B should have been paramount.
54. We start with what the LFB, as an institution, knew. Plainly it was well aware of the historical fires we have already referred to above. Plainly it knew the concerns of the Coroner about the Lakanal deaths - particularly regarding the problems with cladding and compartmentation - and the potential for a “*Stay Put*” policy to be ineffective. We

know, as late as May 2017, the LFB were sending letters to all 33 London Borough Councils warning of the potential problems with clad buildings.

55. Beyond the lessons that should have been learned from the past, closer to home there were reasons that should have worried the LFB about Grenfell Tower - what did they know or ought they have gleaned, from familiarisation visits and the s7(2)(d) process?
56. Did the front-line emergency firefighters despatched from around 00:55 on 14 June know the relevant limitations on the active and passive firefighting measures within the Tower? Did they have sufficient knowledge of its residents? Knowledge of who within that block was elderly or infirm; disabled; young? And where those individuals were located? More fundamentally, given what was known and given the fact that the main policy document required them to have a contingency – a Plan B – if “*Stay Put*” failed, what was it and where was it recorded? How was any Plan B to be accessed by those put in charge on arrival?
57. GRA 3.2 is the DCLG guidance for Fighting Fires in High Rise Buildings. Page 14 emphasises the importance of planning as the key to the safety of firefighters and others in an emergency. Planning for the LFB should have been facilitated by inspection visits and those under s7(2)(d) of the Fire and Rescue Services Act 2004 and at p15 GRA 3.2 notes that operational information is of little value unless it can be readily accessed by those at the scene of an emergency “*to inform critical command decisions*”.
58. At p19 perhaps the most critical guidance is set out, referring to contingency plans:
“Contingency plans for particular premises should cover:
 - *fire spread beyond the compartment of origin and the potential for multiple rescues*
 - *an operational evacuation plan being required in the event the “Stay Put” policy becomes untenable.*”
59. What was the contingency plan at Grenfell Tower - it is completely unclear from the disclosed material? No doubt the obvious contingency - when “*Stay Put*” is no longer tenable - is one of evacuation but in addition, the guidance requires contingencies relating to the moving of bridgeheads when compromised, alternative communications systems when radios did not work and alternatives to fixed installations when they did not work. All of these contingencies and indeed the failure to address them were in fact relevant to what happened at Grenfell Tower but none are apparent on the material we have been disclosed to date.
60. The same Guidance document, GRA 3.2, refers to the requirement for the ‘*responsible person*’ - here the Chief Executive of RBKC - to have a Fire Risk Assessment (FRA) and for any evacuation plan contained within it to be followed by the Incident Commander at a fire. It is unclear whether the FRAs commissioned by the TMO and undertaken by CP Stokes was seen by the LFB but we have seen no evidence of it having been shared. The evacuation plan in the last FRA of Stokes prior to the fire refers to the evacuation plan as ‘*Stay Put*’. The FRA evacuation plan goes on to say that the TMO or LFB will arrange for a full evacuation where appropriate. It is a misnomer to describe that as a plan at all.

61. With respect to establishing the facts this must include: exactly what happened to those in the block including the deceased; the contact that the deceased and survivors had with the emergency services and others; where the deceased and survivors were at the start of the fire and where it is known that they went; exactly what was known by decision-makers at precise material points in time. Our clients also have many general questions of fact such that the fact finding must include: why it took 22 ½ hours and the digging of three holes to turn off the gas supply to the Tower; why there was no accessible valve which could turn off this obvious fuel load at the outset of the fire; whether the LFB resources were adequate on arrival and as the response developed; whether aerial ladders and/or positive pressure pumps might have made a decisive difference; and whether there was a means by which oxygen might have been more effectively supplied to those in need of rescue?
62. Our clients have specific questions as well: individuals bereaved by the disaster have questions as to why their loved one was advised to “*stay put*”; as to why there was no targeted rescue of the vulnerable and mobility impaired; regarding the failure to even attempt rescue in certain instances; regarding the apparent lack of aerial ladders.

Phase one recommendations on fire fighting

63. We recognise that the purpose of phase one is primarily to establish the facts of what occurred on the night with a view to making urgent interim recommendations but within that process it is not sufficient simply to look at what happened when but to ask why decisions were taken and what were the alternatives.
64. The clearest of these issues is the operation of “*Stay Put*” and the need for an effective Plan B. It is not sufficient in phase one to determine the material facts, for example, when the first 999 report was made (00:54), when the MI was declared (02:06) and when “*Stay Put*” was finally abandoned (02:47). It is necessary to ascertain what was known by each decision-maker, the Incident Commanders and their superiors, what the range of options available to them were, and why they chose to remain with a policy which was very plainly not working.
65. The issues on “*Stay Put*” appear to be stark. As a default position, there can be little doubt that “*Stay Put*” has been an effective policy on high rise buildings where the integrity of compartmentation has been maintained. Equally, as a matter of logic, it is clear that it is not effective where compartmentation fails. In many of the major high-rise fires reported internationally, casualties have been avoided by urgent evacuation: Melbourne and Dubai being examples.
66. On 14 June 2017 there was a catastrophic multi-faceted failure of the compartmentation – such as it was - at Grenfell Tower. Thus, the compartmentation was obviously compromised from a very early stage. The first Incident Commander could see with his own eyes the very rapid spread of fire from flat 16 up and across the building façade. It reached right to the top of the building within minutes. That plain observation raised a huge question over the effectiveness of “*Stay Put*”. Of course, it is possible that an external fire would remain just that and not compromise compartmentation, but within minutes the integrity of compartmentation was plainly in issue. The fire had somehow emerged from flat 16, it was obviously likely that it would penetrate back into other flats, particularly on a warm June night when many windows would be open.

67. But beyond the obvious observation from the outside we know from the statements of the first firefighters on scene that within minutes residents from flats above flat 16 came down and reported that their flats were on fire. Firefighters immediately went to look and were able to confirm those accounts. Then there were reports of fire and people trapped on the 12th floor and then elsewhere. Within a very short period, 999 calls and Fire Survival Guidance calls had overwhelmed the emergency control room.
68. Nevertheless, it took 2 hours before “*Stay Put*” was formally abandoned. By that time, it was far too late. The LFB were unable to send rescue teams anywhere near those that needed to be rescued by that time. Professor Lane has said that “*Stay Put*” was rendered ineffective by 01:26. Our clients want to know why “*Stay Put*” remained in place for the next hour and a half. Given that Professor Lane reports that 18 people escaped from floors above the hot zone - between levels 10 and 13 - even after the abandonment of “*Stay Put*”, we say it is beyond argument that many more would have survived if the policy had been abandoned at 01:26 or at any rate, long before 02:47. The effect of abandonment would have been to shift the emphasis to rescue and it would have given many more the chance of escaping before it was too late.
69. Thus, the Inquiry should look at three aspects of Stay Put: why was there apparently no LFB contingency plan: no Plan B; why, on the night, Stay Put advice was maintained long after it was clearly ineffective; and why there was no plan put in its place?
70. These questions straddle phase one and phase two. We accept that the question of whether failures by the LFB and fire commanders contributed to loss of life is primarily for phase two. However, the need for urgent interim recommendations is obvious in regard to “*Stay Put*”: first, there is a pressing need for effective contingency planning; and secondly, there is a pressing need for guidance which reflects the reality: “*Stay Put*” works only so long as the integrity of compartmentation is maintained.
71. The need for urgent consideration of the appropriateness of the ‘*Stay Put*’ policy and the safety of alternatives is evidenced from the Government’s own “Update On Interim Mitigation Measures Required Pending Remediation Of Cladding” dated 29 September 2017⁴.
72. People are living in unsafe tower blocks now awaiting the replacement of combustible cladding systems. We have as yet heard nothing from the LFB about what lessons it has learned and what measures it has put in place to deal with simultaneous evacuation including as to vulnerable residents.
73. There is a further aspect too. We do not doubt that evacuation in a high-rise block with one stairway and no general alarm has significant difficulties. We do not doubt that the initial firefighting effort and equipment exacerbated those significant difficulties. Not only should those known difficulties impact on an evacuation policy – including essential provision of either simultaneous evacuation or phased/staged fire alarm systems - they underline the need for strict rules to require only Euro Class A1 materials to be used, they should also lead to consequent recommendations that:

⁴https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/648775/Update_on_Interim_Mitigation_Measures_290917.pdf

- a. Sprinklers/automatic fire suppression systems should be retrofitted to all high rise residences;
- b. General alarms including a centrally addressable fire alarm system with tannoy should be required and retrofitted to facilitate swift evacuation;
- c. All new multiple occupancy residential buildings should be required to have at least two staircases, offering alternative means of escape, commensurate with the current requirements for commercial buildings (see ADB – Vol 2: B1 Section 4);
- d. Landlords should be under a legal duty to maintain a register of vulnerable residents in such blocks, accessible in real time to emergency services, all with ‘Personal Emergency Evacuation Plans’ (PEEPS).

Candour and helping the Inquiry

74. We have consistently argued that all CPs must be required to assist this Inquiry. This was a disaster relating to public housing, a variety of public authorities are involved and the private companies and entities are public-facing in that they were paid from the public purse. A Public Inquiry is set up because of widespread public concern. One of its roles is to help prevent such calamities in the future. Although accountability is an important part of the process, there will be no findings of liability and therefore there should be less room for defensiveness or silence.
75. We have persistently argued for Position Statements and the Inquiry has already requested limited versions. In our submission, the time has now come for full cooperation and full candour from all CPs. On behalf of our clients who are bereaved, survivors and/or former residents of the community we call on all CPs to proactively set out their positions in their Opening Statements. Why? Because this is a public search for the truth and it is not a game of cat and mouse nor smoke and mirrors. Those closely engaged with the processes can help lead the Inquiry to important documents and evidence and they can highlight failings by themselves and others.
76. What we seek from the LFB as we embark on phase one – in respect of which the fire fighters’ evidence is a central component - is a clear statement of what should have been in place with respect to policy: how should “*Stay Put*” have operated on the night and what was the Plan B - if there was one? As an emergency service, we know that they will have conducted a post-disaster learning analysis. Where is it and what does it say? What would the LFB do today in a similar emergency? Did the LFB even have a policy beyond “*Stay Put*” for high rises generally and Grenfell Tower in particular? Does the LFB now think that retrofitting sprinklers, fitting general alarms and tannoy, and banning all but the highest rated, Euro A1, materials from building envelopes should be post-Grenfell requirements? Why has it been virtually alone in welcoming the failure of the Hackitt Review to recommend a ban on combustible cladding, prior to the Housing Secretary announcing that he would consult on a ban in any event?
77. Moving to the RBKC and the TMO. Can they explain why there was no retrofitting of sprinklers or the installation of alarm systems? What was their role in allowing combustible materials to be used in the cladding system and was their decision to change the refurbishment from the intended limited-combustible materials to flammable materials based upon cost-cutting, ignoring the obvious and increased fire risks? Are they able to explain why the firefighter lifts were apparently defective, and the fire doors of a sub-standard fire-rating? Where was the database of vulnerable

residents, the elderly and very young, the infirm and the disabled, and the PEEPs as referred to in the Stokes' FRA. Was this information shared with the LFB? A year on from the disaster, the bereaved and the survivors anxiously await the answers to these questions. The bereaved, survivors and former residents also want to know how Building Control apparently signed-off a project via a 'Completion Certificate' dated 16 July 2016, which had converted a fire safe Tower to one with a flammable cladding envelope and multi-layered breach of its intended compartmentalisation notwithstanding the post-Lakanal concerns and knowledge.

78. Similarly, the bereaved and survivors seek answers to similar questions from Mr Stokes the fire assessor instructed to do the formal FRAs by the TMO. What did he mean when he described the new cladding as "*fire-rated*" in his 2016 FRA? How did he apparently fail to spot that the fire doors were sub-standard and that the firefighter lifts were defective? What did he mean when he described the evacuation plan for Grenfell Tower as '*Stay Put*'. How was the assertion that the Fire Service or TMO would arrange a general evacuation if appropriate, a plan? Was there a joined-up approach between the FRA system and the fire engineering of the refurbishment project? If not, why not? Why did his FRAs⁵ assert: "*You do not have to give a copy of your risk assessment to anybody, not even the fire authority, if you do give them a copy this could be used against you at a later date.*"
79. To those involved in the refurbishment - architects Studio E, the quantity surveyors, the original CDM, Artelia, contractors Rydon, fire engineers Exova, and the various sub-contractors involved in fitting the insulation and rainscreen, the new windows and the gas pipes – where exactly did responsibility lie and how on earth was such an unsafe system designed and fitted, given the depth of knowledge about the risks of flammable insulation and rainscreen composite panelling that was well known from other disasters and near-misses? The bereaved and survivors are of course interested in issues of compliance with guidance – but they also seek answers to why such flammable materials would be used on a high-rise residence where compartmentation was central to the fire risk strategy, irrespective of the effect of the guidance. Each of these entities should set out what they would do differently today and whether their designs and proposals were modified or ignored at the expense of increased risk. That will include matters such as the well-publicised 2014 communications between the TMO and Artelia regarding cutting the cost of the project by replacing then specified rainscreen panels with the even more combustible ones that were subsequently used.
80. To the manufacturers of the products and materials used on Grenfell – including St Gobain/Celotex, Arconic, Kingspan - and those who fabricated and machined the products for the project such as Harley Facades, how did those products and materials come to be used on a high-rise residence?
81. To the Gas company, Cadent, can they explain why their employees worked round the clock to achieve the near impossible task of digging three holes to turn off the gas supply when this could be been prevented by an accessible valve?
82. These questions are not meant to be exhaustive, they are intended to highlight but some of the important issues central to the concerns of the bereaved, the survivors and the

⁵ LFB00000066

former residents. They do not want to hear meaningless condolences or pretences that a company or authority does not want to usurp the role of the Chair or indeed that there has yet to be sufficient disclosure for proper answers to be given. All of those things are yet another smoke screen. This is not a moment for technicalities. The time for candour and frankness is now. A year after the disaster those most affected have the right to transparency and openness. Candour by CPs and full disclosure by the Inquiry shines the lamp of justice into dark corners and illuminates the truth. This is essential not only for justice but to prevent future avoidable tragedy.

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18th May 2018

APPENDIX A

DATE	EVENT
5.4.91	Knowsley Heights fire, Huyton, Liverpool, 11 story block of flats that had been the subject of an over cladding scheme in 1989/90; the original fire was started by vandals setting fire to rubbish and the fire spread through the cladding acting like a chimney.
1993	Factory fire with fatalities linked to composite panels and inappropriate fixings.
11.6.99	Garnock Court fire was a fire that took place on 11 June 1999 at Garnock Court, a 14-storey block of flats in Irvine Scotland, which resulted in one fatality. The fire spread via the external cladding, reaching the 12th floor within ten minutes of the start of the fire, destroying flats on nine floors.
23.9.07	Water Club Tower, Atlantic City a fire on the 3 rd floor spread up the building aluminium/polyethylene composite panel façade.
25.1.08	Fire at the Monte Carlo Resort and Casino in Las Vegas, Nevada a contracting crew was up on the roof of a building performing welding and cutting on a steel fabrication that was to become a catwalk for a window washing system. The hot work ignited adjacent polyurethane-coated foam plastic trim and the fire spread laterally and vertically down the exterior face of the building. The outcome 7 people were sent to hospitals for injuries.
9.2.09	Television Cultural Centre, Beijing: stray fireworks from Chinese New Year Celebrations landed on the roof of the building, 31 storeys up, starting a fire which spread rapidly down to the lower floors, causing the death of a firefighter from toxic smoke inhalation and seven injuries. The whole 159m high building, topped out but still under construction, was ablaze at the height of the fire. Hard facts are difficult to find after a news curfew, but insulating foam panels [and polystyrene insulation] have been implicated.
3.7.09	The Lakanal House fire occurred in a tower block in Camberwell, London. Six people were killed, and at least twenty injured, when a high-rise fire developed and spread through a number of flats in the twelve-storey building. Fire rapidly spread via cladding and breached compartmentation. The Coroner commented with regard to ADB, <i>“it is a most difficult document to use”</i> and the need for <i>“clear guidance ... with particular regard to the spread of fire over the external envelope of the building and the circumstances in which attention should be paid to whether proposed work might reduce existing fire protection”</i> .
6.4.10	Tower block blaze in Southampton killed two firefighters. James Shears, 35, and Alan Bannon, 38, died tackling the fire at the 15-storey <i>Shirley Towers</i> . The coroner raised with Eric Pickles MP the need to fit towers over 30m with sprinklers.
1.10.10	Wooshin Golden Suites fire, Busan, South Korea fire spread vertically upward on the façade reaching the top of the building; aluminium polyethylene composite panel façade.
15.11.10	A 28 Storey apartment building in Shanghai under renovation was consumed by fire resulting in the loss of 58 lives. The available details

	<p>suggest that the 85m high building was fully scaffolded for the installation of energy-saving insulation when the fire occurred. Sparks from welding operations ignited construction materials and the nylon safety mesh on the outside of the building. Fire then spread rapidly along the scaffolding and through the interior of the block. The fire was believed to have spread on polyurethane insulation to external walls. “The fire may have been caused by the accidental ignition of polyurethane foam insulation, commonly used in China without the addition of flame retardants.</p>
14.5.12	<p>Mermoz Tower, Roubaix, France fire spreads through the aluminium/polyethylene composite cladding, second storey fire origin leading to rapid vertical flame spread to the top of the building within a few minutes.</p>
18.01.12	<p>Al Baker Tower, Sharjah - fire involving rapid vertical fire spread.</p>
27.04.12	<p>Al Tayer Tower, Sharjah – fire involving rapid vertical fire spread.</p>
6.8.12	<p>Saif Belhasa Building, Tecom, Dubai fire origin on the 4th floor spreading rapidly to the top of the building panel facade aluminium/polyethylene composite.</p>
18.11.12	<p>Tamweel Tower, Dubai fire spread down the exterior of the building aluminium-faced polyethylene composite panel façade from the roof level.</p>
25.11.14	<p>Lacrosse Building fire took place in the early hours of the morning. It directly affected approximately 450 to 500 people who required immediate evacuation and accommodation. The rapid spread of the Lacrosse building fire, which was sparked by a cigarette on an eighth-floor balcony and raced up 13 floors to the roof of the 21-storey building in 11 minutes, was blamed on flammable aluminium composite cladding that lined the exterior concrete walls.</p>
21.2.15	<p>Marina Torch Residencetower in Dubai - aluminium polyethylene composite panel. The façade fire spread up one side of the face of the building and down the opposite side.</p>
31.12.15	<p>Address Downtown Hotel fire, Dubai: a devastating rapid external cladding fire with 40 storeys burning simultaneously. De-laminated aluminium facings were found all around the tower.</p>
08.16	<p>Shepherds Bush fire with rapid fire spread on the outside of the building.</p>