CLOSING SUBMISSIONS ON BEHALF OF THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA TENANT MANAGEMENT ORGANISATION (TMO):

Introduction

1. Over the last seven months, the Inquiry has heard extensive evidence about the devastating fire that took hold of Grenfell Tower on the night of 14 June 2017. This evidence has come from a wide range of sources, including most significantly the bereaved, survivors and residents and the Emergency Services.

2. It would be an understatement to describe the experiences of these individuals as distressing. It would also be an understatement to describe their actions on that night as courageous. The TMO wishes to pass on its deepest sympathies to the bereaved, survivors and residents, who despite suffering such great loss still had the courage to attend the Inquiry and give such clear and dignified evidence of their experiences and observations. The TMO also wishes to pass on its appreciation to the fire fighters, police officers and ambulance service officers who attended the fire that night, many of whom endured great risk to their own safety. The actions taken by these individuals in responding to this unprecedented fire were incredibly brave and selfless.

3. The evidence the Inquiry has heard in Phase 1 should assist the Inquiry with the grounds for establishing the factual narrative of the events of the night of 14 June 2017. These submissions are intended to clarify the TMO's position in relation to some of that evidence, and in relation to the scope of Phase 1.

4. We respectfully agree that findings at this stage should and can be made in relation to all or parts of the 6 Phase 1 Issues. The Phase 1 issues are[1]:
    1. *the existing fire safety and prevention measures at Grenfell Tower;*
    2. *where and how the fire started;*
    3. *the development of the fire and smoke;*

[1] As set out on the Inquiry website https://www.grenfelltowerinquiry.org.uk

4. *how the fire and smoke spread from its original seat to other parts of the building;*
5. *the chain of events before the decision was made that there was no further saveable life in the building; and*
6. *the evacuation of residents.*

5. Addressing these issues demands analysing the evidence of those who were there, what they did and saw, with the expert evidence of how the fire and the building responded. This is a huge and complex task. It cannot be completed in full now at the close of Phase 1. In light of a number of practical factors, including the limited extent to which the experts have analysed the forensic and eye witness accounts in the short time available, it is obvious that there are elements of issues 3 and 4 that you will not be able to find on at this stage. Principally, where and how the fire and smoke spread once compartmentation had been breached in flat 16 and re-entered the building and how the active and passive fire systems responded to this catastrophic event on the night. These are topics that the experts have confirmed need further detailed work and should form part of Phase 2.

6. The TMO appreciates the importance of your role in making factual findings in relation to these Phase 1 issues and encourages you to do so where the evidence permits it to assist the learning of safety lessons and to inform further investigations to be considered in Phase 2 of the Inquiry. In seeking to make these findings of fact, the TMO invites you to consider the following submissions in respect of the evidence that has been presented to you in Phase 1 and the evidence that has not been called in Phase 1.

7. We respectfully submit that the findings that you can and which we encourage you to make must be in relation to these identified issues and based on the factual evidence you have heard in relation to those issues as they relate to events on the night of the fire. The need for flexibility between phase 1 and 2 issues is acknowledged in order to inform Phase 2 but we submit that findings at this stage should not go wider than the identified issues until full evidence has been properly given and tested in Phase 2.

1. The existing fire safety and prevention measures at Grenfell Tower

8. Multiple active and passive fire safety measures were in place at Grenfell Tower as set out in Dr Lane's table 2.3[2]. There is no provision or statutory guidance for the number or combination of active or passive safety systems that must be in place for any one construction. At Grenfell Tower Dr Lane has identified 16 different passive systems and 11 different active systems, 27 different measures in total designed to operate independently but in concert or layers to provide protection in the event of a fire. The majority of these systems were formed as part of the original build and some have been modified or updated over time, including as part of the building refurbishment programme in 2012-2016. The purpose of these systems is to create a high degree of compartmentation; that is to limit fire and smoke spread from the single flat that is on fire. They are designed to operate in response to a fire in a single compartment and to support the 'stay put' policy[3]. As Professor Torero stated '*at the backbone of the fire safety strategy is the concept of no spread, external spread of the fire*[4]. They are not designed to operate where a fire has breached its compartment and spread into a building. Therefore it is only for the time that the fire in contained in a single flat that '*represents the building operating as designed*[5]'. As observed by Dr Lane '*Once the fire broke into the rainscreen system, the remaining active and passive fire protection measures within the Tower were then required to perform during an extraordinary event.*'[6] It is against this background that, in due course, these safety systems must be assessed.

9. Active systems included fire alarms for individual flats, firefighting lifts and smoke ventilation systems. All flats were provided with smoke alarms individually designed to activate upon detection of heat or smoke in that flat only. There was no whole-

[2] Dr Lane Report 2.13.11 (BLAS000002_0024). Unless otherwise stated all references are to Dr Lane's 2nd Phase 1 report. Dates vary according to sections)

[3] Fire Action Notices were on every floor of Grenfell Tower giving instructions that the 'stay put' policy for residents unless the fire is in or affecting a resident's flat. Instructions are given on what to do in the event of a fire and on how to leave the building. (BLAS0000033_47 Figure L.29)

[4] Professor Torero Evidence transcript Day 78 p13-14

[5] Professor Torero Evidence transcript Day 78 p14

[6] Dr Lane Report 2.13.3 (BLAS000002_0024)

building audible alarm system, one was not required under the relevant regulatory regime, ADB 2013, which does not recommend that fire alarm sounders are automatically or manually operated throughout the building in the event of a fire. It requires fire detection and alarm systems within the flats for the purpose of raising the alarm inside that flat only. There was a smoke detection alarm installed in the common areas to activate the smoke ventilation system. This was a silent alarm. It was triggered, most probably on floor 4 by the fire, or more specifically the smoke, as early as 00:55 by Tunstall which caused the emergency services to be called immediately. This was one minute after Mr Kebede first placed a call to the emergency services at 00:54 and probably coincides with when his front door was opened, and smoke made its way into the lobby of floor 16.

10. It is evident that the control system operated to the extent that it was activated by the presence of smoke on the 4th floor. The automatic opening vent (AOV) system was designed by PSB from specifications provided by Max Fordham and approved by RBKC building control. The AOV system incorporated dampers to the ducts in lobbies at each level and in environmental mode, the dampers would open or close at specified temperatures to control air flows to keep temperatures at ambient levels. If smoke was detected the environmental settings were automatically overridden by a smoke control mode which closed all dampers except on the floor where the smoke was detected and then large fans would blow and draw the smoke from the lobby through ducting and out of the top of the building. Upon being activated the system cut off the gas supply and relayed an alarm message to Tunstall, the off-site remote monitoring company to alert the emergency services. The system could be manually overridden on each floor. It is understood that further technical evidence is required in order to assess both the compliance and performance of the smoke ventilation system including further investigations in its compliance, operation on the night and the issues around the missing data from the HMI panel. We suggest therefore that these matters must be considered in detail and exclusively in Phase 2.

11. The lifts had features consistent with a fire lift that should have enabled the fire service to control the lift in the event of a fire. The lifts at ground level had a fire lift

control switch that was operated by the use of a drop key. Crew Manager Secrett stated in evidence[7] that he was unable to activate the drop key but that he was able to recall the lift in the normal manner in order to access floor 4 and flat 16. The CCTV in the lift lobby depicts this and shows there is no delay in recalling the lift to carry out initial firefighting activities. The recently disclosed WSP report dated August 2018[8] commissioned by the Metropolitan Police concludes that the fireman's switch for the ground floor was '*difficult to operate*' and that on removal of the faceplate '*we discovered that the mechanism was seized and damaged/deformed*'[9]. It is not known when this damage/deformity may have occurred and if it could have occurred on the night of the fire. The TMO has asked over the course of several weeks for facilities for its expert to inspect the fire control switch but to date this has not been facilitated.

12. Further the Policy for Fire Fighting in High Rise blocks[10] provides guidance on when fire lifts should be used during an incident. It states the following:

7.14 Teams must exit the fire lift at least two floors below the floor where the fire is reported or believed to be. This is to ensure that the risk of firefighters becoming involved in the fire is minimised.

7.15 If the location of the fire is not known with a reasonable level of certainty, personnel should approach the believed or likely location of the incident with caution, using a protected staircase. [emphasis added]

13. Fire fighters confirmed that any fire lift should only be used to facilitate travel to two floors below the bridgehead. Deputy Assistant Commissioner O'Loughlin[11] would not have allowed the lift to be used because the fire fighters were working at such low level. Group Manager Welch confirmed *that at no point in that building could I guarantee I could send firefighters to a place where they would be two floors below*

[7] CM Secrett Transcript Day 16 p192
[8] WSP Report MET00019973
[9] WSP Report MET00019973_0021
[10] LFB00001256
[11] MET00012563-0030

the fire because I had seen so much outside[12]. Fire Officers confirmed that at the point where the location of the fire was not known, i.e. after it had spread beyond flat 16 and there was substantial smoke spread, it would not have been safe to use the lifts in any event[13].

14. As set out in Appendix L of Dr Lane's report, the Public Inquiry has now appointed a lift expert to carry out a detailed investigation into the design, construction and operation of the lift and we suggest therefore that these matters should be considered in detail and exclusively in Phase 2.

15. The Inquiry has heard evidence that Grenfell Tower is 65.49 metres high. ABD 2013 required a building of this height to have wet risers installed for firefighting purposes. Grenfell Tower appears to have had dry risers installed at the time it was built and these were retained and extended as part of the refurbishment works. During the refurbishment of the Tower, Rydon engaged JS Wright to make modifications to the existing dry riser[14] by extending it to the new lower floors and this work was in accordance with specification drafted by Max Fordham as approved by RBKC building control, Carl Stokes and LFB during their inspections and familiarisation visits. There was a dry riser on each floor in the lobby. The dry risers functioned adequately on the night. Dr Lane concluded that there could be a delay in setting up a dry riser for an initial firefighting response as opposed to using a wet riser where making the connection to pump would be quicker. The factual evidence of the initial fire crews in attendance suggests that there was no delay in respect of the provision of water for firefighting. We submit that issues in relation to the effectiveness of the dry risers are to be dealt with at Phase 2.

16. As part of a Fire Door Replacement programme across the RBKC stock, 106 front doors were replaced at Grenfell Tower in 2011 to ensure that flat entrance doors adhered to fire safety standards. The TMO appointed specialist fire door contractor Manse

[12] Transcript GM Welch Day4 4 page 129
[13] Transcript SM Myatt, Day 36, 4th September p42-43
[14] J S Wright position statement JSW00001883-0005

Masterdor Ltd to undertake these works. TMO understood that the doors being fitted at Grenfell Tower were '*Suredor composite fire door FD30 - Tested to BS 476 PRT 22*'[15] and were installed with intumescent seals and '*Astra 3003 Concealed Door Closer V1 PL3 door closers*'[16] and were compliant with ADB 2010.

17. Residents were written to on the 2nd March 2011[17] informing them that their doors would be replaced in the following months and providing them with a selection of doors and colours within the Manse Masterdor Ltd range from which to choose from. The doors had a range of different design features some with glazing and some without. Tenants were then visited by Manse Masterdor Ltd who dealt with all aspects of the installation.

18. Dr Lane concluded in her report at Appendix I, having inspected 8 doors on Levels 4-23 on 19th November 2017 at Grenfell Tower, that these doors did not match the specification as set out by Manse Masterdor Ltd in their literature and in their spreadsheet of works[18]. It was not possible without further testing to establish what core materials the door leaf was comprised of. Of the 106 doors that were replaced as part of the programme, 48 doors contained glazing. Dr Lane confirmed that the 'glass specification is not what is specified in the 2011 door upgrade specification listed in the [Manse Masterdor] spreadsheet'[19] of works. BRE Global Ltd tested a single flat glazed door and concluded that it had an integrity of 15 minutes. Therefore the test specimen provided by Manse Masterdor Ltd to the Inquiry[20] cannot be relied on as relevant test evidence for the fire performance of the 48 doors which were glazed, or indeed the remaining 58 unglazed doors. TMO were not made aware at any time of any change to the specification of doors to be installed. It is noted that Manse Masterdor Ltd have provided some documents to the Inquiry that have been disclosed but that they are not currently listed as a Core Participant. Further investigation of these issues is clearly required at Phase 2.

---

[15] Manse Masterdor Information Sheet TMO00831637
[16] MAS00000003
[17] TMO10048276
[18] MAS00000003
[19] Dr Lane Report 15.5.46 (BLAS0000030_0044)
[20] Chit/RF07024 (MAS0000002)

19. It is of note that the single flat door tested by BRE Global Ltd was a glazed door. The test recorded that; at minute 15 there was 'Failure of integrity from sustained flaming at the top edge of the glazing.'[21] Therefore the failure of this door at this time is attributable to the failure of the glazing not the door leaf itself. Further testing will need to be conducted to establish the integrity of the 58 doors that did not contain glazing in order to establish at what point their integrity failed.

20. In respect of the BRE tests Professor Torero concluded that the BRE 'standard test does not replicate a fire event (in terms of the progression of the fire) but creates conditions whereby there is a steady growth of the temperature in time. In 15 minutes the temperature of the standard test would have reached 740°C[22]. 'In a real fire, 740°C is a temperature characteristic of a post-flashover fire. Therefore it is possible to infer that the failure of the doors leading to the lobby would have occurred … [post flashover fire]'[23]. The doors would only fail once the temperature in the flat was untenable for occupants. Professor Torero goes on to conclude that: 'In cases where moderate or severe damage was observed, smoke and flame entering the unit from external fires would not provide sufficient thermal insult for sufficient duration to affect such failures. This is evidenced by the fact that the flat doors in flats where damage was of this nature, i.e. no post flashover fire, did not experience damage that cannot be explained by either firefighter intervention or thermal insult from the communal lobby side due to failure of all other flat doors on that floor[24].

21. Professor Torero explains how this is relevant to the consideration of the breach of internal compartmentation and the mechanism for the spread of smoke. Re-entrant fires were reported on levels 5, 12, and 22 at early stages, at approximately 01:18, 01:24 and 01:28. Re-entrant fires have the potential to breach closed doors. 'Nevertheless, the timelines associated with the fire development rule out this

[21] MET00019996_0011
[22] see Professor Torero Report Line 2319 Figure 53 Comparison between the fire resistance test temperature history and those of a compartment fire typical of residential building compartment. The table shows the range of possible values for Grenfell Tower.
[23] Professor Torero Report line 160ff (JTOS000001_0006)
[24] Professor Torero Report line 2454ff (JTOS000001_0099)

mechanism as being responsible for initial reports of smoke logged lobbies during Stage Two' [01:05-01:30][25] . Therefore during this period any assessment as to the performance of the flat doors would have to considered in relation to smoke spread only.

22. There is currently no forensic analysis of smoke spread. Dr Lane makes the important point that BRE Global Ltd have not conducted any fire resistance and smoke control test for any of the flat or stair doors pursuant to BS EN 1634-3:2004. The result of this is that the smoke leakage performance of the flat entrance door and stair doors is unknown[26], whether compliant or not. In light of the fact that the doors will not be compromised by flame until and if 740°C is reached, and flashover occurs, it will be crucial to have an assessment of smoke leakage and smoke spread at Phase 2 for the Inquiry to understand not only compliance but performance. The assessment of the spread of smoke leakage will be a key component when understanding how the doors worked as a passive system on the night. It is therefore not possible at this stage to conclude whether and to what extent the doors would have contributed to the worsening of conditions inside the building.

23. This also highlights the need for careful analysis of the hazard presented to each flat and stair door, as well as establishing whether in fact the door was open or closed during the incident before any conclusions as to the performance of the doors can be made. The BRE Report titled On Site Investigation Interim dated 9th March, provides a summary of flat front doors findings. It concludes that 79 flat doors were closed at the time of inspection[27]. It also contains a survey of door closers. The TMO understood that door closers were fitted onto all flat and stair doors during the door replacement programme. Fire Risk Assessments conducted by Carl Stokes Associates Ltd, most recently completed on 20th June 2016, included a check list that confirmed that where appropriate fire doors were fitted with self closers[28]. The TMO will assist,

[25] Professor Torero Addendum (JTOS000002_0002)
[26] Dr Lane Report 14.6.9 (BLAS0000030_0062)
[27] MET0001252_0011
[28] LFB00000066_0021

where it is able to do so on the issue of where door closers may have been removed or broken at Phase 2. However further information is needed on this report, detailing how and when the data within it was compiled as well as evidence gathering in relation to the positioning of doors during the incident before any conclusions can be drawn. Professor Torero states in the Addendum to his most recent report that the interactions between occupants and fire fighters and doors inside the building are of 'critical importance to the performance of compartmentalisation and to the validity of the 'stay *put' strategy*'[29]. He impresses that these issues require significant attention at Phase 2.

2. *Where and how the fire started*

24. This issue relates directly to events of the night and to that extent we respectfully submit that you have heard sufficient evidence to be able to make findings of fact in respect of the source of fire.

3. The development of the fire and smoke

25. "The development of the fire and smoke" has been addressed by the eye witness evidence, the expert evidence, the compilations of video footage on the night. You have heard sufficient evidence to be able to make findings of fact as to how the fire and smoke developed in and across the envelope of the building. Dr Lane, Professor Torero and Professor Bisby all conclude that the UPVC window surrounds, provided a route for the spread of fire into the external façade of the building and that the column rainscreen system and Reynobond 55PE rainscreen cladding panel backed by the Celotex insulation or Kingspan K15 insulation on the exterior of the Tower was then responsible for the spread of fire which rapidly took hold of building. Multiple catastrophic fire-spread routes were created by the cladding materials, but also the construction detailing of these materials, such as the 14 columns around the building,

[29] Professor Torero Addendum (JTOS000002_0002)

and the architectural crown. Unchallenged by effective cavity barriers provided direct pathways for flame spread both vertically and horizontally around the building. The experts have also concluded that the composite materials used in fact propagated the spread of fire.

26. This is a complex topic however the experts are unanimous. Ultimately the rain screen cladding that encased the building was the key proponent in the spread of this fire and the devastation that followed. When the fire in the cladding spread beyond a certain point, the effect was that it created a hazard which was impossible for the building to mitigate. We encourage the Chairman to make factual findings in respect of how the fire spread across the envelope of the building. An important outcome of this Inquiry must be to ensure that steps are taken to ensure that a fire of this scale and devastation never happens again, by ensuring that this composition of materials is not erected on high-rise buildings. With the consideration of recommendations at the end of Phase 1 of the Inquiry, we hope that significant steps will be taken to achieve this. However, the reasons for the development of fire and smoke inside the building and any failures of internal compartmentation are matters that require further investigation at Phase 2.

4. How the fire and smoke spread from its original seat to other parts of the building

27. In respect of Issue 4, we submit that findings of fact should be made in respect of how the fire and smoke spread from flat 16, through the window and consequently horizontally and vertically across the envelope of the building. How the fire and smoke spread once it had re-entered the building cannot be established until further investigations have been carried out as has been set out in detail in the experts reports and in these submissions at paragraphs 9-25.

5. The chain of events before the decision was made that there was no further saveable life in the building

28. The Inquiry has heard an abundance of vivid evidence to establish the key incidents during the night before the decision was made that there was no further saveable life. It is appropriate to make findings of fact in this regard in order to learn immediate safety lessons and where appropriate to make relevant recommendations in relation to high-rise buildings.

29. On 15th November the Inquiry heard evidence from the two Local Authority Liaison Officers (LALOs) Nicholas Layton and Mike Rumble, employees of the RBKC, who attended the incident as the representatives of the RBKC and from the TMO staff who were also in attendance. The RBKC Contingent Management Plan (CMP)[30] was in operation from a very early stage. Nicholas Layton was first to arrive at 02:47am[31] and he immediately determined that it was a level 3 major incident. He contacted David Kerry the Emergency Planning manager at RBKC and the RBKC CMP was activated and the BECC (the Borough Emergency Command Centre) which manage requests for resources, was set up. In these circumstances the TMO emergency plan was properly not put into operation because it was superseded by the Borough's CMP. It would have been inappropriate to have separate and different plans in operation at the same time. As a consequence, the TMO had no formally defined role in the response to the emergency. The employees of the TMO that attended on the night did so voluntarily to offer assistance in whatever capacity they could.

30. The TMO understood, as did the LALO Nicholas Layton[32] that they would have a role in assisting with dealing with displaced residents in the wake of the incident and to assist RBKC and the Red Cross with managing rest centres, once they had been set up by RBKC. Mr Layton stated that when he first spoke to Mr Black he told him that '*we were setting up rest centres and that he needed to get staff there to assist*'[33] and that was the only topic that was discussed with Mr Black.

---

[30] RBK00004398
[31] Transcript Nick Layton Day 74 p26
[32] Transcript Nicholas Layton Day 74, p37
[33] Transcript Nicholas Layton Day 74, p41

31. The Inquiry heard from Teresa Brown the TMO's Director of Housing. She mobilised her team and staff from the TMO who assisted in running the rest centres, 41 staff members attended in total. She took the decision herself to organise a system at the rest centres to record a list of survivors and those missing in order to assist the LFB's rescue operation. Neither the LFB nor any other organisation requested her to do this. Staff were instructed to record in writing the names, addresses and household information of persons safe or missing[34] and this information was passed back to Teresa Brown who passed it directly to the LFB.

32. She also confirmed that she did not forward any list of residents to the LFB, but that she was aware of the resident lists that had been sent by David Noble[35]. She stated in evidence that these lists were of limited use however: '*Because this is data on our system for who is our tenant at a moment in time, which I believe is as up-to-date as possible, but it wasn't giving us information about who was actually there on the night and who was safe and missing. I was concentrating on that information from the rest centres because that was, in a sense, more helpful than relying on data that isn't really telling you if someone is in a building on the night.*'[36]

33. The second Tactical Coordination Group (TCG) meeting started at 04:34 according to the Roe Log and although Mr Layton does not make any contemporaneous notes on the matter, he gave evidence that he was asked at this meeting for a list of residents and that he passed this information on to Mr Black and that at the next TCG at 05:50 he still had not acquired this list from anyone. Mr Black has no recollection of being asked for this information. It is clear from the evidence of both Mr Layton and Mr Rumble that there was no sense of urgency around this request and Mr Layton did not record any such requests in his contemporaneous notes. Mr Rumble gave evidence that Nick Layton raised this issue with him but it was not until after he attended the 07:10 TCG meeting that he made any requests of Robert Black and Teresa Brown and this information was supplied at 07:56.

---

[34] TMO0084032 shows examples of these records of information that were recorded by TMO staff at the rest centres.
[35] RBK00014629 and LFB00024371
[36] Teresa Brown Transcript 16th November p77

34. Mr Layton's evidence was that he has no recollection of being asked for plans prior to his departure at 07:00. He stated in evidence that if the LFB had been asking for plans they had not made those requests to him: *'If they had, they weren't made to me'*[37]. There is no record for any request for plans in either the first, the second or the third TCG meeting according to the Roe Log. According to the Roe Log, plans were previously discussed, although not during a TCG. At 04:53 there is the first note in the log in relation to plans which states '*CU staff report building plans should be in fire box in lobby*'[38]; suggesting, there have not been any previous attempts to locate them. There was no premises information box at Grenfell Tower, as was recorded on the ORD. The ORD was incomplete, there were also no plans stored on the ORD. At 06:13 in the Roe Log there is a note '*Will attempt to locate plans*'[39]. There is no direct evidence of any specific requests for plans at any stage prior to this.

35. Mr Black confirmed in evidence that he has no recollection of being asked for plans. There is no contemporaneous note of him being asked to provide plans. The only evidence of Mr Black providing plans is an email he sent to RBKC's Building Surveyor John Allen, from whom there is no evidence, but who was in attendance to assess the structural integrity of the building. The assortment of emails that have been produced by the Inquiry show a number of discrepancies with respect to time, as can be seen most notably in the email referred to above, disclosed by RBKC[40] as part of an email chain. This suggests Mr Black forwarded plans to John Allen at 05:16, impossibly, one hour before he received originally the email from David Noble at the time shown as 06:14. TMO has produced evidence to the Inquiry demonstrating that the correct timing for this first email was 06:16 not 05:16 and if that is correct, Mr Black sent plans to Mr Allen within 2 minutes of receiving them. TMO has highlighted further anomalies where emails produce by the Inquiry may bear the wrong times[41]

[37] Transcript Nicholas Layton Day 74, p74
[38] Roe Log MET00015755_0004
[39] Roe Log MET00015755_0005
[40] RBK00001468_0001
[41] e.g. TMO10036956_0001, TMO 10048901_0001, TMO10031176_0004

36. The Chairman may feel, that the timings of when certain emails were sent or forwarded between recipients is not a matter that he needs to make a finding on specifically. However, if this is required in order to establish these timings accurately there will need to be a forensic examination of when emails were sent or forwarded along with the issue of any delay of email traffic in reaching recipients on the night. It appears that the Inquiry has also not been provided with any emails from the LFB that deal with correspondence to Thomas Goodall identified as the LFB single point of contact for emails nor any between LFB staff and Council representatives on the night of the fire. Teresa Brown has identified 2 other fire fighters and provided their email addresses in her witness statement[42] with whom she says she had contact on the night that could be explored if it is concluded that further details are needed in order to establish this timeline of communications. For these reasons we submit that it would not be safe to make findings in respect of any specific times that information was provided and as a result what was requested.

6. Evacuation of residents

37. The Inquiry has heard detailed and harrowing evidence of the evacuation of residents during the course of the fire and will no doubt be assisted by the record of those leaving the building caught by the CCTV in operation in the lobby[43]. We respectfully submit that you can and should make findings of fact on this Issue.

Conclusion

38. The Inquiry has achieved a huge amount in the months since it began in May of this year. The evidence of those who were inside and around the Tower that night and the expert analyses already completed paint a vivid and haunting picture of the events of

[42] TMO10048960 para18 Vincent Bell and Chris Lines.
[43] MET00016072

14th June 2017. This has provided invaluable information to inform the Inquiry's investigation.

39. However, we respectfully submit that further detailed analysis is required to establish exactly what happened when the fire spread back inside the building; how internal compartmentation failed; and how fire and smoke spread and affected those who were inside Grenfell Tower. This should not preclude the Chairman from making findings wherever he is able at this stage, balancing the need to do so against the value of further investigations to achieve reliable conclusions. We submit that the Chairman can and should make significant findings at the close of Phase 1 in relation to the issues of how and where the fire started, how the fire spread from its seat to the exterior of the building together with the fire and rescue efforts and evacuations on the night. This is in the hope that recommendations can also be made that may be of importance to the safety of residents living in high-rise accommodation around the UK.

Kennedys LLP

6th December 2018